Table 7. Number of clinic visits conducted in 1994 and number that would be conducted if unused time were reduced; and projected number of visits required in 2004, by trend in contraceptive prevalence rate; all according to type of clinic

<table>
<thead>
<tr>
<th>Type of clinic</th>
<th>Conducted in 1994</th>
<th>Required in 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Reduce unused time</td>
</tr>
<tr>
<td>Total</td>
<td>1,641,740</td>
<td>2,912,052</td>
</tr>
<tr>
<td>Family welfare center</td>
<td>1,110,364</td>
<td>2,125,673</td>
</tr>
<tr>
<td>Thana health complex</td>
<td>81,806</td>
<td>130,065</td>
</tr>
<tr>
<td>Satellite clinic</td>
<td>449,570</td>
<td>683,315</td>
</tr>
</tbody>
</table>

*We assumed that prevalence will increase from 46% to 63% (see: A. Barkat et al., Strategic Directions for the Bangladesh National Family Planning Program, 1985–2006, Ministry of Health and Family Welfare, Dhaka, 1996), that the demand for services other than family planning will increase in proportion to the demand for family planning services and that the method mix will remain unchanged.

ers were to increase the number of days and hours worked, the costs of the program could remain at the current level (or even fall) over the next 10 years. An important question is whether these changes are realistic, in that they assume an increased work effort on the part of fieldworkers. One way of answering this question is to compare government fieldworkers with fieldworkers from nongovernmental organizations who have similar salaries. Fieldworkers employed by nongovernmental organizations are less likely to take unauthorized leave and therefore spend more days making home visits than government workers; this suggests that it is not unreasonable to expect fieldworkers to work additional days. Moreover, family welfare assistants can increase the number of eligible couples for whom they are responsible by visiting more couples per day.

Not only must management be strengthened, but technical issues concerning the appropriate job of the family welfare assistant also need attention. For example, given that family welfare assistants spend a high proportion of their workdays traveling, alternative service delivery strategies should be considered that can reduce travel time and increase client contact time.

One such strategy would be a cluster visitation system. Another strategy would be for family welfare assistants to reorganize their work plans to target specific subgroups of clients who are most in need of their services. For example, women who get their pills or condoms from a source other than the family welfare assistant and clients who are established users of resupply methods might be contacted less frequently. Women who use clinical methods, especially those who have been sterilized, do not need to be visited frequently.

A reduction in time spent on visits to women requiring less attention will allow more time to be spent with nonusers, new users, and users having side effects and other problems. The government should consider revising visit guidelines to reduce the number of required visits for users of particular methods. In the last several years, the number of family welfare centers has expanded and the use of long-acting methods has stagnated. As a consequence, there is underutilized capacity in the clinic program. Existing facilities can therefore continue to accommodate client demand as the population of women of childbearing age grows, provided that women have reasonable access to these facilities. Decisions regarding clinic expansion should take into consideration that in the short run, these facilities are underutilized. Moreover, provision of long-acting methods can be expanded at low cost by using the unoccupied time of family welfare visitors. An important concern for the program, therefore, is how to encourage the acceptance and continued use of long-acting methods.

The existence of two overlapping systems of service delivery has important implications for the costs of family planning service delivery. Efforts to reduce costs per couple-year of protection must take this into consideration. For example, acceptors of methods at clinics also receive visits at home, and the home visit costs constitute a significant part of the total costs per couple-year of protection. If the number of home visits for clinic method acceptors were reduced, then the costs per couple-year of protection would decrease. However, this reduction of overlap will not lead to any reduction in overall costs per couple-year of protection for the home-visit program unless the time that the family welfare assistants save is redirected in ways that can increase contraceptive use and continuation rates, or the number of family welfare assistants is reduced.

The current structure of the family planning program has had remarkable success. The program has significantly increased awareness and use of family planning services. Moreover, the expansion of the home service delivery program has led to significant improvements in contraceptive use. However, challenges lie ahead, especially with regard to serving a growing number of married women of reproductive age under conditions of diminishing resources. This article points to areas that can be improved and to strategies that can be used to reduce costs. Changes in strategies and program structure should enable Bangladesh to make gains in contraceptive use while increasing use of long-acting methods without incurring significant increases in program costs.

References

4. Ibid.
13. M. B. Rahman, director, Population, Development and Evaluation Unit, Ministry of Planning, Dhaka, per-
(continued on page 145)