



USAID-DFID NGO Health Service Delivery Project

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Acronyms

ANC	Antenatal care	NGO	Nongovernmental organization
ANGEL	Adolescent Newly Married Girls Events of Life	NHSDP	NGO Health Service Delivery Project
ARI	Acute Respiratory Infections	PD	Project director
BCC	Behavior Change Communication	PNC	Postnatal Care
CAP	Community Action Plan	PPFP	Postpartum Family Planning
CEmOC	Comprehensive Emergency Obstetric Care	PoP	Poorest of the Poor
CHT	Chittagong Hill Tracts	QMS	Quality Monitoring and Supervision
CM	Community Mobilization	RH	Reproductive Health
COP	Chief of Party	RFP	Request For Proposal
CQI	Continuous Quality Improvement	SAA	Social Action and Analysis
CSP	Community Service Provider	SBA	Skilled Birth Attendant
CSR	Corporate Social Responsibility	SHCSG	Surjer Hashi Community Support Group
DGFP	Directorate General of Family Planning	SMC	Social Marketing Company
DGHS	Directorate General of Health Services	SRH	Sexual and Reproductive Health
DSF	Demand-Side Financing	SP	Service Promoter
DTC	District Technical Committee	TL	Technical Lead
ENC	Essential Newborn Care		
EmOC	Emergency Obstetric Care		
EPI	Extended Program on Immunization		
ESP	Essential Services Package		
FAM	Finance and admin. manager		
FP	Family Planning		
GBV	Gender-Based violence		
GIS	Geographic Information Systems		
GOB	Government of Bangladesh		
GMP	Growth Monitoring and Promotion		
HMIS	Health Management Information System		
ICAAP	International Conference on AIDS in Asia and Pacific		
IMCI	Integrated Management of Childhood Illness		
IR	Intermediate Result		
IUD	Intrauterine Device		
IYCF	Infant and Young Child Feeding		
JHU-CCP	Johns Hopkins Center for Communication Programs		
KM	Knowledge Management		
LAPM	Long-acting and permanent methods		
M&E	Monitoring and Evaluation		
MCH	Maternal and Child Health		
MH	Maternal Health		
MIS	Management Information Systems		
MOHFW	Ministry of Health and Family Welfare		
MOWCA	Ministry of Women and Children's Affairs		
MRFP	Post Menstrual Regulation Family Planning		
MSB	Marie Stopes Bangladesh		

Executive Summary

NHSDP's fourth year, out of five, was one of solid progress towards meeting or exceeding nearly all USAID-mandated performance indicators and milestones. It was also a year in which a strategic transition initiative was launched to strengthen the sustainability of the Surjer Hashi (SH) network, and to better enable it to contribute to achieving universal health coverage (UHC) in Bangladesh.

The transition began with the decision, supported by USAID technical concurrence, to establish an independent company limited by guarantee which will begin functioning in the coming year as a franchisor for the Surjer Hashi brand and network of service delivery facilities. This initiative will be supported by a health financing strategy for the SH network that began to be developed in Year 4 and will be available in the first quarter of Year 5. Preliminary findings and analysis indicate that there is scope to move from the current supply-side grant funding to NGOs, to a more progressive demand-side design that will specifically benefit the poor and ultra-poor; will be more efficient; and will ensure greater financial sustainability over time.

In Year 4 the SH network reported over 42m service contacts (105% of the annual target). This was slightly higher than the life-of-project Milestone (MS 1.1.19) to increase annual service contacts by 25% from the baseline of 33.6m per year. 43% of service contacts were with the poor, against a target for the year of 39% (and a life-of-project target to reach 40%). 9.8m contacts (23% of the total) were with adolescents, well ahead of the annual target of 7.2m which indicates positive impact of the ANGEL model which targets unmarried and married adolescents as well as gatekeepers. Cost recovery, based on initial reporting by the NGOs, was 40% for the year, meeting the life-of-project target.

Maternal, newborn and child health service indicators were all ahead of targets, including 1,835,925 ANC visits (113%); 40,697 safe deliveries (123%); 275,306 PNC visits for mothers within 48 hours (324%); and 246,591 (199%) ENC visits for newborns within 72 hours. Significantly narrowing the gap between number of PNC visits and ENC visits was of particular note as service providers were trained to ensure care for both mother and newborn in the immediate postnatal period.

FP services performed fairly well, with 1,886,699 injectable contraceptives provided (100% of target) and 1,536,730 CYPs (97%). LAMP contributed 7.3% of the total CYP, an increase from 5.5% in the previous year. The uptake of LAMP may be further strengthened if and when USAID agrees to allow use of non-USAID funds to pay promoters and clients for long-acting FP methods as per the practice of the Government of Bangladesh.

Gender based violence (GBV) screening, counseling and referral expanded by a factor of more than five compared to the previous year, with 21,026 women screened and counseled. Out of these 2,943 (14%) accepted referral to various human rights and legal aid support organizations, including the MOWCA's One-Stop Crisis Centers.

Nutrition services were particularly strong in Year 4 due to expanded training and staffing in selected areas in collaboration with USAID's FANTA-III project: 1,617,525 (153% of target) pregnant and lactating women were counseled on infant and young child feeding practices (IYCF); and 984,591 (209%) growth monitoring and promotion (GMP) service contacts were provided to children less than two years of age. TB services also performed strongly, with 7.6% increase over the previous year in number of cases reported; and an increase in case notification rate (CNR) to 232/100,000 population compared to 219 the previous year.

Quality of service monitoring and reporting was strengthened in Year 4 with consolidation and updating of the Quality Monitoring and Supervision (QMS) system guidelines and standards. Quality Assurance Managers from each SH NGO were further mobilized and capacitated to regularly support and monitor quality performance including peer review and quarterly meetings of the Clinical Quality Council (CQC). The clinic-based management information system (MIS) was streamlined to include only one reporting form (the Client Record Sheet) with data entered into a single database, thus reducing the reporting work load for service providers and enabling more effective analysis and reporting of indicators at clinic, NGO and project levels.

A Pro-Poor Strategy was completed and rolled out for all SH NGOs in Year 4. Coordination with DFID's Urban Health Program and its implementing partners was strengthened, focusing more attention and efforts on reaching the urban poor. This included orienting and supporting SH Community Support Groups (SHCSGs) to more effectively identify, map and follow up the poor in their communities to ensure better access to SH services.

As part of an initiative in Year 4 to better integrate BCC and Community Mobilization (CM), two leaders from each of the 10,170 SHCSGs were selected for a one-day training on using the extensive range of project behavior change communication (BCC) materials which were consolidated and made more accessible in Y4 for SH NGOs, clinics and community members. This training was rolled out to about 70% of SHCSGs in Year 4, with the remainder to be covered in Year 5. The training culminated in a practical exercise by SHCSGs to produce a Community Action Plan (CAP) that identified major health issues; set priorities and goals; identified and mapped the poor; and identified resources to support improved health outcomes and access to health services. 5,044 SHCSGs (50% of the total) completed CAPs in Year 4, and the rest will complete these in the coming year.

A series of Health Fairs implemented by 23 out of 25 SH NGOs during Year 4 attracted thousands of participants and generated positive media attention. Increased demand for services in SH clinics was noted by a number of NGOs following the Health Fairs. Other media events during the year also raised awareness. Close liaison efforts, coordination and advocacy with the government of Bangladesh during Y4 ensured that the SH network continued to benefit from strong GOB support. At the end of the year 99% of SH clinics had up-to-date District Technical Committee (DTC) registration, receiving FP and EPI commodities and contributing significantly to national FP and immunization coverage.

The Inter-Ministerial "USAID-DFID NHSDP Advisory Committee" with representatives from eight ministries and chaired by the Additional Secretary MOHFW, met once during Year 4 resulting in decisions to promote SH services through GOB-sponsored TV programming and to issue licenses for SH women-friendly pharmacies. A number of senior government officials visited and appreciated SH clinics during the year. NHSDP staff contributed to government strategies and plans related to health financing, nutrition, maternal and child health, adolescent health, urban poor, TB and HIV.

The institutional capacity of the SH network NGOs was built in Year 4 through follow-up on earlier assessments and roadmaps for achieving specific organizational capacity benchmarks. This was supported by governance, leadership and management trainings for NGO managers. Consultants were engaged to develop staff retention strategies and revise salary structures to be more competitive in light of government having significantly increased salaries in recent years.

Sustainability of the SH network was strengthened through an initiative to develop a network of for-profit Surjer Hashi Women Friendly Pharmacies (WFPs), with five in operation by the end of Year 4 attracting a

high proportion of female clients. An additional five WFPs are planned for Year 5, with another 12 existing pharmacies upgraded to a similar level of standardization and women-focus.

A study of the cost of selected services in SH clinics was completed and submitted to USAID in Year 4, contributing to a broader analysis of health financing options and opportunities that is currently underway. SH NGOs' achievement of project indicators continued to be strengthened by the performance-based grant (PBG) program which was widely recognized in Year 4 to be a significant driver of performance for selected incentivized service indicators and management functions, a positive effect that seems to have positively spread across virtually all performance indicators.

Staffing turnover, particularly as the project nears its end, was an ongoing challenge for NHSDP in Year 4, with eight staff members leaving the project. In some cases there were significant time gaps before replacement staff could be identified and brought on board.

The Year 5 Work Plan process required significant time and effort, with the overall NHSDP Work Plan as well as Work Plans for each of the 25 NGOs developed and reviewed during Quarter 4. The project Work Plan was approved by USAID in a timely way in the first week of October 2016. NGO Work Plans will be finalized in November 2016.

Section I: Yearly Progress -Year 4

Introduction

Building sustainability of the SH Network and supporting UHC

The main body of this Annual Report follows the outline of NHSDP's Results Framework, with three Intermediate Results (IRs); three sub-IRs under IR1 and two under IR2; and the Milestones and Activities under each of these. There are also narrative sections of the report covering M&E, Grants under Contracts, and Management. The report demonstrates excellent progress for all Milestones and Performance Indicators.

During Year 4 **two strategic activities** were initiated, with specific guidance from USAID, that are not readily categorized under any IR and for which no contractual Milestones have been set. These activities specifically address sustainability of the Surjer Hashi (SH) network and the emphasis on working towards Universal Health Coverage (UHC) in Bangladesh. These inter-related activities are to establish an independent SH network organization; and to explore more effective and sustainable financing options for the future.

Establishment of an SH Network Organization

In Year 4, NHSDP initiated a strategic process to establish an independent legally registered entity that will own the Surjer Hashi brand and manage the SH network. A local consultant was hired to facilitate the process. Initial review and discussions resulted in a decision, with technical concurrence from USAID, to register a company limited by guarantee as soon as feasible (with plans in place to achieve this by the end of Quarter 1 of Year 5). Following registration, the company will function as the franchisor for SH clinics. Over time, under future projects, the company may become the direct manager of the SH network.

The purpose of the SH company is to ensure effective management of SH clinics and services to contribute to UHC in Bangladesh. This includes leveraging the reach and strengths of the existing network (e.g., providing health service access to a catchment population of 26 million); moving beyond the historical donor-dependent supply side financing model to a more equitable and sustainable business model (more targeted coverage for the poor); and ensuring standardized quality of services.

Health Financing for the SH Network

As a complementary activity to establishing the SH Network Company, NHSDP engaged an international health financing consultant to develop a health financing strategy for the SH Network, based on analysis of the health financing landscape in Bangladesh and the current financial picture of SH clinics. This will result in recommendations for a phased action plan, beginning in project Year 5, to strengthen the network's preparedness to more sustainably deliver services to the poor and extreme poor. The review was started in Quarter 4 and the consultant's report will be available towards the middle of the next quarter.

During Year 4 a unique opportunity emerged for two SH NGOs to participate in a small health financing project initiated by a local company, Pragati Life Insurance (PLI) in collaboration with CARE Bangladesh through another donor-funded project called SETU in Rangpur Division. The SH NGOs, Kanchan Samity (KS) and UPGMS, signed MOUs with PLI to provide health services for POP clients referred by the SETU Project. CARE pays the insurance premium to PLI for these clients, and PLI pays SH clinics the listed prices for the services provided.

The table below shows uptake of insured POP clients at SH clinics through this arrangement, and the increase in service contacts (which also means increase in cost recovery), as reported by PLI and the NGOs.

Number of poorest-of-the-poor clients insured by PLI in collaboration with CARE Bangladesh who accessed services at SH clinics in Rangpur Division, August – September 2016

SH Clinic	Male	Female	Children	Total	Increase in Service Contacts*
Lalmonirhat (UPGMS)	64	31	10	105	
Mulatole (UPGMS)	109	40	31	180	
Saidpur (KS)	23	94	12	129	2%
Nilfamari (KS)	52	112	4	168	4%
Total	248	277	57	582	

*Total service contacts for these insured clients was 2,171

This small program indicates useful opportunities for increasing access to quality services for the poor while ensuring financial protection, in keeping with the principles of UHC.

IR 1: Client base expanded, especially for the poor, for a quality essential service package

Sub IR 1.1: Improved access, especially for the poor, to a quality ESP through a cohesive network of NGO static clinics, satellite clinics and CSPs

Milestones 1.1.1 – 1.1.7 were all scheduled for, and completed, in Year 1 as reported and approved by USAID at that time. However, some of these include ongoing activities as noted below.

MS 1.1.1: Selection criteria for local NGO partners are documented

Completed in Year 1 as a one-time activity

MS 1.1.2: GUCs awarded to local NGO partners

Grants are renewed annually for the NGOs, with approval by USAID

MS 1.1.3: At least 35% of service contacts qualify as poor

Achieved in Year 1.

MS 1.1.18 specifies achieving 40% service contacts with the poor by end of project.

This was achieved in Year 4.

MS 1.1.4: SH clinic management guidelines are revised

Achieved in Year 1 with an update of guidelines in English. The guidelines were subsequently translated to Bangla in Year 3 and distributed to all SH clinics, with training of clinic staff on the guidelines, in Quarter 1 of Year 4.

MS 1.1.5: Clinic management information systems established and data used for program planning and management

Completed in Year 1, with an update to consolidate and improve the MIS completed and rolled out to all SH clinics in Year 4 (see M&E Section below).

MS 1.1.6: Plans for technical assistance to NGOs developed**MS 1.1.7: Supportive supervision plan for NGOs to supervise clinics developed**

These two Milestones were completed in Year 1, but implementation is an ongoing process.

Technical assistance and supportive supervision were provided by NHSDP throughout Year 4 through trainings, workshops and the Quality Management and Supervision (QMS) system as per the Work Plan for the year. Annex D provides a summary of trainings conducted in Year 4. Details of the QMS are found under MS 1.1.9 below.

Project Technical Leads assigned to each NGO provided day-to-day support to Project Directors and other NGO staff to implement work plans and resolve challenges. Thematic Leads provided technical support for key components of the essential service package (ESP), including planning and overseeing trainings and ensuring technical updates were communicated and put into practice at clinic level. In Quarter 4, Technical Leads and Pathfinder HQ staffs were regularly engaged with the NGOs to review their work plans for Year 5.

In the first quarter of Year 4 the Bangla version of the “Clinic Management Guidelines”, used for many years in English, was distributed to all Surjer Hashi (SH) Clinics, with training on these guidelines conducted for all Clinic Managers (CMs) along with some Project Directors (PDs) and Monitoring Officers (MOs). This completed the project response to one of the recommendations from the USAID RIG audit conducted during Year 3.

A particularly strategic “Integrated Training” program was undertaken in Year 4 aimed at building the capacity of Service Promoters (SPs) and Community Service Providers (CSPs) across all components of the ESP. This initiative was based on recognition, earlier in the project, of the key roles these workers have in providing health and family planning information at community level and linking clients to service provision. Preparation for this Integrated Training began in Year 3 with curriculum development and training of Master Trainers from the NGOs who were prepared to conduct cascade training.

During the first three quarters of Year 4 a total of 349 SPs, covering the majority of SH static clinics, received a 4-day version of the Integrated Training. In the final quarter of Year 4 the Integrated Training was rolled out to 617 CSPs as a 3-day training, with two CSPs selected from each static clinic area where CSPs operate (some urban clinics do not have CSPs). The aim was to train 660 CSPs but one NGO, CWFD, was unable to participate due to time constraints—a gap which will be addressed in Year 5. CSPs were highly appreciative of the training. For most of them it was the first opportunity to meet colleagues from several different clinics within the SH network, allowing them to exchange ideas and learn from each other. With a pool of Master Trainers and trained SPs, the SH network has capacity to train more CSPs on an ongoing basis. However, budget and time constraints must be considered.

MS 1.1.8: At least 90% of clinics have women and girl-centered services as confirmed by quality assurance checklist

At the end of Year 3, 86% of clinics reported satisfactory performance with regard to women and girl-centered services based on a checklist covering seven key areas related to counseling, privacy, confidentiality and informed choice. During Year 4 the underperforming clinics were provided specific technical support by the project’s Gender Advisor. More than half of them raised their performance to meet the standards, bringing the overall proportion of clinics with satisfactory women and girl-centered services above 90%.

A number of initiatives were undertaken in Year 4 to further strengthen services for women and girls and to ensure gender mainstreaming throughout the SH network. These included:

- All 25 SH NGOs developed their organizational Gender Policy which was signed by each respective Executive Committee or Board Member
- Guidelines on “Women and Girl-Centered Services”, “Gender Equity”, “Gender Based Violence (GBV)” and “GBV Counseling” were translated in Bangla and printed copies distributed throughout the SH network. A book on “Legal Rights of Women and Children of Bangladesh” published by Plan International Bangladesh was distributed to all SH clinics
- The Social Analysis and Action (SAA) approach—which particularly helps service providers improve counselling for sexual and reproductive health, family planning and GBV—was strengthened by distribution of a Bangla SAA Manual; assessment on the use of SAA; and one-day training for 2,976 clinic staff out of a total of around 3,000 (approximately 97%)
- 2,396 clinic staff (approximately 78%) received training on gender equitable approaches in service delivery and GBV counseling
- The Integrated Training for SPs and CSPs included a module on “Gender Equity and Gender Based Violence”
- A GBV screening checklist, highlighting the legal rights of women and children in Bangladesh, was produced and circulated for use by SH clinics
- The QMS was updated to include quality indicators on women and girl-centered services and GBV, ensuring ongoing routine quality improvement and assessment of these areas
- SH Community Support Groups (SHCSGs) ensured that their Action Plans and monthly meeting agendas included addressing gender barriers

An organizational gender assessment was conducted for 24 of the 25 SH NGOs by an external consultant, with the report submitted to USAID in the third quarter. Generally it was found that gender equitable approaches have been introduced and implemented at the institutional level (eg., Gender Policies) and individual level. Work environments at NGO offices and health facilities were found to be equitable and women-friendly. Overall staffing of the SH network heavily favors women, which is appropriate for the cultural setting given that clients are mostly women and children. A number of NGOs have women in senior management positions, but overall in the network women are not equitably represented on all NGO Executive Committees (EC). A couple of NGOs have all-women ECs. Others have included in their gender policies to work towards at least 40% representation of women.

NHSDP’s Gender Advisor participated in a National Working Group to develop a “Gender Equity Strategy” for the Ministry of Health and Family Welfare (MOHFW). The project signed a Letter of Collaboration (LOC) with the Ministry of Women and Children Affairs (MOWCA) to help ensure support for GBV survivors through MOWCA’s national network of One Stop Crisis Centers (OCCs).

Gender Based Violence (GBV) screening, counseling and referral

Number of Persons	Achievement by Quarter				Annual Achievement	
	Q1	Q2	Q3	Q4	Total	%
Screened	3,959	5,391	6,862	7,904	24,116	--
Counseled	3,492	5,069	5,813	6,652	21,026	87%
Accepted Referral	532	779	737	895	2,943	14%

In Year 4 a total of 24,116 GBV cases were identified through screening at SH clinics and community level, with 21,026 (87%) counseled by trained counselors at SH clinics. This large increase from 3,715 cases

identified and counseled in Year 3 was due to the fact that GBV screening was first introduced in Year 3 and then was scaled up throughout Year 4 through the following interventions:

- Dissemination of GBV information and guidelines through static and satellite clinics, with awareness raising campaigns aimed at both women and men
- Extensive observation of international awareness days including Elimination of Violence Against Women Day and International Girls Day
- Improved quality of counseling following SAA training
- Strengthening of referral linkages and local advocacy activities

The 14% of cases which accepted referral to different human rights and legal aid support organizations, including One-Stop Crisis Centers of MOWCA, is considered a strong achievement given the prevailing socio-cultural limitations for women to access such services.

MS 1.1.9: At least 90% of clinics implement a continuous quality improvement plan

All SH Static Clinics (100%) implement a continuous quality improvement plan, which was verified for Year 3 by the PBG indicator: “% of clinics implementing a continuous quality improvement (CQI) plan”. Since all NGOs were able to achieve this indicator by implementing a CQI plan, for Year 4 this was changed from a performance indicator (which results in a 1% bonus) to a system indicator (failure to achieve results in a 1% penalty).

NGO Quality Assurance Managers (previously called Monitoring Officers) conduct 6-monthly quality checks in each clinic that results in an Action Plan for improvement. During Year 4 this Quality Management and Supervision (QMS) system was strengthened with the aim to build a “culture of quality” within the SH network, ensuring that quality is more effectively measured, reported and improved on a continuous basis, led by the NGOs themselves.

See ANNEX C: SH Network Quality Management and Supervision (QMS) Scores for Year 4.

An extensive review and updating of the QMS system was undertaken during Year 4, with technical assistance from Pathfinder HQ to support NHSDP’s Quality Assurance Specialist. Due to staff turnover in the final quarter of the year, with the QA Specialist recruited to another USAID-funded project, finalizing the updated QMS manual will be done in Year 5. Meanwhile the overall QMS process continues to be implemented on a regular basis.

The NGO QA Managers collectively form a Clinical Quality Council (CQC) which met quarterly in Year 4 (27th December, 30th March, 05th June and 22nd-23rd August). These meetings were an opportunity to review findings from quality monitoring, discuss challenges in implementation of services, get updated on technical information, review FP and EMMP compliance and receive further orientation on the QMS as it was being updated.

One of the key challenges highlighted by the CQC throughout the year was the difficulty of retaining clinic staff, particularly Doctors, Paramedics, and Monitoring Officers. Salaries in the SH network lag significantly behind both the government and private health sectors due to rapid economic progress and salary increases in recent years; the SH network has been unable to keep up due to donor contract limitations. In the final quarter of the year NHSDP’s Finance and Operations Department initiated a review of salaries and HR policies and procedures that will be completed in Year 5 and will hopefully lead to positive changes in discussion with USAID.

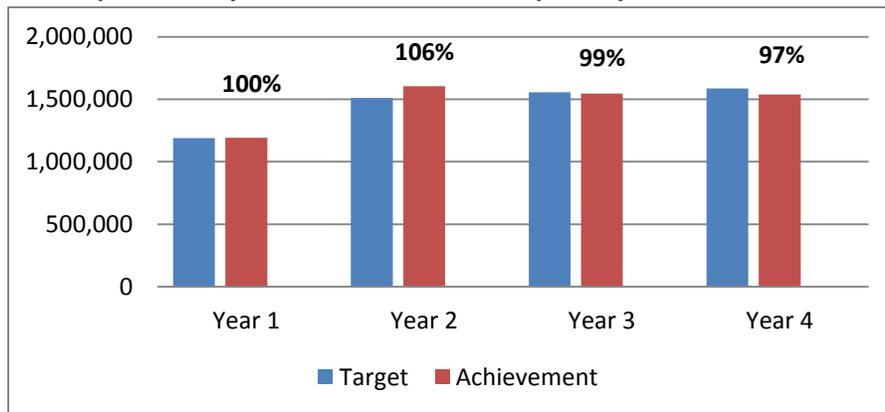
MS 1.1.10, 10a: At least 25% increase in CYP from baseline
MS 1.1.10a: 948,264 additional CYP over the life of the project

Year 4 Achievement of Key FP Indicators

Indicator	Achievement by Quarter				Annual		
	Q1	Q2	Q3	Q4	Total Y4	Target	%
CYP	391,413	383,692	376,738	384,886	1,536,729	1,585,986	97
Injectables	474,021	475,356	466,204	471,118	1,886,699	1,886,986	100

CYP achievement in Year 4 was almost on track at 97%; with injectables just marginally below the target. Early in the year CYP performance had been of greater concern, but it appears that training of Paramedics and Doctors on IUD and PFP, and the contribution of Roving Teams, helped to bring CYP up somewhat in Quarter 4. Long-acting and permanent methods (LAPM) contributed 7.3% of the total CYP which is an increase from 5.5% in Year 3. CYP performance over the life of project has generally been satisfactory, as seen from the following graph, but there is room for improvement in the final year ahead.

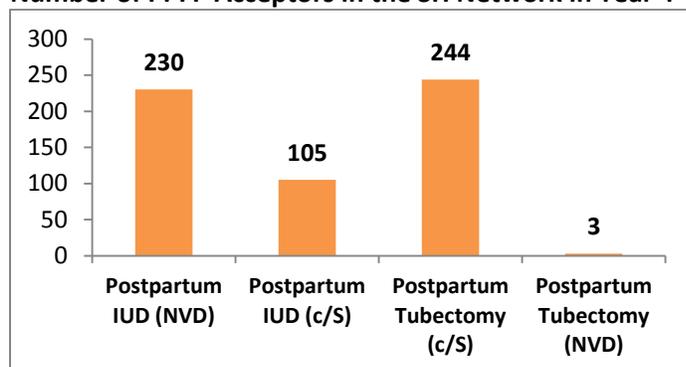
The number of CYPs provided by the SH Network for the past 4 years, with % achievement against targets



In Year 4 Roving Teams supported by USAID’s Mayer Hashi II project (implemented by EngenderHealth and a local organization, RTM) provided LAPM services at SH clinics where these methods are not available. In Year 4 the Roving Teams conducted 235 outreach sessions at 136 SH clinics of 19 NGOs, providing 825 IUDs, 729 implants, 25 tubectomies and 6 vasectomies.

The graph below shows performance of post-partum family planning (PFP) in Year 4 for 28 EmOC clinics which reported PFP services during the year. As might be expected, acceptance of IUD after normal delivery is relatively high, as is tubectomy after C-Section. There were negligible cases of tubectomy after normal delivery, as clients clearly don’t prefer this option in that circumstance. SH clinics therefore put emphasis on IUD and other relevant methods of PFP.

Number of PPF Acceptors in the SH Network in Year 4



A number of trainings were conducted during Year 4 to improve capacity of SH clinic staff for FP counseling and service provision. Improved PPF counseling during ANC visits was promoted throughout the year. The Integrated Training for SPs and CSPs included emphasis on promotion and referral for PPF for home deliveries. FP trainings included the following:

- 6- Day clinical IUD training provided by EngenderHealth for 34 Paramedics
- 3-day implant training provided by EngenderHealth for 10 Doctors
- 3-day PPF training provided to 11 Doctors and 25 Paramedics by EngenderHealth
- 3-day FP counseling training facilitated by EngenderHealth for 43 Counselors
- 2- Day training on post-abortion care, post-abortion FP and MRFP for 15 Quality Assurance Managers and 4 Doctors by the national NGO RHSTEP

During Year 4 the National Technical Committee of the Director General Family Planning (DGFP), MOHFW, approved progesterone-only-pills and implants for immediate postpartum use, within 48 hours of delivery. This information was shared with the SH NGOs. Currently postpartum implants are offered by 10 SH EmOC clinics out of 72.

NHSDP's FP Advisor participated in meetings on the National Action Plan for PPF, which is in the process of finalization by MOHFW with support from UNFPA.

NHSDP continued dialogue with USAID about payments to promoters and beneficiaries of long-acting contraceptive methods. To date, such payments—which are available to clients from government facilities and other NGO service providers—have not been allowed in the SH network. The discussion to resolve this matter has been ongoing for most of the life of project and final guidance remains pending from USAID.

MS 1.1.11: At least 30% increase in delivery assisted by SBA in targeted communities from baseline

MS 1.1.11a: 38,292 additional births assisted by skilled attendant

MS 1.1.13: 7,070,466 ANC checkups provided to pregnant women over the life of the project

MS 1.1.14: 331,248 PNC services are provided to women with childbirth within 48 hours after birth

Year 4 Achievement of Key Maternal Health Indicators

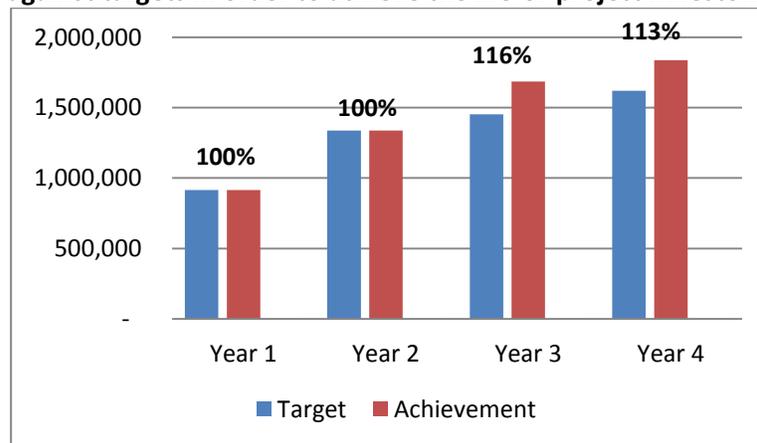
Indicator	Achievement by Quarter				Annual		
	Q1	Q2	Q3	Q4	Total Y4	Target	%
Safe Delivery	10,695	9,918	9,496	10,588	40,697	33,088	123
Total ANC	469,106	451,570	460,362	454,887	1,835,925	1,620,000	113
PNC - 48 hrs	65,729	66,402	69,913	73,262	275,306	84,731	324

Maternal health performance indicators exceeded targets for Year 4, with the following factors contributing to strong performance:

- Expanding ANC services beyond existing catchment areas, including special outreach services in underserved communities
- Continuing to promote 4 ANC visits through satellite clinics and at community level, including a strong emphasis on ANC and other Maternal Health services in the Integrated Training for SPs and CSPs
- Strengthening counseling by all SH service providers on birth preparedness and complication readiness
- Strengthening linkages with, and referral to and from, other providers listed through community mapping around SH clinics—including nurses, midwives, Family Welfare Visitors (FWVs) and SBA providers

ANC performance over the past four years has consistently been just ahead of annual targets, with the large number of ANC service contacts (1-2 million per year) reflecting the large-scale access to ANC provided by the entire network at community and clinic levels. The network provides ANC services for many women who do not deliver in SH clinics, given that only 72 out of 388 clinics provide EmOC services. Increase in numbers of ANC service contacts each year has been consistently strong.

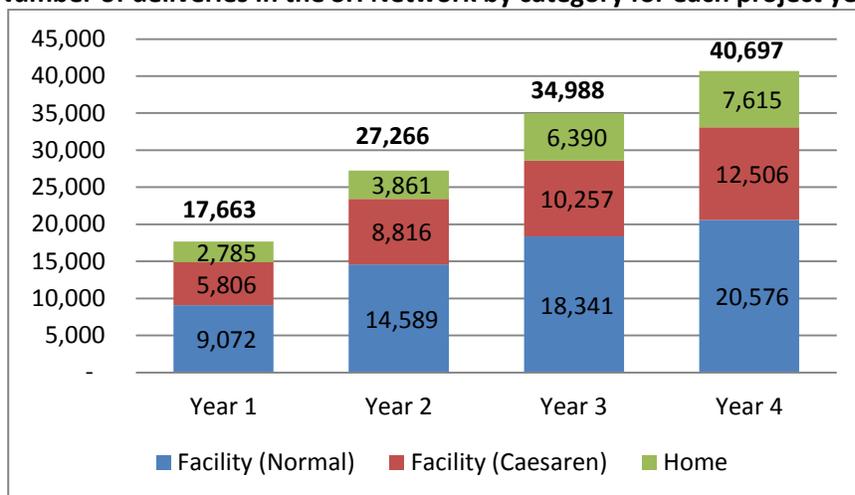
Number of ANC service contacts in the SH Network for the past four years, with % of annual achievement against targets in order to achieve the life-of-project Milestone.



Deliveries in all categories (home, normal in facility, C/S in facility) have increased in the SH Network from year to year, as shown by the graph below.

In each year the total number of deliveries exceeded targets by the following percentages: Y1: 104%, Y2:108%, Y3:122%, Y4:123%. During this four year period, more than 300 Paramedics—including 76 in Year 4—received intensive 3-week refresher training on safe delivery conducted at the well-recognized Mohammadpur Fertility Services and Training Centre in Dhaka.

Number of deliveries in the SH Network by category for each project year



In collaboration with EngenderHealth, SH network staff at both community and clinic levels were oriented on identification and referral of vesico-vaginal fistula clients. Information of fistula prevention and treatment was distributed for display at all SH clinics, and courtyard meetings to raise awareness were organized by SPs and CSPs.

Collaboration with USAID’s MaMoni project included identification of some hard-to-reach areas where services are lacking and organizing some satellite clinics in these areas. Collaboration was also undertaken with Revitalization of Community Health Care Initiatives in Bangladesh (RCHCIB) to link some Community Clinics and SH Clinics to provide greater access to underserved areas and poor clients, including two-way referral for laboratory investigations, ultrasonography, ANC and deliveries.

MS 1.1.12: At least 30% increase in number of newborns born in supported clinics receiving immediate newborn care from baseline

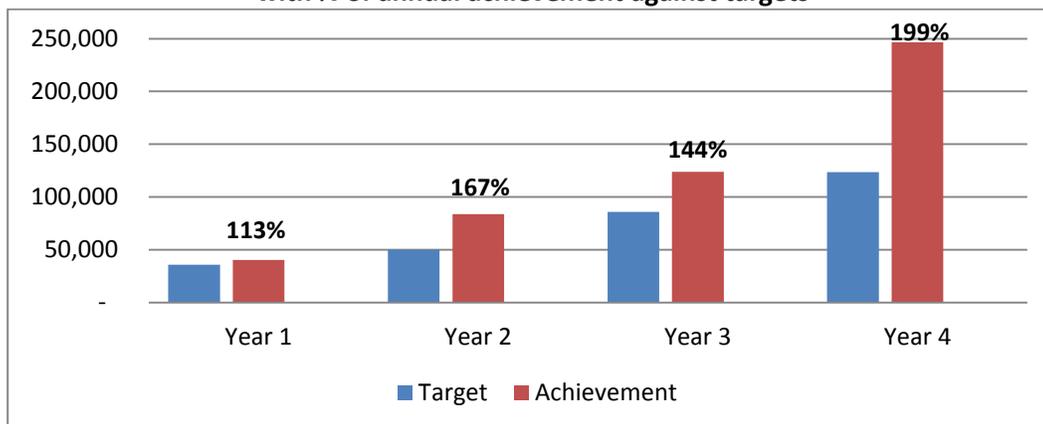
MS 1.1.15: At least 30% increase in number of childhood pneumonia cases treated with antibiotics by training facility/community workers from baseline

Indicators	Achievement by Quarter				Annual		
	Q1	Q2	Q3	Q4	Total Y4	Target	%
ENC - 72 hours	50,174	61,997	64,487	69,933	246,591	123,633	199
Child pneumonia	53,442	58,075	61,414	64,069	237,000	196,777	120

Uptake of newborn and child health services increased throughout Year 4, significantly exceeding targets for the year.

The trend for ENC services over the past four years can be seen in the following graph. High achievement over targets reflects the fact that SH service providers were trained and encouraged over the past two years to ensure ENC for babies along with PNC for mothers. Previously many more mothers were receiving PNC compared to newborns receiving ENC. This gap has almost been closed in Year 4 (275,306 PNC contacts for mothers vs. 246,591 ENC contacts for newborns) due to strong efforts and performance of service providers.

Number of ENC service contacts for newborns within 72 hours in the SH Network for the past four years, with % of annual achievement against targets



Application of 7.1% Chlorhexidine on the newborn umbilical cord was scaled up in Year 4 and is an almost universal practice for facility and home deliveries in the SH network.

The following trainings were conducted in Year 4 to further strengthen the capacity of SH service providers in the areas of newborn and child health:

- A series of twelve 4-day trainings on Comprehensive Newborn Care Package, five of which were in collaboration with Save the Children, was provided to 179 Paramedics and 20 Doctors
- Two 11-day Facility-Based IMCI trainings were provided to 52 Paramedics, in collaboration with RTM and the Institute of Child and Maternal Health (IMCH) in May

To promote and improve newborn care services at clinic and community level, 190 Sepsis Management Card Sets, 9,900 Leaflets and 99,500 ENC cards were distributed in the third quarter. These materials will be used by Counselors, Paramedics and Doctors as service provision guidelines and while counseling mothers and caregivers.

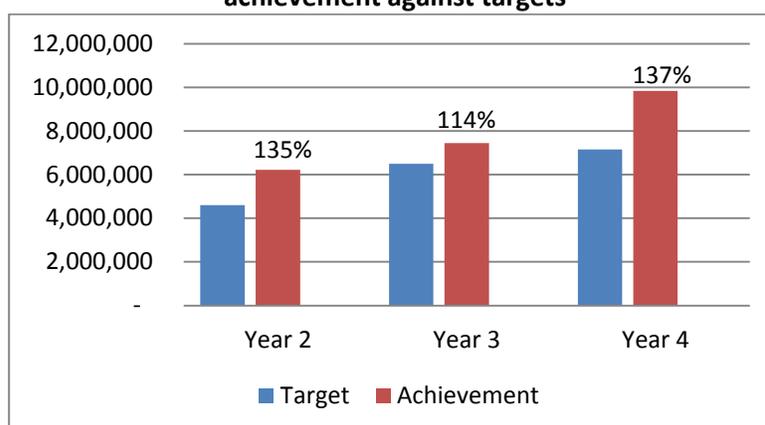
NHSDP received 125 sets of Neonatal Bag & Mask and Penguin Suckers from the GOB through Bangabhandu Sheikh Mujib Medical University (BSMMU). These were distributed to all 72 SH EmOC clinics to support neonatal resuscitation.

MS 1.1.16: At least 25% increase in number of youths (15-25 years) accessing reproductive health services

Indicator	Achievement by Quarter				Annual		
	Q1	Q2	Q3	Q4	Total Y4	Target	%
Adolescent Service Contacts	2,420,568	2,396,596	2,515,898	2,496,688	9,829,750	7,154,312	137

The number of adolescent service contacts in Year 4 significantly exceeded (137%) the target for the year. There has also been a strong year-on-year increase in adolescent service contacts over the past three years for which reporting is available, as shown by the following graph.

Number of adolescent service contacts in the SH network over the past 3 years, with % annual achievement against targets



This success has been strongly supported by the **ANGEL Model** which targets unmarried and married adolescents as well as gatekeepers. In Year 4 this approach included:

- Provision of ARSH information in more than half (3.9 million) of all service contacts with adolescents and youth
- 6,822 student health leaders provided information to around 33,000 students through programs in schools
- SH clinics listed 89,341 newly married couples in their communities, with 14,694 newly married couple ceremonies performed
- 322,000 pregnant women and first time parents were listed; 11,637 group meetings were held with pregnant women and mothers with one child; 7,737 group meetings were held with husbands; and 6,606 group meetings were organized with mothers-in-law.

Youth Friendly Health Services (YFHS): A training curriculum for YFHS was developed in Year 4 with support from Pathfinder HQ, based on existing materials available nationally and from Pathfinder and ensuring adaptation appropriate to the context of SH Clinics. Thirty Quality Assurance Managers and NGO Project Managers were trained on this for two days on 19th-20th September, enabling them to cascade orientation on YFHS for all SH clinic staff by the end of Year 5.

The government-approved “Nijeke Jano” (Know Yourself) set of four booklets on adolescent sexual and reproductive health, originally developed by JHUCCP/BCCP, were reprinted by NHSDP with over 38,000 sets distributed in the fourth quarter to all SH static clinics, satellite clinic teams, SHCSGs, CSPs, student health leaders, and three sets each to schools and colleges in SH clinic catchment areas. The booklets cover the topics of Puberty; New Feelings and Sensations; Marriage and Family Health; and Sexually Transmitted Infections and HIV and AIDS. The booklets help providers in giving comprehensive information on ASRH to adolescents, and will be used by SHCSGs for mobilizing communities to understand the importance of ASRH information for both married and unmarried adolescents. Health leaders will be able to share ASRH information more effectively with other students in schools.

A guidebook for CSPs and SPs was developed in which FP-related questions (on LAPM, PFPF, HTSP) and answers facilitate better counseling at the community level. Questions related to adolescents are also included, focused on child marriage, age of childbearing, hygiene during menstruation, TT vaccination, nutrition, HTSP, and sexual harassment.

Coordination with government: NHSDP’s FP/ARSH Advisor supported development of the draft National Strategy for Adolescent Health in Bangladesh developed by the DGFP with support from UNICEF, UNFPA and WHO. This was finalized in a 2-day stakeholder workshop on 30-31 May, for implementation up to 2030 in support of the Sustainable Development Goals (SDGs). Priorities in the strategy include increasing ASRH services, reducing child marriage and adolescent pregnancy, improving adolescent nutrition, addressing mental health of adolescents, reducing risk-taking behavior of adolescents, reducing RTIs/STIs and providing more and better social/behavior change communication for adolescents.

NHSDP actively participated in a national Sexual and Reproductive Health and Rights (SRHR) conference organized by MOHFW in May which engaging Civil Society Organizations. Awareness about the high priority of SRHR was raised, with practical steps recommended such as increasing the training and availability of midwives throughout the country.

MS 1.1.17: At least 20% increase (over life of project) in clients that respond favorably to provider-patient interaction

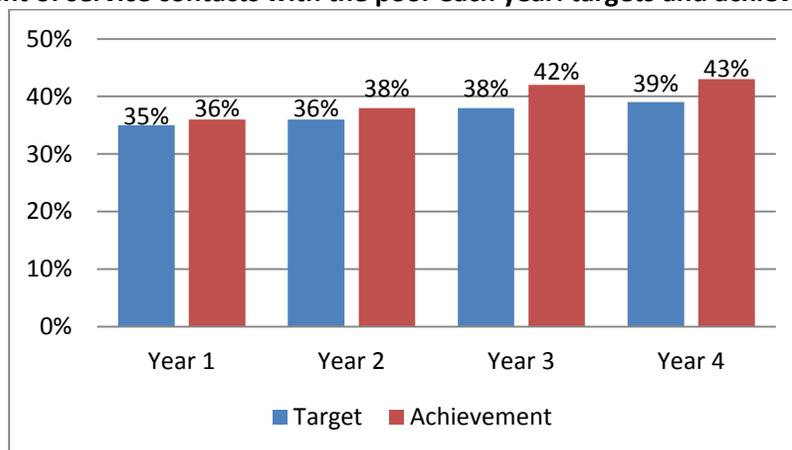
This MS will be included in the end-of-project report. See MS 2.2.1 for more information on client satisfaction.

MS 1.1.18: At least 40% of service contacts qualify as poor (by the end of the project)

Overall in Year 4, 43% of service contacts in the SH network were reported as being with poor clients. For urban clients the proportion was 48% and for rural clients 37%. Nine percent of all service contacts in Year 4 were provided free of cost and 23% were provided at rates discounted from the listed fees.

The proportion of service contacts for the poor has increased steadily in each project year, consistently exceeding annual targets.

Percent of service contacts with the poor each year: targets and achievements



An “Access Barrier Study” report was finalized and disseminated in Year 4. This explored barriers and opportunities for the poor to access services from the SH network, and helped to inform a “Pro-Poor Strategy” and action plan. A series of orientation workshops on the strategy and plan were held with NGO BCC Focal Persons, NGO managerial staff and clinic staff, with a total of 719 participants. A final one-day meeting was held on 25th July with all 25 NGOs represented to endorse the Pro-Poor Strategy. Key elements of the strategy include the following:

- More proactive identification and inclusion of the poorest-of-the-poor (POP) in order to increase their uptake of services above the current level of around 6%
- Participatory identification of the poor at community level through PRA and community mapping
- Community feedback mechanism through community score cards in selected satellite clinic areas
- Better access of information by the poor through SHCSG meetings and community level distribution of promotional materials to mobilize the poor

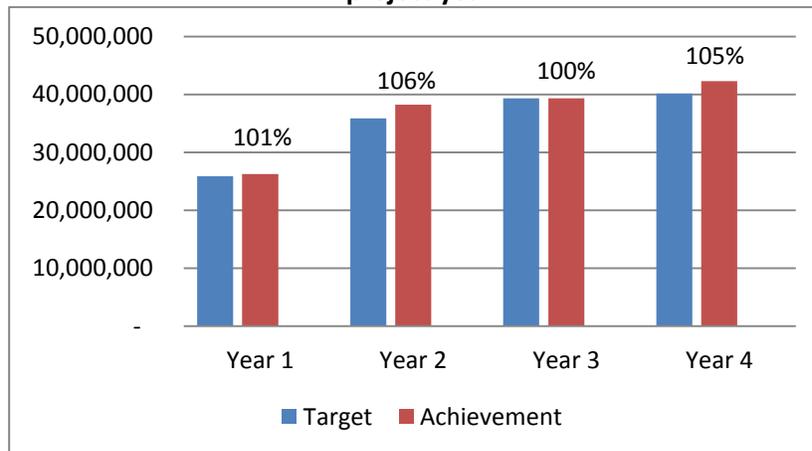
Fifteen SH clinics are enrolled in the GOB’s Demand Side Financing (DSF) program which promotes uptake of maternal health services through vouchers for the poor. In Year 4 NHSDP discussed with the MOHFW to extend this program to additional clinics. Negotiations are ongoing.

MS 1.1.19: At least 25% increase in annual service contacts from baseline at NGO partner clinics

In **Year 4** the number of service contacts reported throughout the SH network was **42,280,743** against a target of 40,130,370, an achievement of 105%. This number of annual service contacts was slightly higher than the life-of-project Milestone to achieve a 25% increase, to 42,051,866, from the baseline of 33,641,493.

The graph below shows that annual service contacts have met or exceeded targets in each of four years of the project.

Number of annual service contacts in the SH network, with % achievement against targets for each project year



MS 1.1.20: Expansion of SRH services to integrate selective HIV interventions in selected areas

In Year 4 the SH network provided 205,726 service contacts for most at risk populations for HIV against a target of 213,404 (96.4% achievement). This included HIV/STI prevention messages through individual and/or group meetings and voluntary counseling and testing (VCT) services through static and outreach services. 4,766 clients were tested for HIV, with 8 positive cases identified. This reflects the low prevalence of HIV in Bangladesh. Six of the positive cases were put on treatment (ART) through the Ashar Alo Society, but two were lost to treatment for unknown reasons.

STI counseling and diagnosis services were provided to 6,006 clients, and treatment services to 2,463 during this year, an increase from the previous year. 410,209 condoms were distributed for prevention of STI and

HIV. Among those at risk for HIV, 457 presumptive TB cases were screened; 9 were found to be positive, all of whom were put on treatment with the support of the NTP.

Through NHSDP's pilot program to integrate ESP and HIV services 7 clinics managed by SMC, 109,369 ESP service contacts were provided, 77% for poor and POP clients. These included the following (all of which are reported in overall NHSDP performance indicators):

- 8,209 child health services (ENC, EPI, other child illnesses)
- 1,886 ANC and 238 PNC services provided to pregnant women and postnatal mothers
- 300 pregnant women and 636 WRA clients received TT vaccination
- 11,818 limited curative care services, primarily for women
- 35,347 family planning services
- 19,314 other curative care and GBV counseling services

Due to funding constraints as NHSDP enters its final year, the seven HIV-ESP clinics run by SMC will be closed out by the end of the first quarter of Year 5, as per guidance from USAID.

MS 1.1.21: Expansion of selected services in Chittagong Hill Tracts (CHT) to augment health service activities

During Year 4 extensive project planning and consultation with local stakeholders was undertaken to expand services, especially for maternal health, in CHT. This resulted in design of a project to establish 18 "Midway Homes" to provide safe delivery services (BEmOC) in all 25 Upazillas of the three CHT districts. FDSR already operates SH clinics in the other 7 Upazillas. Emergency transport for referral of complicated cases will also be established. The USAID-approved project plan includes aspirational aims, based on the population of CHT, to annually provide 64,000 ANC visits; ensure 16,000 safe deliveries; and provide emergency transport for referral of 2,400 cases. Given the short timeframe of 14 months from project initiation to the end of NHSDP, it seems unlikely that these numbers can be achieved within life of project.

The project was tendered for bid and subsequently awarded in the fourth quarter to Green Hill, an NGO based in CHT. Green Hill began mobilizing in the final quarter of Year 4, including arranging a project launch event in Bandarban in the first week of Year 5 (05th October). The project is being rolled out in close collaboration with the Ministry of CHT Affairs (MOCHTA), local government at all levels, tribal leaders and community stakeholders, UN agencies active in the area (particularly UNICEF) and other USAID-funded projects (particularly SAPLING, a nutrition project implemented by Helen Keller International in Bandarban district).

MS 1.1.22: Coordination with selected urban governance bodies to improve urban health governance to provide needed services

During Year 4, NHSDP established and/or strengthened the following collaborations for improved health services in urban areas.

MOU signed with Water & Sanitation for the Urban Poor (WSUP) project in February. SH clinics will provide health and family planning services to slum populations referred by WSUP in Dhaka and Chittagong City Corporations. WSUP will provide technical assistance in capacity building, awareness raising and school health program to the SH network. An initial joint activity was carried out in March to orient sanitation workers on health and safety, with 50 workers given health checkups and vaccinated against typhoid at Nasirabad Clinic operated by IMAGE.

Coordination with Dhaka North City Corporation (DNCC) and Dhaka South City Corporation (DSCC):

NHSDP participated in a DNCC meeting in the second quarter on progress sharing and EPI planning; and in a DSCC progress sharing and urban health strategy planning meeting on 28th March. An agreement was made with DNCC to conduct joint assessments in SH clinic catchment areas to identify poor and underserved areas and to organize coordination meetings with other service providers to avoid duplication of services.

One such coordination meeting was held with UNICEF on 06th June in which UNICEF reviewed their plans to ensure comprehensive health services in Zone 2 of DNCC (Mirpur area) where 15 SH clinics are already functioning. An additional 5 clinics supported by UNICEF through local government will ensure complete coverage, along with developing a special care unit for newborns at an existing hospital in the area.

Coordination meeting with Urban Primary health Care Service Delivery Project (UPHCSDP):

A joint meeting was held in May, at DSCC premises, to review respective activities. UPHCSDP agreed that SH clinics are providing valuable services in the area and should continue to do so. UPHCSDP will not seek to establish such services where SH clinics are already functioning.

Coordination with Urban Health System Strengthening Project (UHSSP) funded by DFID:

NHSDP participated in a number of meetings and activities with UHSSP throughout the year. This included a series of interactions regarding an effort to have health facilities in three pilot urban municipalities report service statistics to a common HMIS under the Health Department which is run by the Local Government Department (LGD). A reporting format was developed by UHSSP, but NHSDP and the participating SH clinics have not yet found this to be a feasible mechanism. The format is not yet clear enough or simple enough for SH clinics to effectively manage. Discussions with UHSSP and DFID are ongoing to find a better way forward.

In the fourth quarter UHSSP initiated a “Willingness To Pay” (WTP) study which will include SH network catchment areas. NHSDP participated in a number of meetings of the core technical group overseeing this study, and also shared the costing study conducted earlier this year as complementary information to the WTP study. NHSDP also supported UHSSP with a health seeking behavior study and preparation of a city health profile; and participated in a Project Monitoring Committee (PMC) meeting held on 22nd June chaired by the MOHFW to review six-monthly progress and finalize the next six month plan for UHSSP.

Strengthen urban health governance at Municipality and City Corporation levels:

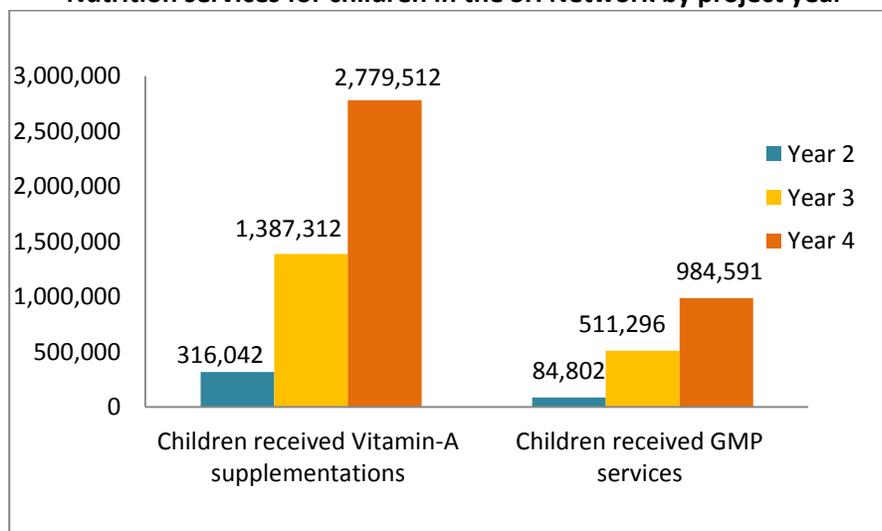
In the fourth quarter, four urban health coordination meetings were held with Municipalities at Lalmonirhat, Kurigram, Rangpur and Faridpur, coordinated by UPGMS and VFWA. Urban Health Working Groups, led by the respective Mayors, were formed with the main tasks of identifying health service overlaps; effective resource utilization; and monitoring and supervision of health services by the Municipality Medical Officer of the municipalities. Urban Health Working Groups will be functionalized in additional Municipalities in Year 5.

Activity 1.1.23: Mainstreaming nutrition services across the SH network**Year 4 Performance Indicators for Nutrition**

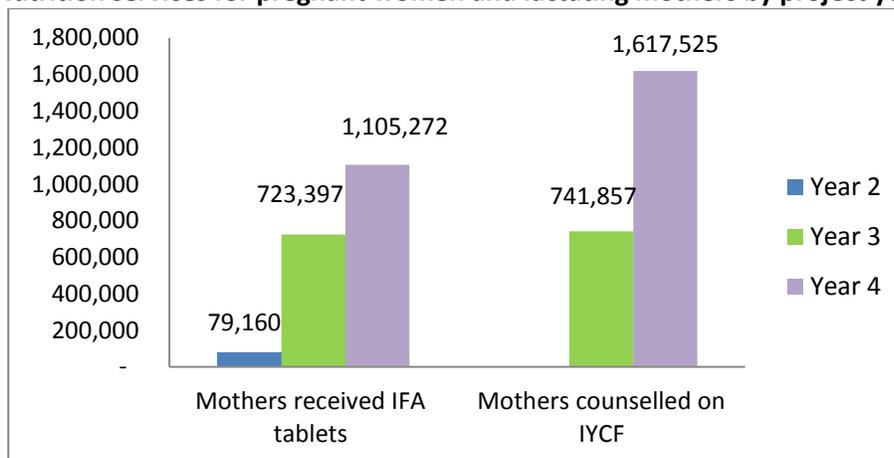
Indicator	Achievement by Quarter				Annual Achievement		
	Q1	Q2	Q3	Q4	Total Y4	Target	%
GMP for children <2	248,435	255,841	236,163	244,152	984,591	470,800	209
Vit-A for children <5	13,90,890	4,538	2,45	13,81,639	27,79,512	2,211,000	126
IYCF Counseling for	384,214	397,475	406,170	429,666	1,617,525	1,057,103	153

mothers							
Iron Folate for mothers	309,745	322,147	232,025	241,355	1,105,272	740,820	149

Nutrition services for children in the SH Network by project year



Nutrition services for pregnant women and lactating mothers by project year



Nutrition performance indicators for Year 4 significantly exceeded targets for the year, and also showed large increases from previous years. This was mainly due to collaboration in Year 4 with USAID’s Food and Nutrition Technical Assistance (FANTA-III) project that intensified nutrition interventions in selected SH clinics in the Feed the Future (FtF) zone; and contributed to mainstreaming nutrition services throughout the SH network.

The focus of collaboration was around 34 SH static clinics managed by CRC and PKS in the Khulna-Jessore region. This included recruiting and training two Community Service Providers for Nutrition (CSP-N) per clinic to assist with GMP and nutrition counselling at static clinics, satellite clinics and in the community. Additional CSP-Ns will be recruited and deployed for some of the higher volume clinics in Year 5.

A Clinic Readiness Assessment (CRA) was conducted in the 34 focus clinics plus 8 clinics managed by PSKS. This assessment identified nutrition service need as well as availability of equipment and capacity of staff capacity for nutrition interventions. The baseline will be used to regularly monitor progress during the course of project. Basic Nutrition Training was provided for clinic staff including Counselors, Paramedics, Medical Officers, Quality Assurance Managers, M&E Officer and CSP-Ns. Two NHSDP Technical Managers for Nutrition were recruited in Khulna and Jessore to provide regular technical support and oversight for the intensified nutrition programming.

FANTA-III also supported Basic Nutrition Training for SH clinic staff throughout Khulna and Jessore Divisions (total of 72 clinics) and Dhaka Division (124 clinics). In all, 671 staff were trained during the year. In addition, UNICEF organized a series of 5-day Competency Based Training (CBT) sessions on nutrition in Khulna City Corporation from May through September in which 95 service providers of urban clinics of PKS participated.

With support from FANTA-III, 3,000 promotional Food Plates and Guidelines were provided to all 388 SH clinics to use during maternal nutrition counseling; along with 688 wooden height boards and 102 Salter scales. NHSDP also distributed GMP cards, GMP posters, MUAC tapes, IYCF brochures and Basic Nutrition Modules. This ensures that all SH clinics are better able to offer basic nutrition services including GMP and IYCF counselling.

In collaboration with USAID's SPRING project, two special satellite camps were organized by CRC and SWANIRVAR Bangladesh for SPRING beneficiaries in *Bagerhat Sadar* and *Char Fassion Upazilla* in the third quarter. Ninety-one least-advantaged clients received ANC, EPI, GMP, adolescent health and LCC services.

NHSDP convened one meeting of the Nutrition Technical Advisory Group (NTAG) on 09th May. Participants included government officials, USAID representatives and experts from the NGO sector. The role of the SH network in improving access to quality nutrition services, especially in neglected urban and hard to reach areas, was emphasized.

Support from the government continued throughout the year, with the National Nutrition Services (NNS) distributing 50 height boards and 100 BCC-Nutrition tool kits for 33 clinics in Dhaka through UNICEF and Dhaka City Corporation. In Khulna PKS received 39 Height boards, 7,200 GMP cards and 40 BCC-Nutrition tool kits through UNICEF and Khulna City Corporation.

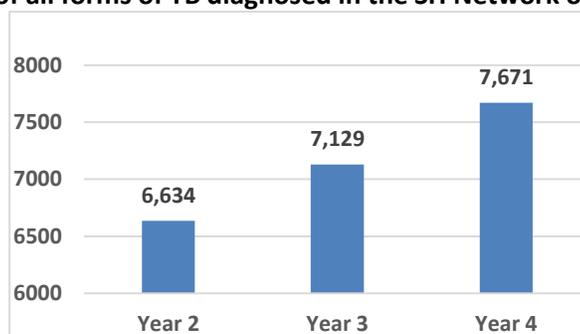
An MoU was signed in July with the National Nutrition Services (NNS) of IPHN to ensure support for nutrition interventions at SH service delivery points. This includes access for SH clinics to updated GOB information, IEC materials, training manuals, tools and nutrition commodities and logistics. Senior officials from NNS (Dr. Md. Moudud Hossain, Deputy Director DGHS and Program Manager NNS, IPHN; and Dr. Md. Moinul Haque, Planning & MIS Specialist NNS) visited SH clinics of NISHKRITI and IMAGE in Chittagong during the fourth quarter. They observed GMP sessions and nutrition counseling conducted by Paramedics, along with Nutrition Field Staff supported by Concern Worldwide. The NNS team appreciated SH activities and reiterated the need for more intensive nutrition counselling services for all clients.

Activity 1.1.24: Strengthen TB services through the SH network

Fifty-eight SH clinics, managed by eight NGOs, implement TB diagnostic and treatment services in collaboration with the GFTAM and the NTP. GFTAM provides funding for additional TB-focused staff in these clinics, including TB volunteers, Field Supervisors, Laboratory Technologists, M&E Officers and Admin Officers. GFTAM supports treatment and follow-up of TB patients. GFTAM funding is currently committed

through December 2017, with a likely extension of three years beyond that time. The overall clinic setting and broader provision of ESP services in these SH clinics is supported by USAID funding. The success of TB services in SH clinics is a joint achievement of GFTAM and USAID support. All TB services are reported to the NTP.

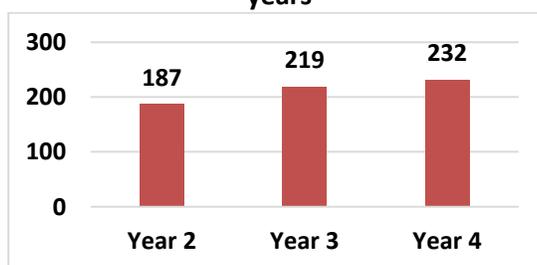
Number of cases of all forms of TB diagnosed in the SH Network over the past 3 years



In Year 4, 7,671 cases of all forms of TB were registered, an increase from 7,129 in Year 3. Among these, 533 (6.32%) cases were children which were an increase from 487 in Year 3 and 6,634 in Year 2. In addition, 413 children in contact with a TB patient were put on INH preventive therapy (IPT) in Year 4; whereas in Year 3, 347 children were registered for IPT and successfully completed six months of therapy.

The Case Notification Rate (CNR) of all forms of TB in Year 4 was 232/100,000, up from 219/100,000 in Y3 and 187/100,000 in Y2. 7,256 cases of TB were successfully treated, with an average treatment success rate of 94.6%. Thirty two Multi Drug Resistant (MDR) TB cases were diagnosed with support of GeneXpert machines operated by MSH and icddr,b.

Case notification rate (CNR) of all forms of TB per 100,000 population in the SH network over the past 3 years



A total of 216 NGO staff received training on TB from the NTP, BRAC and MSH’s Challenge TB project. This included 44 staff and medical officers receiving training on child TB, X-ray, EPTB and e-TB Manager. Forty DOT providers in Dhaka and Chittagong were provided refresher training on TB diagnosis and management.

Orientation and awareness programs on TB were organized for 8,500 private medical practitioners, pharmacists, industry workers, slum dwellers and former TB patients. 7,586 community members were reached with TB messages through film shows, street dramas and folk songs. SH NGOs implementing TB services observed World TB Day on 24th March in collaboration with the GOB and BRAC by attending national and regional rallies and organizing various community level activities.

Activity 1.1.25: USG Family Planning Compliance**Activity 1.1.26: USG Environmental Compliance**

Starting from the Quarter 2 of Year 4 NHSDP introduced an online digital application—developed by Pathfinder International globally—for monitoring and recording FP/RH and Environmental Mitigation and Monitoring Plan (EMMP) compliance at clinic level in keeping with USAID regulations. This digital tool significantly improves the efficiency and effectiveness of compliance monitoring, with automated reports and action plans generated to address compliance gaps. Follow up to corrective actions can be documented directly in the online system, ensuring one comprehensive source of compliance information. Two FP and Environmental Officers were recruited, trained and deployed, starting from the third quarter, to conduct routine SH clinic visits and ensure coverage across the entire network on an annual basis going forward.

The total number of compliance visits conducted in Year 4, by quarter, was as follows: Q1 48 + Q2 66 + Q3 32 + Q4 103 = 249. Out of these, 156 were done using the digital application, with the following results and findings.

Compliance Visits and Results	Q1	Q2	Q3	Total
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Family Planning Compliance

# Clinics Visited	22	31	103	156
# Clinics Compliant / Non-Compliant	20 / 2	27 / 4	95 / 8	142 / 14

EMMP Compliance

# Clinics Visited	20	31	103	154
# Clinics Compliant / Non-Compliant	9 / 11	15 / 16	65 / 38	89 / 65

Key findings regarding FP/RH compliance included the following:

- Documentation of orientation of clinic staff on USG FP legislative requirements was not well maintained in some clinics
- Copies of the consent form for Post-Partum Bilateral Tubal Ligation (PPBTL) was not preserved at some clinics, as these were submitted to DGFP officials
- There was confusion among some clinic staff regarding the meaning of personal targets vs. clinic projections

Immediate follow-up actions were taken by relevant Clinic Managers, with ongoing monitoring by the FP/EMMP Officers and relevant NGO Quality Assurance Managers, to:

- Maintain documents of annual staff orientation as well as to provide and document orientation on FP compliance requirements for newly recruited staff
- Ensure that copies of signed consent forms are preserved at the clinic before submitting it to the DGFP department
- Clarify concepts with staff and ensure that the correct understanding is emphasized in monthly staff meetings and annual FP refresher trainings

To strengthen EMMP implementation, the following mitigation measures were undertaken, for ongoing monitoring and implementation in Year 5:

- Infection Prevention (IP): NGO Quality Assurance Managers, who are already trained on IP and medical waste management, started cascade orientation/training for all clinic staff with special

emphasis on monitoring of IP practice. In Year 5, 150 batches of 5 clinic staff each will undergo 2-day IP training.

- Medical waste management: Non-compliant clinics developed action plans during compliance visits, with ongoing monitoring by the FP/EMMP Officers. In urban areas NGOs are also communicating with Municipal and City Corporations to provide regular off-site transportation and waste disposal.
- Immunization of clinic staff: Clinic Managers are ensuring updated immunization (e.g., Hep-B, TT) for clinic staff, including ensuring that new staff undergo the complete regime of required immunizations
- Dedicated cleaning staff: In clinics without dedicated cleaning staff Clinic Managers have committed to bringing these staff on board. Concerned Project Directors were contacted to ensure availability of full-time cleaners.

Sub IR 1.2: Strengthened partnerships and coordination with GoB health authorities and other USAID-supported projects

MS 1.2.1: List of all clinics to be supported in program agreed by GOB authorities, Contractor, NGOs and USAID

386 out of 388 SH static clinics (99%) currently have updated District Technical Committee (DTC) approval from the DGFP as of the end of Year 4. Renewal applications for the remaining two clinics are in process and expected to be approved early in Year 5.

MS 1.2.2: At least 90% of clinics have community maps

All SH clinics have community maps, which are updated annually on a rolling basis by SHCSGs (see IR 2.2.2 below). 385 SPs were oriented this year on preparing and analyzing community maps and conducting community coordination meetings. These SPs identified local institutions and identified health problems/gaps for developing Community Action Plans at SHCSG level.

MS 1.2.3: Mechanisms of coordination (e.g. periodic meetings, MOU) with local health authorities established at all clinics.

All SH clinics are mandated to have an annual coordination work plan with the local DGFP and DGHS offices and to attend regular coordination meetings with these departments. These coordination mechanisms are reported by the NGOs to be functioning across all clinics, including for support to receive FP and EPI commodities and to report FP and EPI performance to the MOHFW reporting system.

NHSDP technical staff supported local coordination throughout Year 4 through field visits that included meeting Civil Surgeons, DD-FP and Women Affairs & Information Officers. At national level NHSDP coordinated with the DGFP and DGHS which issued specific instructions to their local staff across the country to ensure functional collaboration between Family Welfare Assistants, Health Assistants and SH CSPs for better provision of MNCAH-FP services. Senior government officials also visited a number of SH clinics during the year, appreciating their performance and reinforcing with local officials the need to support the SH network. Visits included the Additional and Joint Secretaries of MOHFW; Joint Secretary MoWCA; and a number of Directors of DGFP and DGHS.

In keeping with an LOC signed with NHSDP in Year 4, the Ministry of Women & Children Affairs (MOWCA) sent a memo to all Women Affairs Officers to supply their lists of beneficiaries to SH clinics to facilitate access of services. SH Clinic Managers are collecting these lists and planning service provision strategies.

MS 1.2.4: At least 90% of clinics have annual work plans developed in partnership with local GOB authorities

99% of SH clinics have developed annual work plan in partnership with local GoB authorities. NHSDP Technical Leads assigned to each NGO followed up during the year on the status of implementation of annual work plans.

MS 1.2.5: At least 90% of clinics have documented referral systems

SH clinics have documented referral systems in place, with ongoing coordination during Year 4 with MSB, BRAC and the GOB regarding bi-directional referral at different levels. These referral arrangements are documented in agreements with MSB, BRAC and the MOHFW. In quarterly review meetings with SH PDs during the year these referral agreements were discussed and promoted for implementation at local level. The DGFP reiterated a strategy for bi-directional referral of pregnant women for safe delivery from SH clinics where EmOC is not available to nearby Union Health and Family Welfare Centers (UHFWC) where EmOC is available; and from UHFWCs where EmOC is not available to nearby SH clinics where EmOC is available.

MS 1.2.6: At least 90% of clinics submit timely reports to MOHFW authorities on quarterly basis

MS 1.2.7: At least 80% of clinic staff/associated community group members participate in GOB local-level planning.

SH clinics continued to submit timely reports to the MOHFW throughout Year 4. SH clinics regularly engage with relevant local government officials, especially for provision of FP and EPI commodities and reporting of these services.

Additional Government Coordination Activities

As per guidance of the “Inter-Ministerial USAID-DFID NHSDP Advisory Committee”, which met in the third quarter, the MOHFW instructed the DGFP to publicize the names of SH clinics in government-sponsored TV scrolls to motivate communities to utilize health services from SH clinics along with government health facilities. The MOHFW also instructed the DG Drug Administration to issue licenses for SH Women Friendly Pharmacies, which meet the GOB Model Pharmacy criteria.



Third Inter-Ministerial USAID-DFID NHSDP Advisory Committee Meeting

During Year 4, particularly in the third and fourth quarters, NHSDP senior management initiated several advocacy meetings with Secretaries and Additional Secretaries of MOHFW, MOLGRD&C, MOWCA, MOSW, NHSDP Quarterly Performance Report | 30

MO Youth & Sports and MO Information to establish LoCs/MoUs for collaboration and to leverage resources for health. This advocacy has helped to ensure that the DGFP and DGHS offer continuous support for timely renewal of DTC approval for SH clinics, along with sustainable supply of FP commodities, Misoprostol, Anti-helminthes, Vitamin A and EPI vaccines to all SH clinics.

The Directorate of Mass Communication, MO Information, instructed District Information Offices to exhibit the “*Enechi Surjer Hashi*” promotional TV spot along with the information about government development activities through projectors at the community level from the government revenue budget.

Sub IR 1.3: Enhanced sustainability of ESP delivery through innovative financing structures

MS 1.3.1: Rational cost-recovery and program income expenditure plan is developed and submitted for each NGO and approved by USAID

This milestone is met through the annual grant renewal process for each NGO.

MS 1.3.2: At least 25% of costs recovered through program income and other sources (Year 1)

MS 1.3.5: At least 30% of costs recovered through program income and other sources (Year 2)

MS 1.3.6: At least 35% of costs recovered through program income and other sources (Year 3)

MS 1.3.8: At least 40% of costs recovered through program income and other sources (Year 4)

The project has achieved each of the cost recovery Milestones as follows.

Year	Cost Recovery Target - %	Cost Recovery Achieved - %
Year 1	25	31
Year 2	30	33
Year 3	35	35
Year 4	40	40*

*For Year 4 this is the average cost recovery rate based on NGO reporting. As usual, this will be validated later by a third party audit.

MS 1.3.3: Updated ESP costing study conducted

The ESP Costing study was completed by a Brandeis University consultant team and submitted to USAID in February. This was followed by clarifications and further analysis which was finalized with USAID by Quarter 4. USAID, through the Health Financing and Governance (HFG) Project, co-hosted an “Experience-Sharing Meeting on Costing Studies” with WHO and the Health Economics Unit of MOHFW on 22nd September in which NHSDP’s COP presented a brief summary of the ESP Costing Study.

MS 1.3.4: NGO partner internal control systems established to plan, manage and report on various types of funding, including program income

This milestone was completed in Y3. In Year 4 NHSDP continued to strengthen the capacity of NGOs and clinics to manage finances. For example, CMs received training on financial management in quarter three. See IR 3 for more details.

MS 1.3.7: Strategic partnerships with key corporate partners established

During much of Year 4 there was little activity related to this Milestone due to not having staff capacity. A Corporate Partnership and Enterprise Manager joined the project in the second quarter but left by the beginning of the fourth quarter.

In Quarter 3 a needs assessment was conducted by the Corporate Partnership Manager in collaboration with NGOs to identify corporate partnership potential at local level. Findings were compiled and incorporated in a concept note, and a revised list of potential corporate partners, by sector, was developed. NGOs were encouraged to approach these partners to present and discuss needs and sustainability options. A short orientation to corporate social responsibility (CSR) was presented in the Quarterly Performance Review Meeting (QPRM) in Quarter 3 for all PDs and Focal Persons.

CSR proposals were submitted this year to a number of organizations including FBCCI, RAK Ceramics, COATS, Lafarge Surma Cement, Epyllion Group, AB Bank, Standard Bank, Standard Chartered Bank, DBL Group, BSRM, Rangs Group, Pragati Insurance and Nipro-JMI Pharma. However there have been no results from this to date. The Health Fairs conducted by NGOs during the year included CSR contributions, both cash and kind. A report on the success of CSR in this context was prepared and shared with all the NGOs.

Activity 1.3.9: New Business Initiative for SH Pharmacies

NHSDP is committed to supporting the SH network to establish a number of for-profit pharmacies as for-profit ventures that increase access to services for girls and women. Establishing a Women-Friendly Pharmacy (WFP) includes having a pharmacy license, which requires having a qualified Pharmacist in the facility. The Drug Administration is not issuing licenses for pharmacies, with the exception of “Model Pharmacies”. In the Inter-Ministerial Advisory Meeting held on 22 June the Committee agreed that SH WFPs meet the criteria for model pharmacies and that new licenses should be issued accordingly.

The first WFP was established in Khulna in Year 3 by PKS. In Year 4, four more WFPs were initiated at Sylhet by SSKS; Joypurhat by KS; Laksham by SOPIRET; and Shewrapara by Swanirvar. Initial experience in Year 4 is mixed. It is too early to determine whether these pharmacies are commercially viable. It does appear that access to services and products for women and girls has increased, with the majority of clients being female across the board (see table below).

Revenue and Female Client Numbers for 4 Women Friendly Pharmacies in Year 4

Location (NGO)	Q2		Q3		Q4	
	Revenue (BDT)	Female Clients	Revenue (BDT)	Female Clients	Revenue (BDT)	Female Clients
Khulna (PKS)	617,197	716 (59%)	536,191	762 (62%)	614,693	492 (64%)
Sylhet (SSKS)	378,983	1,380 (72%)	455,897	1,537 (69%)	421,471	1,569 (80%)
Laksham (SOPIRET)	212,156	520 (52%)	434,169	1,152 (56%)	393,292	1,045 (57%)
Joypurhat (KS)	93,213	341 (58%)	74,809	315 (53%)	74,726	378 (58%)

In Quarter 4 a Pharmacy Management expert was recruited as a consultant to review and translate into Bangla the pharmacy standard operating procedures (SOPs); and to train pharmacy staff on these procedures. This will strengthen the professionalism and standardization of the pharmacies.

An additional 5 new WFPs are planned for start-up in Year 5, along with strengthening 12 existing pharmacies to operate at a similar level of standardization, professionalism and with a focus on women and girls.

IR.2. Optimal health behavior promoted

Sub. IR 2.1: Healthy behavior and care seeking practices improved through behavior change communication/ knowledge management

MS 2.1.1: BCC materials (e.g. print messages, radio spots) developed/adapted from the BCWG-identified best practices and resources

Key materials developed and disseminated in Year 4 included the following:

BCC material use video: This video guides clinic staff on effective use of BCC materials during clinic counseling sessions as well as community-level interactions, aimed at increasing health seeking behavior.

NHSDP informational video: This video explains the mission of the SH network in providing an Essential Service Package across the country. It highlights project achievements and promotes the services available at SH clinics. The video is being used at SH clinics, stakeholder meetings, community gatherings and national and international events/conferences.

eHealth Toolkit: A flash drive was developed with the assistance of BKMI project incorporating the eHealth Toolkit along with the eLearning Toolkit. This was distributed all SH static clinics, including provision for new clinics in the Chittagong Hill Tract program. Availability of these toolkits helps to build staff capacity to generate more interaction with the clients and to help staff members themselves to understand different health issues.

Another flash drive was prepared with a series of enter-educative videos previously available on DVD but now made more easily accessible for showing to clients in clinic waiting areas.

Promotional print materials: To increase demand for services and create better dialogue with the community, three high standard take-away print materials were developed and distributed in bulk quantity throughout the SH network. The materials were approved by the GOB's IEC Technical Committee and included the following:

- **Brochure promoting Infant Young Child Feeding (IYCF):** This includes messages on immediate and exclusive breastfeeding, child nutrition and supplemental food intake from 6 to 59 months of age.
- **Leaflet on promotion of services for poor:** This is designed to raise awareness and increase health seeking behavior among the poor and POP customers, encouraging them to come to SH clinics for primary health care services.
- **Advocacy brochure for preventing Gender Based Violence:** The SH network has increasingly been promoting prevention and treatment of Gender-Based Violence (GBV). This brochure helps to initiate discussion with the female clients who are vulnerable to GBV and to advise them how to avoid such incidents or get help if they suffer from GBV.

Job aides were developed in Year 4 to strengthen the capacity of NGO staff, CSPs and SHCSGs with regard to ESP components. These included:

- **Interactive ESP Q&A Guidebook:** This comprehensive and innovative guidebook with service delivery messages and illustrations covering 32 health topics is designed to facilitate clinic staff to respond to queries from clients and community members. Topics are addressed in simple and interactive language so that service providers are able to enrich their knowledge and disseminate the same to clients. 20,000 copies were distributed to SPs, CSPs and SHCSG leaders.
- **Flip chart on ESP components:** This was developed to explain the major ESP services for 24 health topics. 22,000 copies were distributed for the use by Paramedics, Counselors, Physicians, SPs, CSPs and SHCSG leaders to assist customers in understanding health needs and priorities and thus increase health seeking behavior.

MS 2.1.2. At least 80% of clinics have at least one service provider trained in IPC/C to include BCC messages while counseling on ESP interventions

All (100%) SH clinics have providers trained in IPC/C. During Year 4, 159 Counselors and Clinic Managers were trained in six batches from clinics newly added to the SH network during Year 3. This training helps to increase their capacity to understand customer demands and behavior change issues, helping to ensure provision of quality health services in a friendly environment.

All 388 Clinic Managers plus NGO BCC-CM Focal Persons were oriented on the integrated approach of BCC and Community Mobilization. These orientations were held in 12 batches in four sub-stations and were useful for Clinic Managers to review the ongoing BCC and CM activities at the ground level. Focal Persons' capacity was built to monitor BCC-CM activities and provide supportive supervision and guidance to Clinic Managers.

MS 2.1.3. At least 80% clinics implement monitoring systems (e.g. mystery client) to assess the quality of counseling services:

An initial phase of Mystery Client exercise was conducted in Year 3 in 100 urban and rural SH clinics using four checklists for ANC, FP, limited curative care and child health. This showed that quality of counseling had considerable room for improvement. In addition to immediate feedback at each clinic, an action plan was developed and implemented across the SH network to provide additional training, coaching and mentoring to counsellors and other staff. Improved counselling was included in the Integrated Training for CMs, SPs and CSPs.

A second phase of Mystery Client exercise was conducted in another 100 SH clinics during Year 4, with an emphasis on supporting each clinic visited to address gaps in dealing with clients and to help service providers and counselors improve the quality of their services. A third phase of Mystery Client exercise will be rolled out in Year 5 covering 188 clinics.

Example of feedback and action taken in response to a Mystery Client (MC) visit

50 years old Madhuri Bala has been working with IMAGE NGO as a cleaner at Fatikcherry SH clinic. Every day she cleaned the office and also helps bringing the client to the Counselor room. During counseling she kept herself standing in front of the Counselor regularly which is not a standard practice at all. This issue was discussed during MC visit debriefing session as one of the MC observation. This has made Madhuri and Counselor realized their mistake and committed to not repeat this in future.

MS 2.1.4. BCC strategies harmonized across communities and health facilities and with other USAID projects:

In Year 4 an Integrated BCC/CM Strategy was finalized and rolled out to all SH NGOs and clinics in both Bangla and English. The strategy helps clinics in developing action plans for implementation of integrated and coordinated BCC approaches addressed to specific audiences with appropriate messages provided through the right channels. The strategy takes into account cost effectiveness, user-centered design and public demand in the current context, with a blend of mass media, social media and community level media. It emphasizes coordination and partnerships at the local level through motivating community members, youth clubs, community-based organizations, SH Community Support Groups, and other community networks. The strategy contributes to better leveraging of local resources to support linkages between communities and health facilities.

Other BCC-CM Program Highlights

Poster on BCC and Knowledge Management (KM) Strategy: A one-page color poster summarizing the BCC and KM Strategy was distributed for display at all SH clinics to readily reference the strategy in developing their plans for BCC activities at the local level. The poster highlights the different population segments, channels of communication, coordination with different stakeholders, campaign strategy on different services and mobilizing resources.

Media dialogue for advocacy and SH clinic promotion: A regional level media dialogue was held at Sylhet in December 2015 to gather inputs, perceptions and recommendations from media personnel and to leverage media for advocating for utilization of SH clinic services. Highlights of the dialogue were published in different national and local print media urging the public to adopt healthier behaviors and increase their health seeking behavior.

Creation of Communication Hub at community level: CSPs and SHCSG leaders now have access at community level to BCC materials including the Q&A Guidebook on ESP and the ESP Flip Chart. They have been oriented on the use of these materials. During home visits and courtyard meetings they can use these materials to support their interactions with the community members to disseminate key health messages.

Community Outreach Activities - Observation of Special Events: In Year 4 the following international special events were observed by the SH network: World Hand Washing Day, World AIDS Day, International Women Day, World Health Day, World TB Day, Safe Motherhood Day, World Population Day and World Breastfeeding Week. Factsheets and banners were utilized; rallies were organized; community meetings and discussion groups were held; and for some occasions relevant clinic services were provided at discounted rates.

SH Health Fairs: As part of integrating BCC with Community Mobilization, and to strengthen community—clinic linkages, 25 Health Fairs were held in Year 4 by 23 NGOs across the SH network. Activities included:

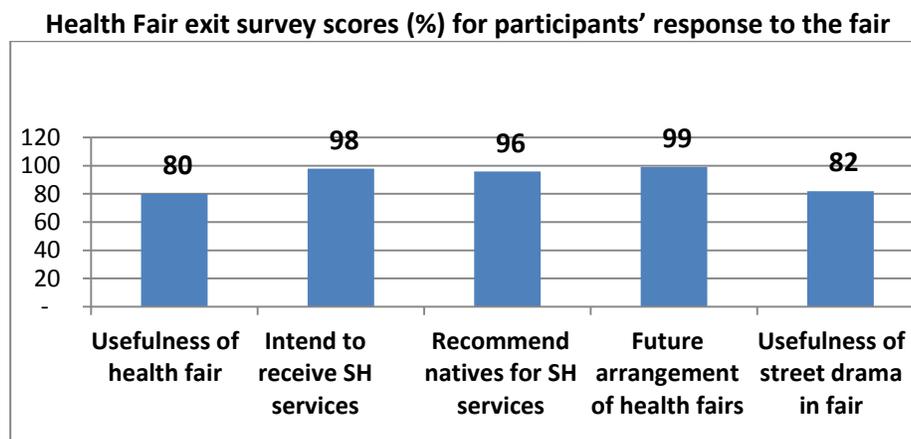
- Health dialogues through community meetings
- Delivery of services and display of development activities by different organization
- Introduction of CSPs to participants, along with recognition of satellite clinic house-owners



- Quiz competition on health topics and sports competitions—particularly for youth
- Cultural shows and street dramas organized by local groups

Average attendance at the Health Fairs was 600 people, with strong representation from Members of Parliament, City Corporation and Municipal Mayors, Upazila and UP Chairmen, groups of school and college students and a variety of community members. District and Divisional level GOB officials from Health, Family Planning and the Local Administration were also active supporters and participants.

At the end of each Health Fair a quick exit survey was conducted. The results are shown in the graph below. It was found that 80% of participants thought the fair was useful for them to get information on different health issues; 98% intended to receive services from SH clinics in the future; 99% wanted to arrange such Health Fairs at regular intervals in future; 82% thought the street dramas were informative and useful; and 96% intended to inform their relatives about the fair.



Based on the success of the Health Fairs at clinic level, a national event was held in Quarter 4 at Dhaka for showcasing the success stories of Health Fairs. Participants included government and media representatives, along with representatives from SH NGOs and communities. There was strong interest in continuing such events as a bridge between community and clinics to increase uptake of ESP services. NGOs indicated that they would seek to hold such events in the future with their own resources as well as raising resources from other local stakeholders.

MS 2.1.5 At least 60% of children 0-5 months are exclusively breastfed in catchment areas.

A brochure promoting Infant and Young Child Feeding (IYCF) was developed, with 700,000 copies distributed to all SH clinics as take away material for mothers. Key messages include promotion of immediate and exclusive breastfeeding (EBF); and supplemental feeding from 6 to 59 months. The brochure helps service providers provide better counseling for mothers/caregivers. World Breast Feeding Week was actively observed throughout the SH network in August, with widespread promotion of EBF and community dialogue on its importance.

Sub IR: 2.2. Communities are actively engaged in promotion of healthy behaviors and care seeking practices

MS 2.2.1: At least 90% of targeted communities report increased satisfaction with NGO clinic services.

In Year 4, the number of client contacts at satellite clinic and community level increased by 27% compared to the previous year. This indicates strong client satisfaction.

In Quarter 4 a new client exit interview format and process was developed and tested, but due to the departure of the project's Quality Assurance Specialist this was not put into full implementation yet. In the first Quarter of Y5 this mechanism will be put in place throughout SH static clinics so that client satisfaction can be monitored quantitatively on a monthly basis.

During Year 4, SHCSGs systematically included client satisfaction as a standing agenda item for their monthly meetings. With renewed emphasis on, and support to, SHCSGs through training of group leaders, the reported number of group meetings and attendance of group members has increased. In Quarter 3, 10,979 meetings were reported and in Quarter 4, 13,000. Feedback on client satisfaction and other matters is routinely provided by SHCSGs to SH clinics.

BCC-CM team members attended a number of SHCSG meetings and found, anecdotally, that clients are generally satisfied with SH clinic services and counselling, especially for women and girls. Some communities indicated a desire for more childbirth facilities to be available. In Year 5 a more rigorous assessment of client satisfaction is planned.

MS 2.2.2: At least 90% of clinics are linked with community groups that participate in health planning and mobilization activities.

MS 2.2.3: At least 90% communities served by clinics supported by groups of mobilized local influential stakeholders

All (100%) SH static clinics are linked to community groups that participate in health planning and mobilization activities. At the end of Year 4 the SH network reported having 10,754 satellite clinics, with a total of 10,170 (95%) functioning SHCSGs.

Integrated BCC-CM Initiative for SHCSGs: In order to build the capacity of SHCSGs to more effectively mobilize communities and plan ways to increase access to services, an initiative was undertaken in Year 4 to train one SP from each static clinic area and two leaders from each SHCSG.

- 385 SPs were trained on community action planning and implementation
- SPs, in turn, conducted a one-day training for CSPs and SHCSG leaders in their respective catchment areas, with a total of 15,527 participants from 6,785 out of the 10,170 (67%) SHCSGs trained by the end of the year
- Training included preparation of updated Community Action Plans (CAP), completed by 5,044 SHCSGs (50% of the total) in collaboration with 77,102 community members. Plans included identification of major health problems; prioritizing and setting goals; mapping of the health situation; and resource identification.
- Training will continue in Year 5 to cover the remaining one-third of SHCSGs.

Key actions taken through this planning process included:

- Identification of newly married couples and linking them with CSPs
- Identification of poor and poorest-of-the-poor (POP) families. 70% of SHCSGs reported preparation of a list of poor and POP families validated by local government institutions and/or other projects in the area
- Arranging health education sessions/courtyard meeting, as well as conducting Health Camps in which 66,076 clients received primary health care services
- Preparing emergency transport services for pregnant women

- Referring adolescents to SH Clinics for counseling; and conducting blood grouping for 88,408 school students
- Following up on ANC clients, including promoting Red Flag to identify pregnant mothers and arranging emergency transport when required

In Year 4 the number of client contacts at satellite level increased by 27% compared to the previous year.

Young Mothers Clubs: NGOs reported forming 407 such clubs in Year 4, with 4,274 members. These groups are largely a response to community demand and interest. They contribute to awareness raising, information sharing, mutual support and mobilization to increase access to services.

PBG Indicator for CM: An indicator for community mobilization was included in the Performance Based Grants (PBG) indicators during the previous year. During Year 4 the indicator and reporting template were revised, with new guidelines sent out to all NGOs. The new indicator shows that 65% of SHCSGs are meeting regularly with at least one community mobilization activity undertaken per quarter. These activities included distribution of Health Cards by group members, religious leaders and community SBAs to benefit the poor; and more actively engaging with local government institutions (LGIs).

At Ramgong Clinic in Laxmipur Municipality, the Clinic Manager attended a monthly meeting of the Municipality and presented SH clinic services. Following this the commissioners, with support from the Mayor, established five new satellite clinic spots where Ramgong Clinic has been providing health services. In the last quarter, service contacts reported by the clinic have increased by 13%.

Support from JHUCCP: Experts from JHUCCP provided support throughout the year, including three STTA visits, to help develop the BCC-CM integrated strategy; formulate a simple monitoring tool for SHCSGs activities and SP/CSP performance; and to support greater engagement with government and other key stakeholders.

IR 3: Local ownership of service delivery enhanced

Sub IR 3.1 Institutional capacity of all local NGO partners strengthened

MS 3.1.1: Baseline analysis of local NGO partners' institutional strengths, weaknesses and areas of focus for future capacity building updated

Completed in Y1

MS 3.1.2: Roadmap for each NGO partner developed to outline customized capacity building requirements in relation to baseline and pre-determined benchmarks

Completed in Y1

MS 3.1.3: All NGO partners achieve at least 90% of capacity building benchmarks identified in roadmaps

During Year 4, an intensive Technical Assistance (TA) plan was implemented to further support achievement of targets against the Capacity Building benchmarks of SH NGOs. The plan was coordinated with NHSDP technical staff across all IRs to maximize implementation.

Technical Assistance for Capacity Building was provided to 24 NGOs (excluding SMC which is in a close-out process) based on review and revision of an NGO Technical Assistance Plan for Year 4. This included the following:

- Support to SH NGOs on Governance, Leadership and Management (GLM) for implementing the requirements of the Action Plan, along with refresher training on Leadership and Management and orientation on succession planning
- Provision of monitoring and mentoring support and TA to the SH NGOs on Capacity Building Benchmarks and other Capacity Building areas of the organization
- Orientation of 75% NGOs Executive Committee on leadership and governance, with encouragement to increase female membership in the Executive Committee
- Review of organizational structure of SH NGOs
- Updated HR Policies and implementation of HR Retention Strategies
- Updated Gender Policies, with follow-up and support provided for implementing women and girls centered service strategy (in collaboration with the Gender Specialist)
- Monthly coordination meetings with the GOB at district level attended by Project Director/Program Manager/Clinic Manager
- Support to complete a communication plans; develop service fee collection policy; and to develop Stakeholders' Feedback Strategies
- Orientation on how to conduct "Best Practice" documentation using a template provided by NHSDP with Pathfinder HQ support

Coordination and Collaboration:

- Shared Integrated Technical Assistance (TA) Plan with all IRs for leveraging technical support and effective implementation to ensure contributions to wider project outcomes
- Coordinated and followed-up with all SH NGO Capacity Building Teams through emails, phone calls, Skype, and cross-learning visits on a regular basis. This helped the NGOs to implement the Benchmarks and other Capacity Building tasks more efficiently and effectively. It also enhanced their learning capacity on the validation process, with NGO staff engaged in validation visits to other NGOs.

Capacity Building Activities as per Y4 Work Plan:

Staff Retention Strategies, Updated HR Policy, Revised Salary Structure and Benefits Package of SH NGOs:

The challenges of staff retention and low salaries have been repeatedly raised by the NGOs in recent months as the GOB has increased the salaries and benefits of government staff significantly, and the SN network now lags behind this trend. Most competitors of SH NGOs have revised their salary structure to cope with this changing context. Considering the work plan and contextual ground, NHSDP took this issue as a high priority and hired a Consulting Firm to develop Staff Retention Strategies; guidelines for a customized HR Policy for SH NGOs; and revised salary structure of SH NGOs in close collaboration with network NGOs.

The consulting firm initiated their tasks in Year 4 as per the SOW provided by NHSDP, with finalization of their report expected in Quarter 1 of Year 5. The NHSDP IS Team worked closely with the consultants, overseeing and monitoring activities to ensure quality deliverables. SH NGOs prepared an action plan for implementation of Staff Retention Strategy, Updated HR Policy and Revised Salary Structure and Benefit Package under the close supervision of the IS Team.

SH NGOs Capacity Building Team Formation and Functionality: A Draft TOR for a Capacity Building Team for each NGO was revised by NHSDP and finalized by incorporating recommendations through a review

workshop with six Dhaka-based NGOs. All 24 NGOs were oriented on the TOR. The teams started functioning as a driving force for strengthening institutional capacity and carrying forward the IS activities throughout the process with assistance and technical guidance from NHSDP.

Following NHSDP recommendations, NGO Capacity Building Teams met monthly, participated in capacity building activities and training, prepared meeting documents, preserved all documents in separate files and maintained communication with NHSDP and other stakeholders.

Support Training for NGO Internal Control Staff: A training module on “Internal Control Management” was developed in collaboration with the NHSDP Internal Control Team. A one-day training was conducted for the Internal Control Managers of five SH NGOs (BAMANEH, FDSR, PSTC, JTS and Swanirvar Bangladesh). Collectively, these NGOs are managing about 41% (158 out of a total 388) SH static clinics. The training helped the NGOs to ensure proper utilization of funds including: reducing the rate of unallowable costs; effectiveness and efficiency of operations; reliability of financial reporting; compliance with applicable laws and regulations; and prevention and reduction of fraud and corruption.

Training for Clinic Managers and Administrative Assistants: A training module on “Financial Management, Reporting, and Governance & Leadership” was reviewed and finalized with discussion among the Capacity Building Team and Finance & Grants Teams to improve clinic management skills and efficiency. An intensive training plan and implementation strategy were developed for all the Clinic Managers and Administrative Assistants of SH NGOs. A day-long training was conducted for 55 Clinic Managers (CMs) and Administrative Assistants (AAs). Trainings will continue through the first and second quarters of Year 5 for the remaining CMs and AAs.

Capacity Building Benchmark Validation—Reviewing Progress Against Benchmarks: In Year 4, NHSDP conducted a Capacity Building Benchmark Validation event for 24 SH NGOs to assess their current progress against Benchmarks as identified in the roadmaps. Validation was undertaken in each NGO by a two-member team from NHSDP using a validation tool. Findings were shared with senior management of the respective NGO. To accomplish the validation exercises efficiently and effectively, NHSDP formed four in-house teams which were first oriented on the tool, technique, methodology and process to ensure equal levels of assessment skill and capability.

Development and Implementation of Gender Policies: The Capacity Building Team supported the Gender Specialist in holding a “Gender Policy Development Workshop” at the NGO Forum Conference on 01-02 February 2016 for five SH NGO Executive Committee Members, Gender Focal Points, Project Directors, and other selected participants. This was the last in a series of workshops covering all the NGOs, providing clear guidelines on how to develop gender policy for their organization. The Capacity Building Team followed up on Gender Policy finalization and implementation with the SH NGOs during field visits. This included discussions with NGO Executive Committees and Management Teams to support activation of Gender Policies on a priority basis.

STTA was provided during Year 4 by Julia Monaghan, Technical Advisor, from Pathfinder HQ. This included a half-day orientation session for the Capacity Building Team of NHSDP. The Technical Advisor reviewed the Benchmarks with the team and assisted them with prioritizing follow-up actions for the remainder of the project. The Year 4 work plan was reviewed and plans were made to operationalize required activities on a timely basis, including establishing NGO Capacity Building Teams based on terms of reference (TOR) that were finalized.

Section II: Monitoring and Evaluation

Improved MIS

In Year 4 NHSDP established a standardized Management Information System (MIS) for project and SH network monitoring and evaluation (M&E) that is more simple and user-friendly. From April 2016 all SH clinics are using a single unique database to capture performance data. This not only simplifies the data entry process, reducing reporting time for clinic staff, but also means that managers at all levels—from clinic to NGO to the SH network as a whole—can access, analyze and use their own data for decision making.

Introduction of the new MIS began from Quarter 1 with training of all M&E Officers and one Clinic Manager from each NGO. Training included orientation to the new Access database and data collection tools, along with refresher training on clinic and project indicators; data demand and information use for better program planning and management; and data quality control. Trainees were made responsible to disseminate the new information and train their respective clinic staff including Clinic Managers, Counselors, Paramedics and Data Entry Operators.

Routine support to M&E functions

Quarterly Review Meetings with NGO M&E Officers were held in each quarter of Year 4. Issues addressed included review of M&E Officer responsibilities, along with challenges and gaps in implementation and solutions to address those. M&E Officers were increasingly empowered to ensure that M&E activities are implemented successfully with good data quality.

To further strengthen data quality control systems, NGO M&E Officers and the M&E team developed improved field visit tools that help to track observations and action plans for better M&E implementation. To enhance data demand and information use, several database templates were developed and shared with the M&E team and Technical Leads to ensure that the project has simple templates and analytic strategies that allow staff to make effective programmatic decisions based on reliable data.

The M&E team conducted ongoing field visits to SH static and satellites clinics, as well as CSPs, to monitor data collection based on instructions in the MIS manual. During the last quarter of Year 4, 5 NGOs and 10 clinics were visited. Review and on-job-training included ensuring proper data entry and accurate data compilation, management and reporting. Any discrepancies observed were discussed and corrected on the spot.

Regular meetings were held with NHSDP Technical and Thematic Leads to brief them on indicators applicable to their respective areas; ensure data quality; review status of milestones; and track achievement against project indicators and targets. This included helping to develop data collection tools and methodologies for Client Exit Interview and Quality Improvement.

Support to project reviews and assessments

The M&E team was actively engaged with providing data, in various formats and based on a variety of parameters, for the first phase of the USAID mid-term review (MTR) in November 2015. A second phase of the review process in June 2016 similarly put high demands on the team for data and explanations of project performance indicators.

USAID conducted data quality assessment (DQA) in 7 SH clinics in June to verify data on four selected performance indicators. Findings and feedback were provided to NHSDP and follow-up actions were taken during the third and fourth quarters. One action that will continue to be worked on in Year 5 is to design

and implement a checkout system for clients at SH clinics in order to ensure that reported service numbers are consistent with what actually took place during the clinic visit.

An external DQA for PBG indicators for Apr-Jun 2015 and Jul-Sep 2015 was conducted by the audit firm A. Wahab & Co. This was reviewed by the M&E team before finalization. The process to hire an audit firm to conduct DQA for the subsequent project periods was also completed in collaboration between the M&E team and F&O team.

Project performance indicators

The M&E team prepared the Monthly Statistical Reports throughout Year 4 for submission to USAID. These reports were regularly shared with the Technical Leads and feedback given to the SH NGOs. Monthly and quarterly trend analyses facilitated better understanding regarding access to and use of SH network services. Performance reports were prepared for DFID on a six-monthly basis (October –March; and April-September) based on their log-frame indicators

Based on performance in Year 4, indicator targets were calculated for Year 5 for each of the SH NGOs and for the project overall. These targets were uploaded to an online data system (ODS) maintained at Pathfinder International HQ. In the fourth quarter the M&E team prepared the annual PPR indicators for USAID as per the prescribed template.

Section III: Performance Based Grants (PBGs)

NHSDP implemented NGOs performance based grants during project Year 4 (which was the third year for PBGs). After issuing the grant modifications for Year 4, NHSDP conducted a post-award workshop for NGOs to explain various changes in the grants including indicators, budget, and organizational policy development as part of the grant requirements.

The performance payment was changed from quarterly in the previous year to annually in project Year 4, following an annual DQA. This change was made at the request of NGOs who found the quarterly DQA process too burdensome. The maximum performance payment remains a pre-determined fixed amount of grants funds annually, equivalent to approximately 10% of an NGO's USAID grants budget, which will be allocated to NGOs at 1% for each indicator. The 2% additional for achievement of all performance indicators was removed due to the addition of two more indicators, for a total of 10 performance indicators. System indicator penalties remain the same, although the third system indicator will be assessed on an annual basis through the DQA process.

Based on the program requirement, changes were made to both System and Performance Indicators. The system indicator "Staff Retention for the Quarter" was replaced with "% of clinics implementing a continuous quality improvement (CQI) plan" which was formerly a performance indicator. As all NGOs were able to achieve the quality indicator of implementing a CQI plan, NHSDP made the decision to remove positive incentives for achievement and instead ensure continued performance through its addition as a system indicator. Additional indicators were added to increase NGOs' focus on essential newborn care, nutrition, and community mobilization, which had not been addressed by performance indicators in previous years.

NGOs submitted all required reports for the PBGs on time. These were reviewed by NHSDP and feedback was provided. Audits of all 25 NGOs, including SMC, were completed during this period, with the audit firm selected through an open competition among pre-approved USAID OIG audit firms in Bangladesh. Grants monitoring through compliance and voucher checking visits were also completed as required.

NHSDP finalized and disbursed performance payments for Year 3 in the second quarter of this year. Payment amounts were determined based on the achievement of PBG performance indicators, which were validated and verified by external firms. NGOs used the performance payment to pay bonuses to their staff at all levels (NGO and clinic), including CSPs.

During Year 4, NHSDP trained NGOs on Tally ERP 9 Accounting Software. NGOs will initiate using the software starting from October 1, 2016. NGOs will use the accounting software in parallel with manual accounting until they demonstrate successful use of the software. NGOs have been using manual accounting systems from the time of first becoming USAID implementing partners. NHSDP expects greater compliance, transparency, and internal control, including reliable reporting, by using the software.

USAID Special Conditions for PSTC and SWANIRVAR were implemented during this period. All Special Conditions were achieved and the final report will be submitted to USAID in October 2016 as per the reporting deadline.

A workshop was held for NGOs on PBG learning and best practices from 26-28 September 2016. The workshop was facilitated by Pathfinder HQ Technical Advisor, Sarah Unninayar, and attended by clinic staff and representatives of 24 NGOs, NHSDP, and USAID. During the workshop, NGOs presented their best practices and challenges they have overcome related to PBG implementation under the general themes of service delivery, management and monitoring. Group work complemented the presentations and encouraged NGOs to select the most promising strategies and activities to implement in the upcoming year. Activities considered especially useful by the NGOs included implementation of women friendly pharmacies; mothers' clubs; and student ambassador programs. At the end of the workshop all NGOs developed detailed action plans that outlined one to two new approaches that they will take to overcome PBG achievement challenges. Participants appreciated the opportunity for NGOs to learn from each other, and the extensive group work related to workshop themes.

The final year of PBG implementation was initiated during the fourth quarter of Year 4. NGOs submitted their budgets, work plans and other required documents by the deadline. All documents were then reviewed and finalized by NHSDP Technical, M&E, and Grants Team along with Pathfinder HQ team. Pathfinder submitted a request for USAID approval for the grants in early September 2016 and received approval by the end of September 2016.

The performance payments for Year 5 will be challenging given the limited time between the end of the fiscal year, for which the targets have been set, and the end of the project. Pathfinder will have two months for NGO reporting, validation, and verifications of reported results and disbursement of performance payments. NHSDP expects to launch the verification and validation early so that the process can be completed within the required timeframe.

Section V: Project Communication and Visibility Strategy

As per project Modification number 2, issued in Year 2, multifaceted efforts are underway to increase the visibility and credibility of NHSDP in keeping with an approved NHSDP communication strategy. Achievements and success stories were highlighted in different media and fora through visible communication materials during Year 4 at both national and international levels, including the following:

NHSDP Newsletter "HighPoint": Two issues of this NHSDP newsletter were published to share activities, events, interventions, success stories, recognition and case studies from the community.

Program and Technical BRIEF: Two Technical Briefs were published featuring NHSDP expansion of services in the Chittagong Hill Tracts and institutionalization of Surjer Hashi Women Friendly Pharmacies. In addition, a technical brief was published through Pathfinder International titled “Implementing Performance-Based Grants (PBG) for Improved NGO Performance in Bangladesh”.

News BRIEF: Nine editions of NHSDP’s in-house publication “NEWS BRIEF” were published in Year 4, including featuring high level visits at Surjer Hashi clinics; participation in ICFP in Bali, Indonesia; participation in ICAAP12 and World Population Day 2016; Surjer Hashi Clinic performance of 303 normal deliveries in one month; and highlights of support from government during the third Inter-Ministerial USAID-DFID NHSDP Advisory Committee Meeting.

Policy BRIEF: Two “Policy BRIEF” documents were published covering “Using Implants in SH Clinics” and “Reciprocal Referral between SH Clinics and Union Health and Family Welfare Centers”.

Participation of NHSDP staff in national and international conferences:

International Conference on Family Planning (ICFP), 25-28 January, 2016, Indonesia: NHSDP’s COP co-moderated sessions on “Health System Issues and Family Planning Services” and “Capitalizing on the Promise of Community Health Workers Program”. NHSDP’s ANGEL model was highlighted in a CEO Round Table for Emerging Leaders; as was the project’s approach to providing 39 million health and FP service contacts per year, which was presented and discussed in the Marketplace for Ideas.

ICAAP12, Dhaka, Bangladesh, 12-14 March: NHSDP registered 70 NGO and NHSDP participants for this conference. NHSDP’s contribution to addressing HIV in Bangladesh was featured in one oral presentation and two poster presentations. A Symposium on “Integrated ESP-HIV Service Delivery Models: Successes and Challenges” was organized to discuss NHSDP’s experience. A booth was maintained by NHSDP throughout the conference highlighting activities on ESP-HIV integration. The COP Dr. Halida Akhter gave a key note speech in the special plenary session, chaired by the Secretary, Ministry of Health and Family Welfare, where she presented on “Exclusion: the Violence of Stigma on HIV/AIDS”.



8th Asia-Pacific Conference on Sexual and Reproductive Health Rights (SRHR), Myanmar, 23-26 February: NHSDP’s COP attended this conference and gave an oral presentation on “Quality Family Planning Services”, which was also highlighted through a poster presentation.

12th International Inter-Ministerial Conference on Population and Development: Every Woman, Every Child, Every Adolescent held in Dhaka, Bangladesh: NHSDP’s COP was the key note speaker for this event, highlighting the unfinished agenda in reproductive health.

National Conference on Sexual and Reproductive Health Rights, Bangladesh, 3-5 May: Staff of NHSDP, along with 70 female SH Clinic Managers and Paramedics from different regions of Bangladesh, attended the conference. A Surjer Hashi information booth was set up and three poster presentations were given by SH staff.

VOA journalist's training on Preventable maternal death: NHSDP's COP participated as a resource person in these events which took place in six districts during Year 4.



COP, NHSDP among journalists from Bogra area after VOA Journalist's training

Communications materials and STTA support: Two senior communications experts from Pathfinder HQ provided STTA to the SH network. They visited several Surjer Hashi urban and rural clinics and conducted around fifty interviews with clients and service providers. They also conducted a workshop for Project Directors and Focal Persons of SH NGOs on developing communications strategies. Each NGO formulated and submitted their first draft Communications Strategy accordingly.

Annex A. Annual Achievement of Performance Indicators

Sl. #	Description of the Indicators/Items	Total Y4 Target	Quarter-1	Quarter-2	Quarter-3	Quarter-4	Total Y4 Achieved (Oct'15-Sep'16)	% Achieved
		(Oct'15-Sep'16)	(Oct-Dec'15)	(Jan-Mar'16)	(Apr-Jun'16)	(Jul-Sept'16)		
SH Network: 25 NGOs, 388 Static Clinics (Rural:192, Urban:196), 10,754 Satellite Clinics, 8,316 Community Service Providers								
1	# of CYP	1,585,986	391,414	383,692	376,738	384,886	1,536,730	97
2	# of service contacts at SH clinics	40,130,370	10,863,628	10,752,632	10,184,160	10,480,323	42,280,743	105
3	% of service contacts who qualify as poor	39%	45.7%	44.0%	41.7%	42.2%	43%	110
4	# of injectable provided through USG supported program to prevent unintended pregnancies	1,886,250	474,021	475,356	466,204	471,118	1,886,699	100
5	# of deliveries with an SBA in targeted communities	33,088	10,695	9,918	9,496	10,588	40,697	123
5.a	Home births	5,462	2,116	2,034	1,656	1,809	7,615	139
5.b	Facility births	27,626	8,579	7,884	7,840	8,779	33,082	120
6	# of ANC checkups provided during pregnancy through USG supported programs	1,620,000	469,106	451,570	460,362	454,887	1,835,925	113
6.a	First visit	550,800	154,719	156,567	153,357	151,308	615,951	112
6.b	Fourth visit	340,200	95,430	88,258	82,553	88,533	354,774	104
7	# of youth (15-25 yrs) accessing reproductive health services	7,154,312	2,420,568	2,396,596	2,515,898	2,496,688	9,829,750	137
8	# of newborns born in supported clinics receiving immediate newborn care (within 72 hours)	123,633	50,174	61,997	64,487	69,933	246,591	199
9	# of childhood pneumonia cases treated with antibiotics	196,777	53,442	58,075	61,414	64,069	237,000	120
10	# of children ages <12 months received Penta3 from USG-supported programs	396,270	111,240	89,309	38,209	34,784	273,542	69
11	Number of pregnant women who receive counseling on adoption of IYCF practices	1,057,103	384,214	397,475	406,170	429,666	1,617,525	153
12	# of Pregnant & Lactating Women prescribed with 30IFA (FTF Clinics)	740,820	309,745	322,147	232,025	241,355	1,105,272	126
13	# of service contacts with children <5, included growth monitoring in USG supported programs in project areas	470,800	248,435	255,841	236,163	244,152	984,591	149
14	# of vitamin A supplementations provided to children U5 (including NID)	2,211,000	1,390,890	4,538	2,445	1,381,639	2,779,512	209
15	# of post-natal care (PNC) services by skilled provider within 48 hrs. of delivery	84,731	65,729	66,402	69,913	73,262	275,306	325

Annex B: NHSDP Visibility (Publications & Communications)

SI	NHSDP Visibility Events/materials	Status	Time of Publication
1	NHSDP BRIEF on USAID-DFID CHT	Printing & Online	November, 2015
2	NHSDP BRIEF on 2 nd Advisory Committee Meeting	Printing & Online	November, 2015
3	NHSDP poster on	Printing & Online	October, 2015
4	NHSDP BRIEF on ICFP, Bali, Indonesia	On NHSDP participation in ICFP 2016	December, 2015
5	Poster on ICFP	On NHSDP participation in ICFP 2016	December, 2015
6	NHSDP Quarterly Newsletter (July-September, 2015)	Shared through online and printed version	October, 2015
7	12th International Inter-Ministerial Conference on Population and Development: Every Woman, Every Child, Every Adolescent, Bangladesh	COP, NHSDP chaired a session and highlighted NHSDP activities	November, 2015
8	Ending Preventable Child and Maternal Death	Raadio Borno, Rajshahi	November, 2015
9	NHSDP BRIEF on US Undersecretary of State for Political Affairs, Thomas Shannon, and US Ambassador to Bangladesh, Marcia Bernicat, to the Surjer Hashi clinic at Aftabnager	Online	January, 2016
10	NHSDP BRIEF on NHSDP's participation in the International Conference on Family Planning (ICFP) in Bali, Indonesia	Print & Online	January, 2016
11	News BRIEF on Signing MOU with Water and Sanitation Urban Project (WSUP)	Online	March, 2016
12	News BRIEF on participation in the International Conference on HIV/AIDS in Asian and Pacific (ICAAP12)	Online	March, 2016
13	News BRIEF on NHSDP Participation to a local BCC event, Shfollo Gatha (Success Story)	Online	March, 2016
14	Policy BRIEF on using Implant in Surjer Hashi clinics	Online	March, 2016
15	News BRIEF on NHSDP participation in WPD 2016	Online	July, 2016
16	News BRIEF on Weeklong Health Campaign for Poor and POP	Online	August, 2016
17			
Press Coverage:			
1	Ending Preventable Child and Maternal Death	Newspaper: banglamail24.com	November, 2015
2	Surjer Hashi made the patients happy in Bogra	Newspaper: Journalbd24.com	November, 2015
3	5270 Mother dies to deliver child per year in Bangladesh	Newspaper: Thereport24.com	November, 2015
4	Journalist Training has done by NHSDP	The Rajshahi Press Report	November, 2015

SI	NHSDP Visibility Events/materials	Status	Time of Publication
5	Press Release on NHSDP Media Dialogue	<u>Newspaper:</u> The Daily Jalalabad The Daily Jugaveri The Daily Kazir Bazar The Daily Sobuj Sylhet The Daily Shyamol Bangla The Daily Sylheta Duk	December, 2015
6	Surjer Hashi Clinic is beside Poor and Poorest of the Poorest mothers	Dainik Deshpranta (Local)	January, 2016
7	Half of the children born through the hand of unskilled providers	Bangla.bdnews24.com (Online)	February, 2016
8	Proper care stressed to reduce mortality rates of mothers, children	The Daily Sun (National)	February, 2016
9	58pc child delivery by untrained midwives	The Independent (National)	February, 2016
10	HIV Prevalence in Bangladesh is low	The Daily Prothom Alo (National)	February, 2016
11	WSUP, PI ink partnership MOU	The Daily Observer (National)	February, 2016
12	Early Marriage Violation Girls Right	The Daily Star (National)	March, 2016
13	Right of married girl child should be ensured	The Daily Prothom Alo (National)	March, 2016
14	Press Release on NHSDP Media Dialogue	<u>Newspapers:</u> The Daily Azadi The Daily Karnafuli The Daily Priyo Chattagram The Daily Purbadesh The Daily Purbakon The Daily Sangu The Daily Suprovat Banglamail24.com (online)	February, 2016
15	Grass root people need optimum reproductive health services	Bangladesh Sangbad Sangstha, Rajshahi	June 09, 2016
16			
17	Preparation meeting of Shastha Mela	Dainik Azadi	May 18, 2016
	Corporation going to organize Health Fair on 4 th June	Suprovat Bangladesh	May 17, 2017

ANNEX C: SH Network Quality Management and Supervision (QMS) Score

SH Network Quality Management & Supervision (QMS) Consolidated Scores for Year 4: Oct 2015 – Sep 2016										
NGO	Round 1: Oct 2015 - Mar 2016					Round 2: Apr 2016 - Sep 2016				
	Clinic Preparedness	Observation Process	Knowledge Quiz	Record Review	Mean	Clinic Preparedness	Observation Process	Knowledge Quiz	Record Review	Mean
BAMANEH	93	97	91	92	93	96	97	98	93	96
Bandhan	95	96	96	96	96	96	97	97	96	97
CRC	84	84	94	74	84	89	82	85	73	82
CWFD	95	90	97	95	94	95	92	94	90	93
FDSR	96	99	93	91	95	97	98	97	92	96
Image	99	99	97	100	99	100	100	100	100	100
JTS	84	83	93	84	86	86	85	88	88	87
Kanchan	90	89	67	94	85	90	86	70	93	85
Nishkriti	93	97	93	96	95	94	94	96	98	95
PKS	89	95	92	89	91	90	93	91	90	91
Proshanti	96	81	77	97	87	96	74	77	97	86
PSF	90	96	81	89	89	91	97	88	90	91
PSKS	88	85	84	87	86	91	84	78	86	85
PSTC	86	84	73	84	82	95	94	86	93	92
Shimantik	89	80	81	91	85	90	85	72	100	87
SMC	86	90	69	91	84	87	90	68	91	84
SPOIRET	86	89	95	93	91	84	88	95	93	90
SSKS	94	89	60	98	85	100	100	72	100	93
SUPPS	88	73	86	99	86	88	67	86	93	83
SUS	92	90	69	90	85	90	90	83	90	88
Swanirvar	94	90	79	89	88	90	89	83	91	88
Tolottama	98	87	82	91	89	97	84	82	89	88
UPGMS	91	92	92	89	91	89	89	85	85	87
VFWA	83	69	62	80	74	92	86	87	90	89
VPKA	90	92	63	96	85	89	92	80	97	89
SH Network Score	91	88	83	91	88	92	89	86	92	90