



Partners in Population and Development (PPD)
A South-South Initiative
Permanent Observer at the United Nations

COUNTRY REPORT

BANGLADESH

South-South Collaboration in Capacity Development

**Lesson Learnt from
Successful Interventions**

Introduction

During the last three decades, Bangladesh has made significant progress in many areas including an increase in contraceptive prevalence rate (CPR), increase in life expectancy, increase in literacy rate, decline in infant and child mortality, decline in poverty, decline in unmet need for family planning, etc. Bangladesh has achieved progressive gains in the broad sphere of reproductive health, family planning, immunization and poverty reduction. The remarkable success achieved by the Bangladesh Population Program is a consequence of integrating population with development plans. Under the integrated approach of population and development, national policies on population, Health, Women, Maternal Health, HIV/AIDS and STD, Children, Environment, Food and Nutrition have been formulated. Strategies, frameworks and programs for economic growth, poverty reduction and social development, reproductive health, Behavior Change Communication (BCC), Gender equity, Health, Nutrition and Population Sector have been developed.

The government's policy of health, nutrition and family planning services is based on the principles of universal coverage and accessibility; optimum utilization and development of human resources; appropriate use of technology; gender equity; improvement of the quality of life and promotion of health, nutrition and population services as an integral part of overall socioeconomic development. NGOs and private-sector involvement in health, nutrition and population services is being encouraged.

Bangladesh has been passing through a critical phase of fertility transition. Fertility has declined sharply, from 6.3 in 1975 to 3.0 in 2004. During this period, fertility declined rapidly in the late 1980s and early 1990s, and plateaued at around 3.3 for most of the 1990s. The 2004 Bangladesh Demographic Health Survey data indicates that after almost a decade long stagnation, the TFR declined slightly from 3.4 to 3.0 between 1993-94 and 2004. The Total Fertility Rate (TFR) for rural women is higher than that of urban women. On average, rural women give birth to 0.7 children more than the urban women.

The contraceptive prevalence rate in Bangladesh has increased from 8 percent in 1975 to 58 percent of currently married women in 2004. This translates to more than a sevenfold increase. The increase in the use of modern methods is even more dramatic—a more than nine-fold increase (from 5 to 47 percent) in three decades. Between the 1999-2000 BDHS and the 2004 BDHS, overall contraceptive use increased by 4 percentage points, from 54 to 58 percent of currently married women. This increase has been almost entirely due to the higher use of modern methods, namely, the pill and injectables. Condom use has remained unchanged since the 1999-2000 BDHS. A decade-long decline in the use of long-lasting contraceptive methods (Sterilization, IUD, or Norplant) continues.

Bangladesh has not experienced any substantial rise in age at marriage for women, nor in age at first birth. The female mean age at marriage was 19 years in 2001, registering an increase of only one-year from the census ten years before. As a result, women under age 30 account for three out of four births—a higher proportion than generally found in the developing world. This pattern of fertility in Bangladesh is due to the high level of adolescent fertility, which has failed to decline over the past decade. At present, because of the young age structure of the Bangladesh population, 30 percent of all births are to teenage mothers.

The recent studies show that the higher rates of TFR among the poorest. The difference between the richest and poorest is also pronounced. Fertility is negatively related with wealth; according to 2004 BDHS, the disparity in fertility between women in the poorest and richest quintiles is 1.5 children per women. However, the equity ratio (poorest/richest ratio) indicates that modern contraceptive use is quite equitable in Bangladesh, more so than other services. It has remained fairly unchanged, with use among the poorest households being about three quarters of that among the richest households. However, in 2004, the equity ratio was 0.89, more equitable than in 1999-2000.

The 2004 BDHS shows eleven percent of married women in Bangladesh having an unmet need for family planning services—5 percent for spacing purposes and 6

percent for limiting birth. Another 2 percent of currently married women had the last pregnancy while using a contraceptive method. Thus, if all married women who say they want to space or limit their births were to use family planning methods, the contraceptive prevalence rate would increase from 58 percent to 71 percent. Currently, 84 percent of the demand for family planning is being met.

Fertility varies widely by six administrative divisions of the country. Sylhet and Chittagong division have the highest TFRs (4.2 and 3.7, respectively), while the lowest TFRs are in Rajshahi and Khulna (2.6 and 2.8, respectively). Geographic disparities persist, with Sylhet division and Chittagong division (to a lesser degree), lagging behind other divisions on many of the health and family planning indicators. There are paradoxes within these broad inequities. For example, Sylhet has a much later age at marriage and age at first birth than Khulna and Rajshahi, but it has much higher lifetime fertility, additionally, household economic status is relatively high in Sylhet.

Comparisons of mortality estimates over time show that declines in child (age 1-4 years) and under-five mortality in Bangladesh. Between the two most recent five-year periods, there was a 20 percent decline in child mortality and a 6 percent decline in under-five mortality. Under-five mortality in Bangladesh declined by a third, i.e., about 4.1 percent per year, which compares well with the required annual decline of 4.3 percent needed to achieve the MDG of a two-third reduction in under-five mortality by 2015 from 1990 levels.

The mortality risk of children is associated with the economic status of the household. All childhood mortality rates are highest for those in the lowest wealth quintile. But there were encouraging falls in under-five mortality among the poorest quintile recently. According to BDHS 1996-97, children in the poorest quintile households suffered 83 percent higher mortality than children in the richest households. In the BDHS 1999-2000, this inequity had risen to 95 percent higher mortality among the poorest households. But recently this inequity had fallen.

According to BDHS 2004, children in the poorest quintile household suffered 68 percent higher mortality than children in the richest households.

There has been significant improvement in vaccination coverage in recent years. The proportion fully vaccinated among children age 12-23 months has increased by 13 percentage points between 1999-2000 and 2004 (from 60 to 73 percent). Closer examination of the data by types of vaccines indicates that this trend is entirely due to a reduction in dropout rates from the first to the third doses for polio and DPT vaccines.

The immunization program is a good example of a potentially equitable preventable service. However, children in the poorest economic quintile were less likely than those from the richest quintile to be fully immunized. There was encouraging improvement of full immunization among the poorest quintile recently. For example, according to BDHS 1996-97 and 1996-97, the ratio of poorest to richest was 0.69 but in the BDHS 1999-2000, this inequity had fallen to 0.66.

Currently the maternal mortality ratio is 3.20 per 1,000 live births. The five year period estimates of Maternal Mortality from the deaths of sisters show a steady decline from 5.14 per 1,000 live births in 1986-91, to 4.85 in 1991-1996 (5.6 percent decline in 5 years) to 4.49 in 1996-2001 (7.6% decline in 5 years). For the three years before the survey (1998-2000) the estimate was 4.00.

Government of Bangladesh has prepared Poverty Reduction Strategy Paper (PRSP) under full government ownership and direction to substantially reduce poverty within the next generation. Twelve sectors have been identified for the Bangladesh PRSP and the Government strongly emphasized its commitments, especially by focusing on poverty reduction, education and health. Bangladesh has also linked population control with reducing poverty as each has a mutual effect on the other and incorporated population issues into the PRSP. The commitment of Bangladesh to achieve the ICPD and MDGs was also taken into consideration in formulating the

PRSP and a mapping of PRSP thematic sectors indicates that most of the sectors address the MDGs and ICPD in some form or the other.

Bangladesh is constitutionally committed in promotion of international solidarity and cooperation, especially among the developing countries. Bangladesh has always sought to create congenial friendly relations among all peace-loving nations. It has continued to play a positive and constructive role in the international arena including the OIC, SAARC and the United Nations. The foreign policy of Bangladesh is based on, among others, respect for other nations and support to all just causes. Bangladesh seeks partnership with the global community for promotion of peace, and development and also gives due emphasis on South-South Cooperation, which lead to cementing a strong solidarity among the southern nations.

Government of Bangladesh played a pioneering role with other interested partner countries from the inception of Population and Development (PPD). South-South Collaboration was set up and Bangladesh has signed to PPD's mission and goals along with nine other countries: Colombo, Egypt, Indonesia, Kenya, Mexico, Morocco, Thailand, Tunisia and Zimbabwe. Bangladesh continues to extend necessary technical, financial and logistic support and promote PPD's mission to expand and improve South-South collaboration in the fields of family planning and reproductive health. With its different reputed institutions, Bangladesh has experiences of applying capacity development approach through training, workshop or dialogue on different issues of sexual and reproductive health, gender and development. Different participants from Cambodia, China, Egypt, Iran, India, Indonesia, Myanmar, Nepal, Pakistan, Thailand, Vietnam, and Philippines including Bangladesh attended these programs. They shared their experiences and gained knowledge.

This paper documents the experiences gained and lessons learned in capacity development for family planning and reproductive health in Bangladesh through South-South collaboration. The term 'capacity development' refers to the broad definition as stated in the UNFPA evaluation report entitled Support to Capacity

Development: Achievement and Challenges as ‘the ability of individuals, organizations and systems, including networks of organizations, to perform in support of their development objectives’. The South-South collaboration in capacity development is also defined as the exchange of expertise, knowledge, information and products between individuals and organizations from developing countries, disregarding the origin of funds for financing the activities. While documentation of lessons and experiences in family planning and reproductive health continues to be the main way of monitoring progress in capacity development in developing countries, the study of a few initiatives also has a long pedigree. Different South-South collaboration activities include formal and on-the-job training, field visits, consultancies, technical assistance, policy dialogue and commodity exchange and implementation by government agencies, non-government agencies, universities, professional associations and private sector. These initiatives have always been assessed by carefully designed prospective studies with a focus on use-effectiveness. Innumerable follow-up activities or studies have been conducted and a variety of cross-sectional approaches, involving retrospective questioning about recent past family planning and reproductive health behavior, have been developed and applied. For example, in Bangladesh different demographic and health survey reports (BDHS 1993-94, 1996-97, 1999-2000, 2004) have been published to assist policy makers and administrators in evaluating and designing programs and strategies for improving health and family planning services.

The capacity development initiatives through South-South collaboration addressed issues that reflect the needs of individuals and community. At this point, systematization of the implications and effects of South-South collaboration on policy planning, program design, and implementation, and human resources development are necessary. Successful use of capacity development initiatives depends on many factors. Important influences no doubt include the degree of changes and improvement as a result of the collaboration through individuals and institutional provider. Country-specific follow-up and observation of collaborative efforts will be crucial to understand why they have been able or not to transfer knowledge and skills to their respective workplace.

Methodology

The methodology to prepare a country report on Capacity Development through South-South collaboration was designed in consultation with the Partners in Population and Development (PPD). Quantitative and qualitative data were collected through the following instruments and activities.

- desk review of literature, available documents, relevant publications, annual reports, project progress reports, policies and strategies
- In-depth interviews with managers and service providers of service providing institutions and service recipients

According to the agreed methodology, four categories were identified for data collection: (i) Individual as provider of collaboration, (ii) Institution as provider of collaboration, (iii) Institution as recipient of collaboration, and (iv) Individual as recipient of collaboration. Since most of the South-South collaboration targets institution, it is very unlikely to obtain individual as recipient of collaboration. The following table summarizes these categories:

Type of Capacity Development	Type of collaboration		
		Provider	Recipient
	Institution	1-4 cases	2-8 cases
	Individual as institution's member	1-4 cases	Unlikely

The following four institutions were identified purposively as cases of South-South collaboration in the field of reproductive health and population in Bangladesh.

- a) ICDDR,B: Centre for Health and Population Research
- b) BRAC :**
- c) FPAB: Family Planning Association of Bangladesh
- d) ICMH: Institute of Child and Mother Health

Primary data was collected from the key informants who participated in the collaboration activities of the above mentioned four institutions according to the following criteria:

- (a) Collaboration provider (both types): The officers in charge of the experiences four institutions
- (b) Case of collaboration recipient (individuals): Individuals who benefited from the experiences of four institutions. Since most of recipients are from outside Bangladesh, information was collected from a few individual recipients

In addition, a few Bangladeshi participants were interviewed to obtain feedback of the BKKBN course under the Local Initiative Project (LIP). BKKBN and LIP organized the program during the years 1987 to 1993 under USAID support. Most of the participants are currently working with the family planning program. Only a few are working in the same field and we tried to discuss with three participants to obtain information on the LIP-BKKBN training. However, they could not remember all related issues due to the long time gap.

Results

Institution-wise description of collaboration -

ICDDR,B: Centre for Health and Population Research

ICDDR,B organized the following international training courses for the participants of developing countries.

- Improving effectiveness, quality of services and sustainability in reproductive health programs through operations research
- Workshop on Reproductive Health: Rhetoric into Reality through Innovative Approach

International training course on improving effectiveness, quality of services and sustainability in reproductive health (RH) programs through operations research were held each year from 1997 to 2003. At different times, five courses were organized.

The courses were organized at ICDDR,B Dhaka and Matlab training center. Methodology included didactic lecture sessions followed with discussions, group work and group presentations, and field visits to health facilities and to the community. Discussions and field demonstration of BRAC micro-credit program and RH activities were also undertaken.

Specific objectives of the course:

- to identify mutually reinforcing and interactive relationship between population development and RH with challenges and opportunity
- to familiarize participants with Matlab MCH-FP successful interventions
- to acquaint participants with operations research activities for policy formulation on population and RH
- to develop understanding of the importance of community participation and “bottom up” planning for sustainability of RH-FP program
- to develop skills for successful implementation and sustainability of RH and FP program through innovative rural development activities

About 15 topics were addressed among which safe motherhood, FP Gender and health equity, quality of care, and program sustainability. Required readings such as publications and documents that were delivered to trainees in hard copy were inadequate.

The course participants were from 18 developing countries. The countries were Pakistan, India, Ghana, Bangladesh, Indonesia, Malaysia, Egypt, Tanzania, Philippines, Thailand, Vietnam, Mexico, Zimbabwe, Zambia, Kenya, Ethiopia, Uganda, and Senegal.

Out of six Bangladeshi participants, three participants were interviewed. All of them are still working with the relevant fields. According to them, quality of the course was good, course objectives were reached for most of them, and course content was rated very well. They reported that experience and knowledge gained from innovative approach was helpful to utilize in their work situation.

A two week international workshop on Reproductive Health: Rhetoric into reality through innovative approaches was organized at ICDDR,B. Two courses were organized. The workshop aimed to achieve the following five specific objectives:

- to identify mutually reinforcing and interactive relationships between population development and reproductive health with challenges and opportunities
- to familiarize participants with evolving interventions gained from the experiences of ICDDR,B's Matlab Maternal, Child Health and Family Planning Project, MCH-FP Extension Project and the Family Planning success story of Bangladesh
- to acquaint participants with operations research activities into the process of policy formulation in the field of population and reproductive health at the centre
- to develop an understanding of the importance of and strategy for community participation and "bottom up" planning for achieving

long-term sustainability in Family Planning and Reproductive Health performance including safe-motherhood

- to develop skills for initiating innovative rural development activities for successful implementation and long-term sustainability of family planning and reproductive health program under government and NGO initiatives

A framework was developed for the participants to not only enhance their knowledge base but also to enhance operations research and intervention issues contributing to the improvement and implementation of reproductive health programs. The workshop addressed the topics on reproductive health and on areas of mutually interactive relationship between population, reproductive health and sustainable development. The workshop used both concepts and application of reproductive health and related issues that are prevailing in the third world countries. Both public and private/NGO sectors related to RH programs have been shown to the participants to have program level knowledge and research question in the practical application of RH and related issues.

The workshop used different training methods and these were: Lecture-multi media presentation, overhead presentation, group work and group presentation, field visit, sharing the experience of field visit, discussion, case study-country presentation, review session, individual presentation, brainstorming session and video film show.

The workshop participants were from 18 developing countries. The countries were Bangladesh, India, Indonesia, Thailand, Vietnam, Myanmar, Cambodia, Philippines, Kenya, Tanzania, Zambia, Zimbabwe, and Pakistan.

Out of three Bangladeshi participants, one participant was interviewed. The other two were not available. According to the participant, quality of the workshop was good, workshop objectives were lengthy and workshop content was rated very well. According to him, some topics like sustainability, plateauing of TFR, practical demonstration need more time to discuss. The course had too tight a training

schedule from morning to evening with no open session for the participants. However, the experience and knowledge gained from the workshop was helpful to utilize in his work situation.

According to the course Directors, the participants were highly satisfied and they rated the course very useful. They found that overall objectives of the workshop were to a great extent achieved. They thought the experience and knowledge the participants gained from innovative approaches undertaken by ICCDR,B in Matlab, Mirersarai and Chokoria would be helpful to replicate in their respective countries. However, the course director thought that training methodology could be further refined to make it more interactive and participatory.

Family Planning Association of Bangladesh

Development of training Curriculum:

Family planning Association of Bangladesh (FPAB) developed a training curriculum for the Imams and Religious leaders on Reproductive Health. The training covered the following issues:

- The rules, age, responsibilities and physical and economic fitness of men and women for marriage in the light of Islam
- The responsibilities of husband and wife in their conjugal life, particularly the responsibilities of husband, according to Islam
- The responsibilities of parents in Islam, particularly having children and nurturing the children
- To have children or not to have
- RH, family planning and FP methods
- Primary health care, sanitation, using safe water and immunization
- Permissibility of family planning according to Islam
- FP service facilities and availability

The training course used standard training methodology. It covered class lecture on topics using OHP, slide projector, and paper sheet, marker pen, blackboard. The

course also used video/film show, flipcharts, reciprocal discussion, role play and exercise. More over, printed materials were distributed to the participants.

With the support of Partners in Population and Development (PPD) the training curriculum were reviewed at Al-Azhar University from March 18-21, 2001. Support to Muslim Religious Leaders for the Promotion of Reproductive Health and Family Planning among Muslim Community of Partner countries

FPAB organized a course on 'Support to Muslim Religious Leaders for the Promotion of Reproductive Health and Family Planning among Muslim Community of Partner countries' in collaboration with (i) China Family Planning Association (CFPA) (ii) Family Planning Association of India (iii) Planned Parenthood Association of Thailand and (iv) International Islamic Center for Population studies and Research (IICPSR), Cairo Al-Azhar University. The project was funded by Partners in Population and Development (PPD).

Purpose of the course:

To increase the utilization of reproductive health services amongst the Muslim population in the selected partner countries

Stakeholders:

Primary stakeholders for the project were women of reproductive age, adolescents (adolescent students in the Madrasah) children and men. Secondary stakeholders were religious leaders and imams, members, staff of the implementing agencies such as FPAB, CFPA, FPAI, PPAT in Thailand. Key stakeholders were also concerned officials of Family Planning Associations, Government RH-FP managers of the respective country/agencies and Partners secretariat concerned officers/donors.

Through this project six senior level religious leaders received three weeks trainers of training (TOT) at International Islamic Center for Population studies and Research (IICPSR), Cairo Al-Azhar University. The TOT was a comprehensive

training on RH-FP in the light of Islamic teachings. The training prepared the participants as Master trainer.

Country level TOTs were organized under this project. The master trainers who received TOT in Al Azhar University organized country level TOT programs. A seven day country level TOTs were separately held in Thailand, China, India and Bangladesh. Thirty religious leaders (male and female) from Narathiwat and Yela provinces in Thailand participated in the TOT program. The program was held from March 18-25, 2002 in Narathiwat, the southern most city of Thailand. The PPAT and FPAB jointly organized the program. Narathiwat Islamic council provided all out support to hold the program. Similarly, thirty religious leaders (male and female) from Xinjiang region of China participated seven days TOT program at Urumch, Xinjiang, China. The participants were imams/Muslim religious leaders, women representatives, teachers and Islamic thinkers. The program was held from August 12 to 18, 2002 in Urumchi. CFPA and FPAB jointly organized the program. Urumchi Islamic Council provided all out support to hold the program. About thirty Islamic scholars, religious leaders, imams, opinion leaders of Muazffarnagar, UP in India participated in TOT program for a period of seven days, starting from May 20 to May 27, 2002. FPAI organized the program. FPAB provided the technical and academic support. In addition, one scholar from IICPSR, Al Azhar University attended the training as resource person. FPAB also organized TOT for thirty religious leaders of Barisal division of Bangladesh. The program started from March 13-19, 2003.

The TOT training helped the participants to have broader understanding of Islamic interpretation of RH-FP and women status. The participants would be able to train other religious leaders who will form a group to promote RH-FP neutralizing all types of opposition if any in the Muslim communities in their locality. They will enhance the male involvement with program of RH-FP in their communities. They with their follow religious leaders will closely work with RH-FP program and will play an advocacy role to promote RH-FP with the spirit of ICPD and ICPD plus action plan.

According to the organizers of FPAB, the FPAB Islamic research cell is educating Bangladeshi religious leaders on FP-RH through their work and many Muslim clerics (Imams) are supporting family planning work and delivering speeches on RH in Friday prayers. He thought that it is necessary to expand the program to educate 2.5 million Madrasah students and share the program with other Muslim and non-Muslim countries having Muslim population.

Institute of Child and Mother Health (ICMH)

Institute of Child and Mother Health (ICMH) organized ‘Global Leadership Development Program (GLP) in reproductive health special focus on safe motherhood in developing countries’ with the technical support from PPD. The course was designed to address the policy and program perspectives of safe motherhood with special reference to emerging scientific evidences on safe motherhood and their implications. The state-of-the-art knowledge and a scope to learn about the latest developments in safe motherhood approaches were offered within the broader perspective of reproductive health, population and development. First two courses were organized for senior level program managers in the field of RH representing different countries of Asia while a third course was organized for senior and mid-level program managers.

Experience sharing was the core of the courses. The participants and resource persons shared experiences by lectures, group discussions, panel discussions, poster presentations, case studies and field visits. The participants shared the success and failure stories, identified the strengths and weaknesses, the barriers and innovative interventions of the reproductive health programs of different countries. Replicability of policies and programs in individual country situation was also a major concern. Shared experiences were analyzed in-depth and compared with their own country profiles by the participants in groups.

The first GLP course was of three weeks duration and held from February 07, 2001 to February 27, 2001. The experiences of the first course directed the organizers to

concise the duration for two weeks from June 16, 2001 to June 30, 2001. Both the courses were held at the ICMH with field visits in different potential government and non-government organizers working to ensure safe motherhood in Bangladesh. The third GLP course was of sixteen days duration and held from April 06, 2002 to April 21, 2002.

With the experiences from the first GLP course, and also on the basis of the participants' recommendations, the organizers redesigned some of the modules for second course after discussion with recourse persons. Since language was identified as one of the barriers, the organizers tried to change the method of session presentations in the second course to make the sessions more visual as well as more participatory.

The number of participants in the first course was 25 and the participants were from Bangladesh, China, India, Indonesia, Iran, Nepal, Pakistan, and Philippines. Thirty three participants from 9 different countries participated in the second course. The participating countries were Bangladesh, China, India, Indonesia, Nepal, Pakistan, Philippines, Thailand, and Vietnam. The number of participants in the third course was 25 representing 8 countries; these were Bangladesh, China, India, Indonesia, Iran, Myanmar, Pakistan and Thailand.

Among the three courses, 18 participants were from Bangladesh. They were from government and non-government organizations. Four of them were interviewed to obtain feedback. All of them appreciated the courses and observed the importance of sharing experiences and formulation of strategies. Some them felt that the course helped in capacity building on training and communication, coordination, collaboration and net-working. Few of them also thought that GLP training had a good impact on planning and analytical capacity. Almost all of them reported that GLP training failed to develop net-work among the participating countries or participants. They thought that follow-up training or initiating particular activities could help the GLP participants to exchange views on RH policy issues. They also felt the necessity of initiating activities among the participants for the benefits of RH-FP program.

BRAC, Bangladesh

BRAC is one of the world's largest NGOs concerned with sustainable social and economic development. BRAC is working by focusing on people centered empowerment and poverty alleviation by organizing landless people for education, training, credit, income generation, health and social development. BRAC's creative and innovative approaches to the special needs of women and children have complemented the general rural development programs.

In order to provide training to program participants to BRAC staff and to the staff of other NGOs, BRAC has created 14 Training and Resource Centers throughout the country. In 1991, BRAC established the Centre for Development Management (BCDM) to offer short courses for middle and senior level participants from development organizations, including those from other countries.

BRAC is involved in Global partnership for NGO studies, education and training which offers rigorous professional degree programs that are specifically designed for NGO leaders and managers. The program offers two academic programs: (i) Postgraduate Diploma in Bangladesh and Nepal, and (ii) Master degree program in Bangladesh and the US. Initiated in 1997, both the programs recruit experienced and committed NGO staff persons who wish to further develop their leadership and management competencies through a format that combines classroom instruction with practical application and reflection.

The postgraduate diploma program is an 18-credit curriculum, which may be completed in about seven months. It consists of three phases:

- Classroom instruction and field learning in Bangladesh and Nepal (about three months on campus)
- Practical on-the-job application and reflection of learning in the student's own NGO or organization of student's choice (about three months off-campus)
- And a final synthesis and evaluation seminar (about two weeks on campus)

The content of the program addresses very specific and often technical skills needed by development workers, managers and leaders while broadening the participants' self-awareness, conceptual understanding and vision.

Students who meet the admission requirements for the masters and successfully complete the postgraduate diploma program may continue in the masters program. The masters degree provides additional depth in such subjects as strategic management, human resource management, and training of trainers. It also enables students to develop applied research skills considered essential for evaluating the impact of development programs and assessing the extent to which new issues and needs demand new policy and program responses.

The masters program begins shortly after the completion of the postgraduate diploma's synthesis and evaluation seminar in Bangladesh. The program starts with a course in applied research for NGO managers at BRAC, followed by a three-month research practicum during which data collection for the masters continues. The next phase is completed at the campus of the School for International Training (SIT) in Brattleboro, Vermont, USA. Students write their masters research papers, take additional courses to complete their studies and present their papers to their faculty and peers.

Participants came from different countries and these countries included Australia, Belgium, China, Cambodia, Ethiopia, India, Japan, Kenya, Laos PDR, Mexico, Morocco, Namibia, Nepal, New Zealand, Peru, Philippines, Pakistan, Sudan, Swaziland, Thailand, USA, Zimbabwe and Bangladesh.

Local Initiative Project (LIP)

With the support from USAID, the local Initiative Project (LIP) was developed. The project was planned to develop Bangladesh Family Planning program personnel capacity, primarily at Upazila (sub-district) level by collaborating with Indonesian Government (BKKBN) to facilitate a structured learning process of Indonesia's success. Rather than thinking of it primarily as an overseas training activity, more

direct focus was given on program implementation after their return from Indonesia. Moreover, the program tried to train all the related sub district level officials including community leaders to train a critical mass of persons from the same geographical area rather than just a single individual. Under the terms of BKKBN and LIP project, teams of Upazila family planning and community leaders visited Indonesia to observe the family planning program and plan and implement innovative local projects. LIP was contracted by USAID to assist in planning and implementation of the project.

The BKKBN organized the training program in Indonesia in close collaboration with LIP of Bangladesh. The program was treated as a learning process. It is neither a normal study tour nor a traditional training program. The program tried to present structured observation of selected elements of the family planning program of Indonesia. The basic objective of training program was to help participants to think in depth, from a new perspective, about their own situation, as a result of having seen a different approach (Indonesia's) and having discussed what they observed with Indonesia and with each other. The training encouraged participants to come up with creative ideas to improve their own program. It comprised three interrelated parts and these were: Brief orientation, Field Observation and Development of action plan.

From 1987 to 1993, fifteen groups of 24 participants underwent study tours in Indonesia and returned in Bangladesh to implement local-level projects that they had planned in Indonesia. Four-person teams of people from four upazilas plus district-and central level support personnel (a total 24 people per group) were selected by the Bangladesh Government. Each upazila team comprised with two community leaders and two family planning program personnel. LIP provided support to Family Planning Directorate of Ministry of Health and Family Welfare in all stages of selection and orientation for the participants prior to departure.

BKKBN designed and conducted a three-week study tour. It comprised a two and half day orientation in Jakarta; two-week field visits in two provinces (primarily at sub-district, village and sub-village levels); and a 3-day workshop to prepare actions

plans for implementation when they returned home. The participants left BKKBN with a draft upazila action plan.

Immediately upon return to Bangladesh, the participants attended a two-day workshop with officials of the Family Planning Directorate of Ministry of Health and Family Welfare to present their action plan for approval of required budget. LIP organized the workshop and provided the first installment to them to implement their action plans. However, the Upazila teams were encouraged to provide a minimum of 10% of the amount contributed by the project. LIP assisted Family Planning Directorate to monitor the action plans in the field. LIP conducted different types of supporting activities to enhance the likelihood of Upazilas' successfully achieving their objectives and sustaining interest.

The program tried to develop action plan. The action plan of each upazila was prepared jointly by the upazila team. Implementation of the plan was a shared responsibility of the upazila team. The plan included important family planning components:

- Inter-sector coordination
- Involve female volunteers
- Introduce Eligible Couple Mapping (ELCO)
- Emphasis on motivation
- Community responsibility
- Linking beyond Family Planning activities
- Rewards for long-term achievement
- Involvement of local political and government infrastructure

The training follow-up was another important component. A regular follow-up of implementation of the action plan was an integral part of the training. This phase was managed under the guidance of LIP, and with support from a follow-up committee appointed by the Family Planning Directorate, Ministry of Health and Family Welfare. Each upazila team was expected to submit monthly/ quarterly reports with the joint signatures of the team members on prescribed forms. In these

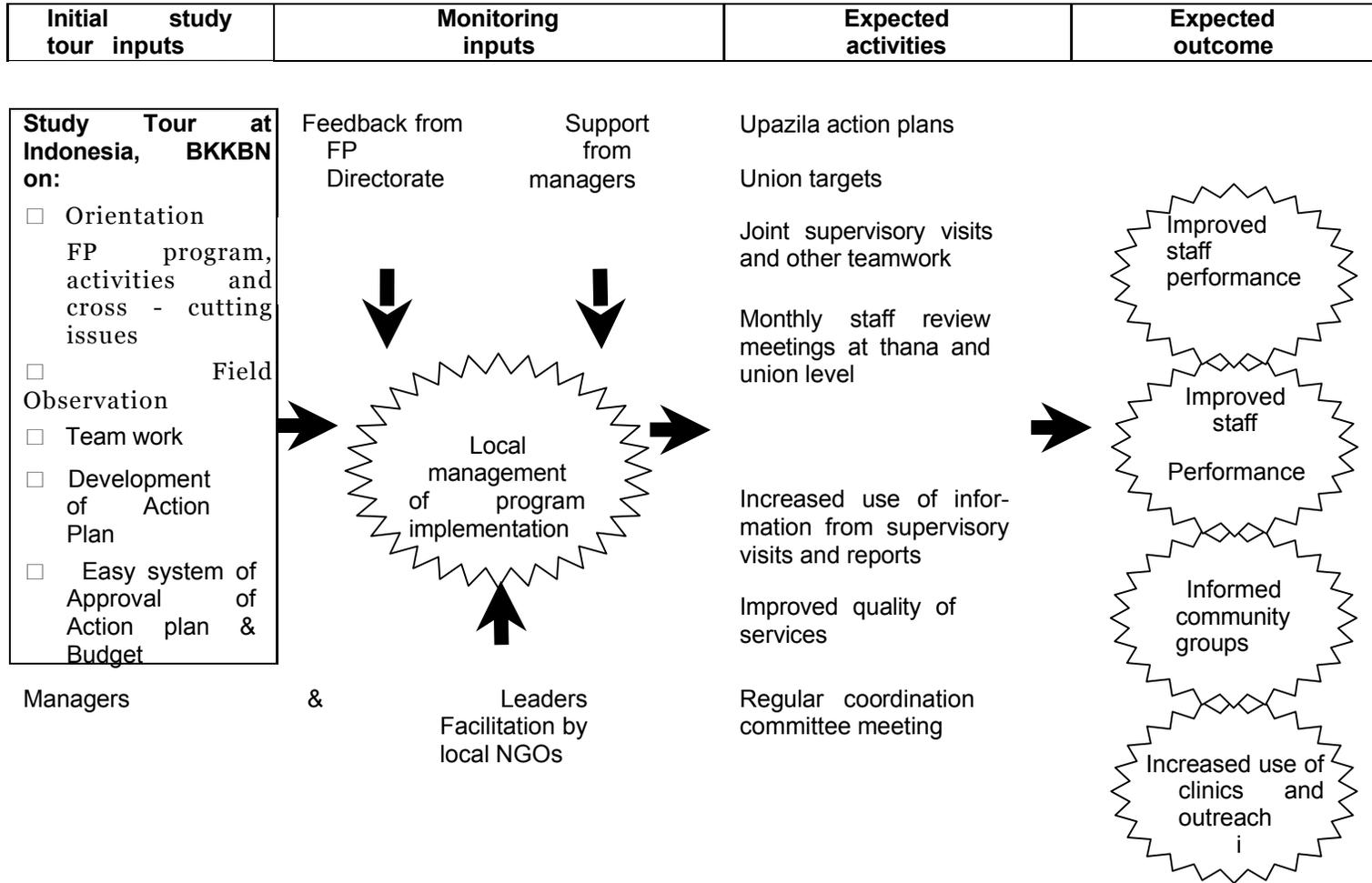
reports, they were supposed to note the progress made by them and impediments, if any, encountered. These reports were to be reviewed by the follow-up committee, and necessary action would be taken by the committee and feedback given to the concerned upazila teams.

Table-1 shows the framework analysis of the study tour. With regard to the conducting of study tour under BKKBN program, it is felt that the program, has generally given a chance to program managers and leaders to work in the field of family planning. The study has given chance to the participants to obtain the Indonesian experience with an opportunity of being abroad. It helped them to be creative in developing a plan that would succeed in improving the family planning program situation in their home sub-district. However, the follow-up of the program played a vital role in applying the experiences.

The trained managers agreed that the orientation sessions were helpful for teaching the necessary contents to the field staff that they learnt from the training. According to the trained managers, they could easily organize the implementation activities easily due to the initiating role of LIP. The LIP helped them in obtaining the required budget and also provided technical support in day to day implementation. In answering the question, “why was it successful?” one trained personnel replied, “LIP staff members frequently visiting the upazila insists that I organize the program and implement the action plan prepared by the trained managers of the upazila but recently there have been no activities because of an absence of LIP program”.

The trained managers were supposed to form teams consisting of the AHI, FPI, FWV, and SACMO/MA in each union to coordinate the implementation of the action plans at the upazila level. Nevertheless, no evidence of this activity was found in any upazila now. However, one trained manager reported that ‘the program was available earlier and we implemented with the support of LIP. Now there is no program and no budget is available to run the program’.

Table 1: Framework for Analysis of Study Tour Activities for Improving Upazila Family Planning Activities



Lessons learned and recommendations on capacity development

The main objective of this paper is to document experiences gained and lessons learned in capacity development in Bangladesh through South-South cooperation. Different institutes are participating in the capacity development. Among them, FPAB, ICDDR,B, ICMH, BRAC and LIP were actively engaged in capacity development for family planning and reproductive health in Bangladesh. Many Bangladeshis are going abroad for capacity development. We reviewed the Indonesian program to develop capacity at the upazila level organized through LIP. In the present study, these institutions were purposively selected to document capacity development through South-South cooperation and collaboration. The information was obtained from the providers of these institutions and the service recipients. Since most of the service recipients were from outside Bangladesh, only a few available service recipients were interviewed to obtain feedback from them.

At the individual level, according to a few Bangladeshi participants, the courses were beneficial for imparting their job responsibilities. They are working in the relevant field and course quality and coverage of the course were consistent with the participants' remarks. Attainment of personal objective was excellent. However, it is also necessary to obtain feedback from participants who attended from other developing countries. The participants appreciated the follow up activities after the training program but due to lack of local initiatives it was recently found non-functional.

All of these institutions that offered courses for the participants of developing countries are very capable in imparting training. They successfully completed the courses. The institutions were benefited from the experience of different participating countries. The institutes had generated capable teams with tested curriculum for imparting training. However, the institutions were financially dependent on the international cooperation agencies or donors. The analysis also shows that follow up action of Indonesian program activities were active due to the local initiatives of a private agency and the program become inactive after withdrawal of the initiatives of the private agency. The team observed the following strengths:

- the institutions have multi-disciplinary background scientists to implement this kind of program
- the institutes infrastructure is supportive of the community
- the institutes were able to mobilize collaboration from other organizations for joint utilization of resources

The following lessons were learnt by the institutions during implementation

- Identified strengths and weakness of the RH-FP program
- Identified success stories and experiences of different developing countries with similarities
- Courses were consistent with participants' view
- Course objectives were mostly met

No important weaknesses have been identified through this exercise. However, the team observed that strengthening the follow-up activities would likely optimize planning and implementation of the program.

Recommendations:

- To keep the course homogeneous, steps are needed to recruit participants from similar background
- Participants were able to take training materials to their country to eventually organize similar courses for RH-FP staff members. Participants should be helped in developing their own plan during the course
- The training institutions should devise and implement a follow-up and mentoring strategy in order to advise participants when encountering difficulties
- Participatory courses should be strengthened and attention should be paid to language proficiency
- Evaluation of participants' knowledge, new skills and capacity should be conducted at the end of each course
- Cross-cutting issues like gender issues must be integrated into the courses and innovative methodology should be developed, tested and introduced

- Absence of monitoring and supervision from the district and national levels affected the implementation of the training program at the upazila level and below. To implement the training program as per design, monitoring from the district and central levels is required.
- Absence of facilitation from any agency in the implementation of action plans affected the program seriously. The findings showed that the LIP staff facilitation in the implementation of the action plans and their regular visits influenced the trainees. Therefore, facilitation from a recognized agency may help the upazila managers implement the action plans.
- The findings showed that the absence of a standard procedure or guidelines led the trained managers to follow different processes in implementing the action plans. So, existence of a manual/ guidelines on the action plan-implementation process may help maintain a standard process.
- Some other fundamental constraints, such as absence of funds, affected the implementation of action plans. Therefore, the fundamental constraints should be resolved before a training program is initiated.
- Responsible persons from FP directorate should be assigned to follow up monitoring and review of the implementation of action plans.
- The role of the community in strengthening health and family-planning service delivery is important. Therefore, community leaders should be involved with the action planning and implementation process at the upazila-level and below.

Conclusion

Bangladesh has considerable experiences in implementing reproductive health including family planning program. A good number of institutions are engaged in the capacity building training program. Many participants from different countries

participated in training programs. Participants came from different countries and these countries include Australia, Belgium, China, Cambodia, Ethiopia, India, Japan, Kenya, Laos PDR, Mexico, Morocco, Namibia, Nepal, New Zealand, Peru, Philippines, Pakistan, Sudan, Swaziland, Thailand, USA, and Zimbabwe.

Training itself is not sufficient for implementation at the operational levels. The training program requires appropriate action developed for implementation at the field. These require formal understanding, instructions and approval of the government for effective implementation.

Budget and supplementary funding is another crucial component for operating the south-south collaboration. It is necessary that the funding agency takes the matter into consideration in supporting the countries to help share their best experiences and practices among each other.

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