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**Urban Family  
Health Partnership  
Annual Report  
1997/98**

**Annual Report for July  
1997 to September 1998**

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Fertility Reduced and Family Health Improved  
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## **A. Summary of Main Activities in 1997/98**

### **1. Outcome of Action Plans**

Progress against UFHP's 1997/98 work plan is best assessed with reference to the 25 action plans contained therein; these all show cross-references to their parent Intermediate and Sub-results. In the commentary below, we note the status of each plan at year-end. Each of UFHP's three management partners – BCCP, CWFP and PSTC – have participated in all plans through their seconded staff within the UFHP structure. In addition, each has made specific additional contributions through its own organisation to specific plans and activities. A summary of the main UFHP-related activities undertaken by each partner in the first 15 months appears in Appendix A.

#### ***Action Plan 1 – ESP Rollout***

Rollout proceeded throughout the year more or less on schedule. We ended the year with 120 static clinics and 244 satellite teams in action in 71 municipalities. They are all offering most of the high and medium priority ESP components but still at varying levels of quality owing to the continued non-availability of quality standards/manuals and the late start on ESP technical training. Our NGOs have identified appropriate referral centres in each municipality they serve; these will be formally documented and a more effective referral system put in place during the coming year. The clinics' main priorities for the next six months will be to distribute emergency drugs, recover from the floods and put staff through 4-6 rounds of ESP technical training.

#### ***Action Plan 2 – Clinical Contraception***

The September deadline for setting up a nationwide network of comprehensive care clinics was pushed back to January 1999 in our last report. We remain comfortably on the new schedule. A contract was signed in May with FPAB covering its four City Corporation clinics and these have now been integrated into the UFHP network. The priority for the next three months is to get started on assessing quality levels in the next 15-16 clinics with a view to extending the existing contract to cover them as well by January 1999.

#### ***Action Plan 3 – Garment Workers***

The research study was finally commissioned with PIACT in June to assess both health needs and current treatment costs of workers primarily in the garment and leather industries in Dhaka and Chittagong. It will take at least five months to complete and we do not expect useable results before November 1998 when we can start further design work on the proposed 'health insurance' scheme for these industries.

#### ***Action Plan 4 – SMC Collaboration***

The tasks listed in the work plan were completed on time. UFHP is selling SMC pills, condoms and ORS in selected UFHP clinics with mixed success. The proposed cooperative venture on HIV/AIDS prevention in selected areas remains stymied by the outline agreement between USAID and SMC that UFHP NGOs cease distribution of condoms in brothels – the main entry route they have used to gain successful working relationships for satellite teams

inside the brothels. A new joint initiative to use UFHP clinics as referral centres for SMC injectables customers is under discussion.

#### ***Action Plan 5 – Private Sector Networking***

The first two tasks were completed but remain undocumented. Subsequent to the last semi-annual report we abandoned any further work on this action plan as being too ambitious in the first year. We are considering a major new initiative for 1998/99 but, at the time of writing, have not yet decided how fast to proceed because of the magnitude of the task and the implication of drawing resources away from the core NGO programme this early in UFHP's life.

#### ***Action Plan 6 – One-stop Shopping***

The government and community stakeholder workshops are now almost complete: approximately six remain to be completed as they were held up by the floods' impact on travel logistics. The concept of the IEC and marketing blitzes changed early in 1998: we decided to hold week-long events, using UFHP staff, with all NGOs and have the NGOs then conduct their own parallel programmes with their own staff in other municipalities which we do not cover. Nineteen of these have now been completed with the help of an external consultant. The remaining seven are on hold because we are now forcing major changes to the Service Promoter cadre by the end of September 1998 – ie before BCC/Marketing training starts in October - and these seven NGOs are significantly affected by this change.

#### ***Action Plan 7 – ESP Support Materials***

Top-line findings from the IEC 'study' (formerly the baseline survey) are now available and are being studied for their implications on priorities for BCC support to the ESP. The best of existing IEC materials have been selected and distributed to NGOs – primarily EPI posters and videos. A new flipchart has been conceptualised and designed jointly with RSDP and QIP; the Bare Essentials pages have been designed and distributed and the Child Health pages have just been completed, in line with the overall ESP phasing. A series of second-level take-away brochures has also been designed: six brochures covering the Bare Essentials have been delivered to NGOs and two more covering Child Health are being field-tested now. We have designed a display cabinet for BCC materials to be used in each clinic and these are being made locally. A Quality Comes First poster and desktop display have been designed and distributed. A special EPI initiative with BASICS and GOB has just produced a hanging display for home use reminding customers of the need for repeat visits and an EPI 'calendar' and satellite team mini-poster are being field-tested for clinic use.

#### ***Action Plan 8 – Adolescent Health***

The original plan slipped behind schedule because of the plan leader's illness and absence from Bangladesh. A new approach was canvassed for discussion in April 1998 and a working group formed. That group has now produced a working concept for a national adolescent health programme for UFHP NGOs which will feature as a priority in the 1998/99 work plan.

### ***Action Plan 9 – Special Target Customers***

The plan was behind schedule because of the delay in the IEC study findings becoming available (see AP 7 above). As a result, this action plan was selected for major re-timing to make way for the cost of 'paid' airtime (previously airtime had been expected to be free under the terms of the SOAG). Now re-scheduled for after September 1998.

### ***Action Plan 10 – Male Involvement***

Again, the IEC study has delayed progress. We have a draft plan ready but have pushed back implementation to allow time for the NGOs to stabilise before we add another new programme. A key element of the plan is the decision to restrict this programme to male involvement in FP; male involvement in other aspects of the ESP will be integrated into other programmes – eg adolescent health, HIV/AIDS. We expect to finalise the plan during the fourth quarter of calendar 1998 and start implementation in our clinics in early 1999.

### ***Action Plan 11 – National IEC Strategy***

UFHP/BCCP's actions were on schedule up to the end of 1997 but getting the draft strategy agreed with GOB is taking longer to arrange than expected. A GOB workshop has now been held but, given all the GOB uncertainties associated with HPSP and floods, the draft strategy is now not likely to be ready until October 1998 at the earliest – with consequent delay to all other tasks of at least six months.

### ***Action Plan 12 – National HIV/AIDS Strategy***

We decided to reschedule UFHP's HIV/AIDS activities early in 1998 when it became clear that both standards and training would not be available within the revised NIPHP phasing this year. The HIV/AIDS standards and protocols are being drafted now (October 1998) by SMC but training is not scheduled until mid-1999. We have been unable to get much active interest from the GOB's BAPCP as the GOB has been through extensive reorganisation; we have however joined the National HIV/AIDS Technical Committee. UFHP's own action plan is being drafted in the context of the 1998/99 work plan; we expect to commence implementation in late 1998. In the meantime, we have encouraged two of our NGOs (PSKP, Dhaka and Mamata, Chittagong) to proceed with their successful HIV/AIDS awareness and counselling programmes at our clinics with partial funding from other donors.

### ***Action Plan 13 – Urban IEC Strategy***

The urban BCC strategy was developed on schedule in June 1998 and circulated in draft to RSDP as input to a joint initiative. RSDP subsequently decided to delay development of its rural strategy until at least September 1998. A draft is now available at UFHP's urgent request but is quite different conceptually from the path that UFHP intends to follow. UFHP will therefore proceed with implementation of its urban strategy in the context of the 1998/99 work plan. The strategy features principally four separate campaigns – on Quality Comes First, Clinic Promotion, Value for Money and Community Health Leadership – each with its own management and materials strategies. All planned BCC activity associated with slums in the 1997/98 work plan have now been rolled into UFHP's BUSTTHI project for implementation.

#### ***Action Plan 14 – ESP Standards Manuals***

The standards manuals have not yet been delivered by the development teams (all due in draft in December 1997). This means that making them available for use by the NGOs is likely to be delayed by up to 12 months and the dissemination strategy will have to be changed since delivery of the draft manuals will now be staggered over a long time period. Routine visits to review implementation of the standards is postponed until the standards become available.

#### ***Action Plan 15 – Standard Equipment Lists***

This action plan was successfully completed on schedule.

#### ***Action Plan 16 – NGOs' ESP Training Needs***

All tasks within UFHP's control were completed on schedule up to January 1998. There were subsequent implementation delays as a new contractor was brought in to take over responsibility for curriculum design and institution-building. A master plan for ESP technical training has now been drawn up by PRIME and Child Health training finally started in July 1998. Curricula for Other Reproductive Health and IPC/Counselling are under development with a view to training starting in the fourth quarter of 1998.

#### ***Action Plan 17 – ESP Management Course In Bangla***

A contract has been signed with CCC and the curriculum agreed in principle. However, the planned start date of 6 September was postponed at the GOB's insistence, since its trainees could not be spared during the flood crisis. The course eventually started on 27 September, with completion by 17 December 1998.

#### ***Action Plan 18 – Customer Satisfaction Surveys***

All of the scheduled COPE exercises are proceeding according to plan; approximately 102 exercises have been completed to date. The formal methodology for surveying customer satisfaction has been rolled together with pricing and costing issues and will be tackled in the fourth quarter of 1998.

#### ***Action Plan 19 – GOB Training Needs***

In the light of the significant delays now expected in the NIPHP training programme (see AP 16), we have postponed any further work on GOB training needs until we can determine whether or when any training capacity will be available. Training required under the aegis of the BUSTTHI project will be incorporated in the ongoing ESP technical training schedule as resources permit.

#### ***Action Plan 20 – NGO Management Capabilities***

We have amended UFHP's approach to management capabilities significantly, in the light of major perceived shortcomings in those capabilities. The needs assessment was brought forward to January 1998 and concluded that IEC/marketing, strategic planning, staff performance appraisal and managing teams were critical weaknesses. A consultant was brought in to tackle all of these and the initial phase of the programme was completed in July

1998. The consultant has helped to develop in-country skills – at both NGO and UFHP levels - to allow us to continue the programme in the longer term. All NGOs are now embarking on their own strategic planning exercises, facilitated by UFHP NGO Liaison Officers. Formal training in BCC/marketing is scheduled to commence in October 1998; a curriculum working group has been operating since July.

#### ***Action Plan 21 – Coordination with Municipalities***

Introductory visits have taken place in all municipalities and, in many cases, fruitful working relationships have been built. The options for better coordination have not yet been developed but a working group has been formed and a clear implementation strategy has emerged for implementation under the 1998/99 work plan. We have already decided that “pilot testing” as originally conceived will not be feasible – instead we are focussing on a coordination structure for limited launch in late 1998/early 1999.

#### ***Action Plan 22 – MIS Rollout***

The NIPHP MIS has been finalised and the version adapted for UFHP use was rolled out through dissemination workshops to all NGOs in July 1998. The new MIS has been in use since 1 August 1998.

#### ***Action Plan 23 – NGO Costing/Pricing***

All of the tasks scheduled to date have yielded results but it is unlikely that the next steps will be completed on time. The critical issue is the need for customer data before we can study customers’ price sensitivity: this requires data from the new MIS. A reliable body of customer data is unlikely to be available before November 1998, at which point consultants can be selected to start analysing price/quality relationships. Cost analysis could start sooner but prices and costs have been planned to go in tandem.

#### ***Action Plan 24 – NGO Revolving Drug Funds***

A final concept was prepared in June 1998 and training for resource groups in Rational Drug Use and Revolving Drug Fund Management was held in September 1998. All NGOs have been introduced to the rules, guidelines and procedures through a new approach to ‘self-training’ recommended by our consultants (RPM). This Monitoring-Training-Planning (MTP) approach will be rolled out progressively from October 1998 to May 1999; the first three MTP modules are in hand and are undergoing translation/field-testing.

#### ***Action Plan 25 – UFHP Partners’ Strategic Plans***

Only PSTC’s planning effort commenced on schedule in January 1998; BCCP’s was delayed by the Advances Workshop in February and CWFP’s by the prolonged absence of the Executive Director. All are now well under way and completion is likely in the fourth quarter of calendar 1998.

## **2. Special Initiatives Undertaken**

During the first 15 months of the project, various activities were undertaken which were either not included in the work plan or which proved to be much more onerous and time-

consuming than originally planned. We define these as 'special initiatives' and have identified seven of them.

*a. Clinic Siting and Layout*

UFHP's NGOs were under instruction from the outset to avoid service delivery duplication. This meant siting any new clinics well away from other service providers. Furthermore, to minimise disruption of the programme by disgruntled, losing NGOs, we asked our NGOs to negotiate joint ventures with losing NGOs or NGOs who did not apply for NIPHP clusters – in preference to setting up a new clinic from scratch in an unfamiliar municipality. Choosing appropriate sites and negotiating the joint ventures meant slowing down the start-up process and involving UFHP staff in an unanticipated series of location decisions. However, it was definitely worthwhile in terms of making best use of scarce health resources.

It took us until November 1997 to complete the first round of visits to all clinic sites and some relocations were requested in the light of possible duplication we observed in the field. In association with site location, we also exerted close control over clinic layout – making best use of rented premises in accordance with broad layout guidelines issued by UFHP - and requested substantial alterations to some clinics as a result. After November 1997, all new static clinics were subjected to individual approval in accordance with both duplication and layout guidelines issued by UFHP. Figure 1 includes a map showing all the municipalities where UFHP is now active.

*b. Baseline Data Collection*

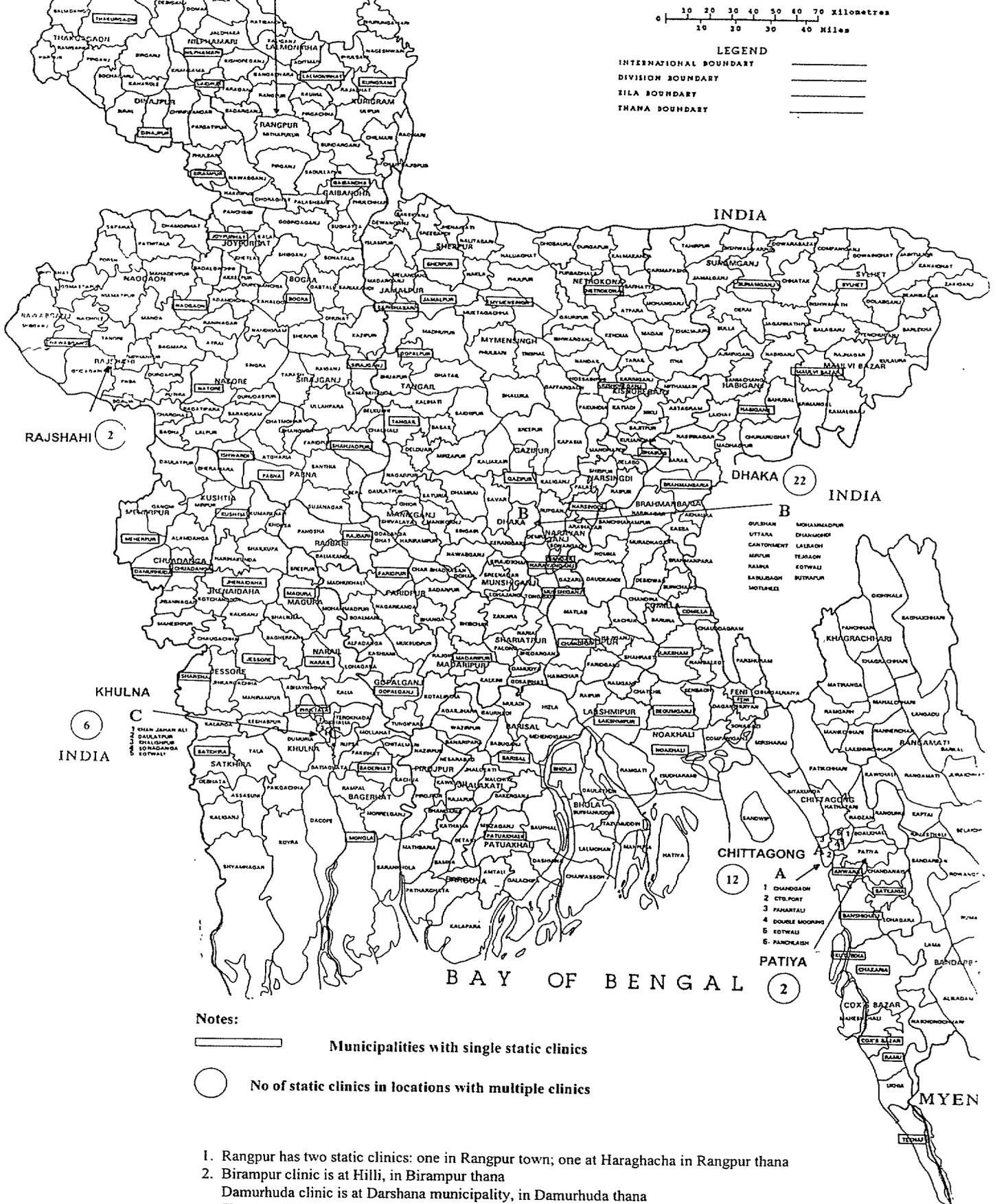
Once the programme was well under way, we discovered that existing data on urban markets was far from complete. As a result, we had insufficient information on which to base any charting of our progress. We agreed with USAID on the specification of baseline service performance data, designed to compare clinic service statistics under the previous USAID programme with those under the NIPHP. This meant an exhaustive search of data sources within NGOs associated with the previous programme, not all of whom survived into the NIPHP. It also meant trying to match old service delivery territories with the territories allocated by UFHP under the new programme.

We succeeded in matching most of the territories and obtaining almost all the data needed for a baseline of clinic service delivery statistics. The areas which proved most intractable were the City of Chittagong and parts of the City of Dhaka, where ward boundaries had changed so much that a fair comparison was difficult. However, we made the best comparison possible in consultation with all the NGOs knowledgeable of the areas in question and, in January 1998, published a set of baseline clinic data for the period July through December 1996. Figure 2 summarises the baseline data.

*c. Catchment Area Study*

The Asian Development Bank (ADB) is planning to finance the City Corporations' direct entry into the health care field and has authorised an \$80 million project. The project involves construction of 190 static clinics within the four City Corporations; these clinics will be contracted out to NGOs for management. In theory, this project constitutes a serious potential overlap with the NIPHP in the four City Corporations and it was agreed between

**Figure 1**  
**Geographical Distribution of UFHP Static Clinics**



**Figure 2**  
**Baseline Data for UFHP Clinics<sup>1</sup>**

ESP Component	Average Monthly Contacts		
	Total	% within section	%total
<i>Child Health</i>			
BCG	2,305	17.4	5.3
Measles	1,360	10.3	3.1
DPT3	1,850	14.0	4.3
Vitamin A	4,275	32.3	9.8
ARI	1,740	13.1	4.0
CDD	<u>1,720</u>	<u>13.0</u>	<u>4.0</u>
	13,250	100.0	30.5
<i>Reproductive Health</i>			
ANC	3,025	15.2	7.0
PNC	1,180	5.9	2.7
TT	3,285	16.5	7.6
Family planning:			
Pills	1,145	5.8	2.6
Condoms	500	2.5	1.1
Injectables	9,195	46.3	21.2
IUDs	600	3.0	1.4
Norplant	15	0.1	-
Tubectomies	10	0.1	-
Vasectomies	25	0.1	-
RTI/STD	<u>880</u>	<u>4.4</u>	<u>2.0</u>
	19,860	100.0	45.8
<i>Communicable Diseases</i>			
HIV/AIDS	260	100.0	0.6
<i>Limited Curative Care</i>			
Common ailments	10,030	100.0	23.1
<i>Total</i>	43,400		100.0

<sup>1</sup> All USAID-funded clinics in municipalities now covered by UFHP; average contacts per month over the period July to December 1996

USAID and the ADB that the ADB-financed clinics 'would not be set up in areas where NIPHP is operating'. This meant that UFHP had to develop a document explaining the catchment areas covered by its clinics in the City Corporations.

We worked with ICDDR,B and our own NGOs to develop a methodology for estimating catchment areas and catchment populations. Although this was needed immediately for ADB purposes, we chose to extend the work nationwide since it provides us with very useful market size estimates. As part of the study:

- We conducted a sample survey of our own clinics to assess where customers are coming from (November/December 1997);
- We collected population census data for all City Corporations and municipalities covered by UFHP, down to mohallah level, and updated it to end-1997;
- We estimated population density and income levels of all wards in which UFHP had static clinics at December 1997 (110 clinics), using census data, local government statistics on municipal areas and income estimates from ICDDR,B adjusted for local conditions;
- We characterised the sites included in our sample in terms of population density and income and then extrapolated their measured catchment radius to produce catchment radii for all of the other clinics;
- We finally measured population within the estimated radii to arrive at catchment population estimates for all clinics.

The results of this work were published in a research memorandum on schedule at the end of January 1998. Appendix B summarises the estimated catchment populations by municipality.

#### *d. NGO Management Training*

UFHP's priority in 1997/98 was quality and NGOs' management capabilities were foreseen as the second step, to be commenced seriously in 1998/99. However, we were unexpectedly able to obtain the services of a Staff Development Specialist on a consulting basis from January to July 1998 and she made significant contributions to improving our NGOs' management capabilities in three areas in particular:

- Staff performance appraisal – An appraisal system was developed and piloted with three NGOs in two rounds over three months. Based on the pilot, a final appraisal system was rolled out to all of UFHP's NGOs in May 1998.
- Managing in teams – An approach to teamwork at the clinic level and between the clinics and the NGO project management was developed and piloted in nine NGOs. The final design which emerged from the pilot was then disseminated to all NGOs using the training services of PSTC, a UFHP management partner, commencing in June 1998.
- Strategic planning – Two seminars of two days each were held at BARD in July 1998 for UFHP NGOs to introduce both project and volunteer staff to the principles of strategic planning. Small group work was interspersed between seminar sessions to give practical experience. NGOs are now being asked to implement their own planning sessions – which will be reported on in the next UFHP annual report.

*e. Design and Launch of Revolving Drug Funds*

There was a revolving drug fund action plan in UFHP's 1997/98 work plan. However, we all over-estimated the planned role for Rational Pharmaceutical Management (RPM), the consultants on this project. Both RSDP and UFHP ended up doing much of the detailed background research and design work for these funds, with the result that this became a much greater initiative than anticipated.

It was decided early on to make this a joint project under RSDP's and UFHP's leadership and an RDF Management Group was formed. RPM undertook a successful case study of the BRAC drug fund while RSDP and UFHP studied their respective NGOs' existing funds. The total drug demand was estimated using some data from ORP and others but largely from data generated internally or from national statistics by the two main partners on the project. QIP developed a Standard Treatment Guideline as part of the project's concern with rational drug use (RDU). The RDF Management Group selected the final shape of the proposed fund with assistance from RPM and then each partner developed their own detailed fund management guidelines. RPM introduced an innovative approach to training for both the RDU and RDF management elements of the project – using a self-training approach based on written modules distributed from the centre. RPM facilitated the production of these modules but they were written by RSDP, UFHP and QIP staff.

Training, all of the RDF management modules and the RSDP and UFHP RDF management manuals were ready by the end of the work plan year (September 1998).

*f. NGO Impact – Baseline Assessment*

The two great innovations implicit in the NIPHP are the switch from doorstep to clinical delivery and the broadening of services from FP and some MCH to the full ESP. In managing these broad transitions, we have to ensure that Bangladesh's traditional success in raising contraceptive prevalence is not put at risk by too abrupt a change in service delivery patterns.

As noted above, there is relatively little data available on urban health care markets – where customers obtain services, how important a player the NGOs are, what changes in service access and customer behaviour have resulted from the introduction of the NIPHP, etc. The DHS is the primary data source for evaluating the impact of the NIPHP but the next survey is not scheduled for publication until the year 2000. As an interim step, we have worked this year with RSDP, ORP and USAID to design a comprehensive survey which will give us some relevant market data for all the municipalities in which UFHP operates. This will supplement the DHS when it is produced, not substitute for it. It will enable the NGOs to know where they are starting from in terms of market size and market share by various ESP components in all of their municipalities.

The survey design was more or less complete by year-end (September 1998). The results will be incorporated in UFHP's next annual report. In the meantime, there is informal evidence from a number of sources which indicates that the short-term negative effect of the transition in service delivery mode on contraceptive prevalence has been minimal:

- A rapid appraisal of pill usage before and after the launch of NIPHP in urban areas suggests that drop-out rates have hardly changed and less than three per cent of drop-out

is accounted for by supply problems (June 1998). 'Supply problems' is the only category where the switch to clinical supply could have had a negative impact.

- ICDDR,B's Urban Panel Survey of selected wards in Dhaka before and after NIPHP launch shows that CPR has increased slightly since July 1997 (March 1998).
- Research being finalised within ICDDR,B on the impact of withdrawing field workers from urban areas is showing little, if any, effect on CPR (August 1998).
- MOHFW's collated MIS results from the field – including both GOB and NGO activities – shows continued growth in both service coverage and CAR (September 1998).

*g. The BUSTTHI Project*

UFHP has been concerned about service coverage in slum areas of the cities: NGOs have little incentive to be active there because of their sustainability objectives and GOB has insufficient resources to be able to satisfy demand. UFHP suggested to both USAID and the Secretary of MOHFW that this was one area where GOB needs to be seen to be taking the lead. UFHP proposed a concept of 'sustainability contracting', under which NGOs are effectively contracted by GOB to provide services in slum areas and, if there is insufficient resource in the short term, UFHP can provide the necessary funding but under a clearly GOB-led programme.

The DG Family Planning accepted this idea and a project proposal was submitted to UFHP for funding. This proposal created the BUSTTHI project – building urban slum teams towards health initiative. Under the terms of the project, 25 new satellite teams will be created to serve 100 selected slums in Dhaka, each team comprising a paramedic from the Directorate of Family Planning, a service promoter from the local UFHP NGO and an EPI vaccinator from Dhaka City Corporation. UFHP's four Dhaka NGOs will provide the management, training and supervision. All three parties to the project agreed to it in principle and final approval from the MOHFW was awaited at year-end.

**3. Success Stories**

UFHP had generally a very successful first year. We have identified seven particular successes to highlight.

*a. Fast Start-up*

UFHP got off to a fast start and maintained a rapid pace of development in the first 15 months:

- Sub-project agreements with service delivery NGOs, including firm six month budgets, were despatched to the field within 24 hours of our CA being signed in July 1997.
- Twenty two static clinics were up and running by the end of August 1997 and the clinic start-up rate remained strong throughout the second half of 1997 (see Figure 3).
- A Vision workshop was held with NGO representatives to agree on the broad vision for the project in August 1997.
- Standard equipment lists and staffing models were promulgated during October 1997.

**Figure 3**  
**Static Clinic Start-up Rate**

<b>Month</b>	<b>No of clinics</b>
<b>1997</b>	
August	22
September	45
October	67
November	91
December	98
<b>Month</b>	
<b>1998</b>	
January	100
February	110
April	112
June	115

- The first NGO staff entered CMT training in November 1997.
- Budgets were revised in the light of the first six months' experience in January 1998 and a second workshop was held that month to formalise working procedures.

**b. *Clear Clinic Siting and Layout Policies***

UFHP's NGOs had to adjust to the new realities of the NIPHP in many ways. One issue was clinic siting. Many NGOs had existing clinics but they were either too small as a basis for ESP service delivery or in the wrong location – a good site as the base for CBD operations is not necessarily suitable for static ESP delivery.

UFHP adopted a uncompromising policy on siting and insisted that clinics in inappropriate locations – eg quiet back lanes or roads well away from town centres – be moved. This was a lengthy process in the face of general reluctance from many NGOs who had close associations with their existing landlords. We now have most of our static clinics in locations where they are likely to be most accessible to most customers.

We also introduced standard layout guidelines early in the programme (November 1997). These are designed to make best use of the rented premises in terms of facilitating customer movement (when the clinics eventually become busier) and maximising infection prevention. A model layout is shown in Figure 4. This is an ideal, containing principles which we have tried to accommodate in all of our clinics. As a result, we believe we now have a network of well laid out and attractive facilities which are likely to appeal to our customers.

**c. *Quality Comes First***

UFHP adopted the motto 'Quality Comes First' in the early months of the programme and it has become a very successful means of focussing everybody's attention – NGO and UFHP staff alike – on the need for improved quality. The concept of putting quality first stems from two factors:

- There is some research evidence that customers are willing to pay for clinical services if they are convinced that the traditionally low service quality associated with NGO clinics has been improved.
- As a result, 'quality' has become the centre-piece of UFHP's strategy for attracting customers from home to clinic – quite contrary to our NGOs' initial instinct to focus on wider service coverage.

Figure 5 shows the trade-off that we faced initially between quality and service coverage. Most NGO clinics were capable of delivering only a 'bare essentials' version of the ESP at the outset – and generally at poor quality. In pursuit of fast growth, represented by staff numbers and budget, our NGOs' inclination was to expand the range of services quickly – whereas UFHP's policy rapidly became to limit expansion until quality had been proven. Again, this difference of approach could have slowed the programme but it was realistic in the circumstances. If we want to attract customers on a sustainable basis, we have to offer quality. Furthermore, all the subsequent phasing of the ESP rollout which stemmed from the thinking in Figure 5 demonstrated quickly that we could not move much faster anyway: the need for massive amounts of training was a major constraint.

Figure 4  
 'Ideal' Layout of a UFHP Static Clinic

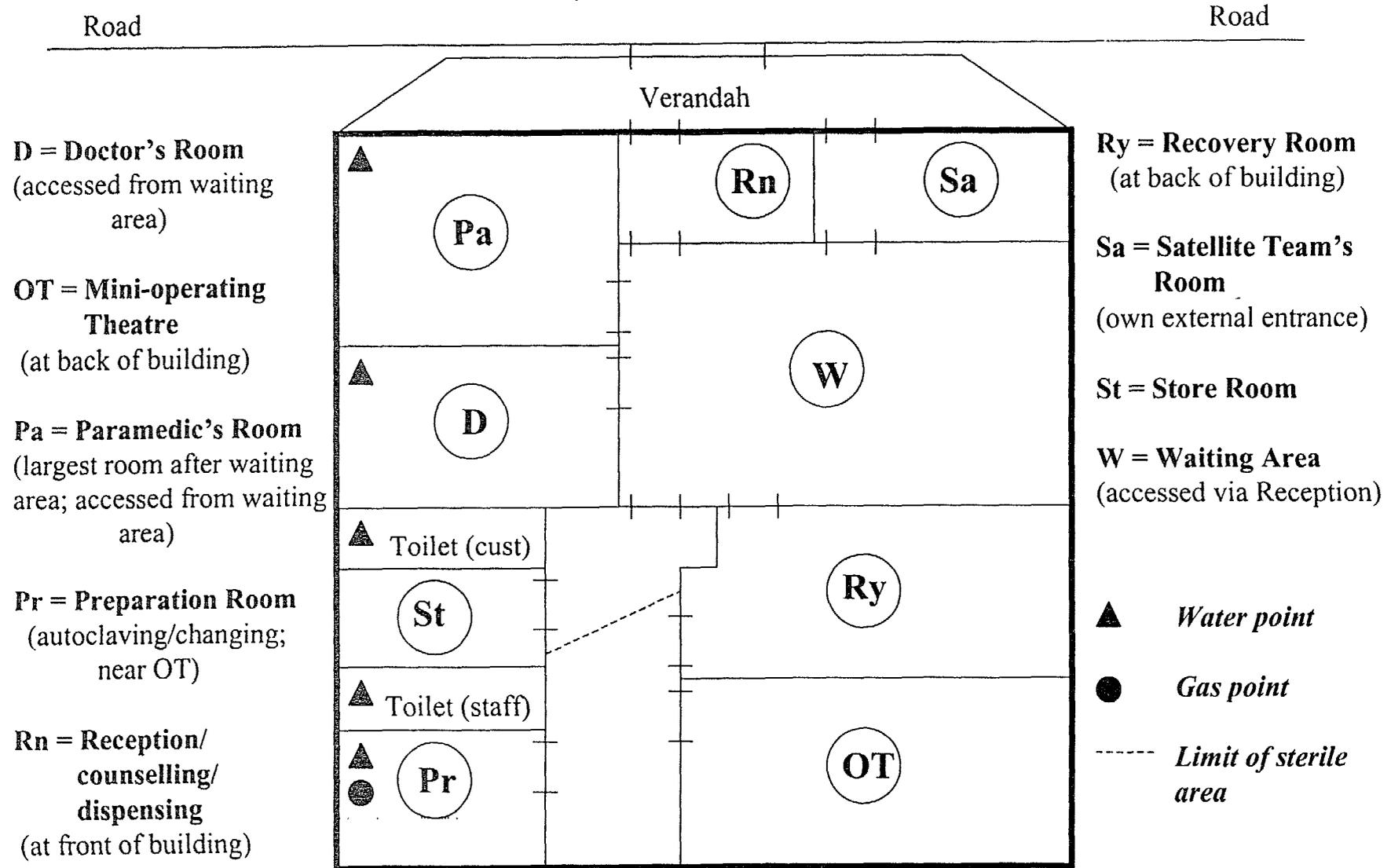
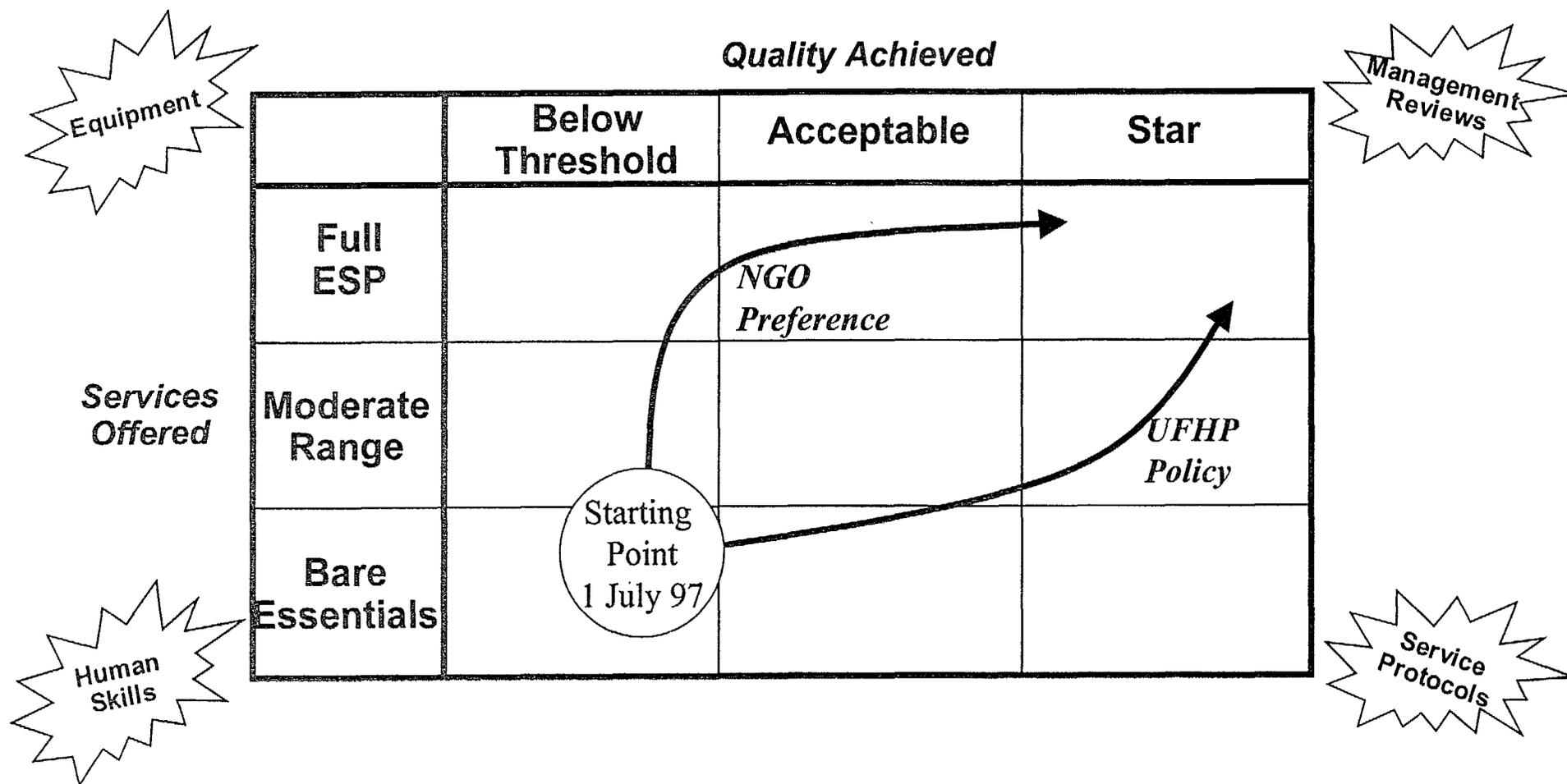


Figure 5  
Tradeoff Between Quality and Service Coverage



*d. New MIS*

Work started on designing a new MIS for use by both RSDP and UFHP in March 1997. ORP conducted most of the design under the leadership of a joint management group. The design took much longer to complete than expected and the new MIS was finally launched in August 1998 but the end result has proved very successful. UFHP's version of the MIS includes:

- A clinic card for use at static clinics – A new card is created each time a member of a new family visits the clinic for the first time. Other members of the same family are added as they subsequently visit the clinic. Details of each family member are included on the card plus details of each visit to the clinic (see Figure 6).
- Continued use of service registers at the satellite clinics – It was felt that the cards are too bulky to transport daily to satellite locations and too much handling would be required to sort out the next day's cards for each satellite location.

The specific advantage of the new system is that it provides us for the first time with the beginnings of a customer database. This in turn will enable us:

- To learn more about our customers and their family circumstances. We can, for instance, identify newly-weds, low parity couples, adolescents, etc – all as prospective targets for group counselling. We can also know something about family income and wealth – if only by reference to where the customer lives – which will help us with pricing policies in future.
- To follow-up on contraceptive discontinuers. By tagging users of different contraceptive methods and also tagging date of last visit, we can identify suspected discontinuers and have them visited by a service promoter. This will reduce discontinuation somewhat and certainly improve our reputation for customer service.

*e. Flood Relief Effort*

While we were unable to get emergency drug supplies to the field during the 1998 floods, we did have a significant success with ORT corners in our Dhaka clinics. In full cooperation with the Civil Surgeon in Dhaka, we set up or reinforced ORT corners in all 22 UFHP static clinics in Dhaka. The Civil Surgeon's office provided emergency supplies of ORS together with mixing jugs and beakers; we also put all of our medical officers and paramedics through a one-day CDD course provided by GOB. All clinics were capable of providing Plan A and B treatment and four clinics (one per UFHP cluster) were designated as referral locations for Plan C. We equipped the latter with drip stands and obtained IV fluids through the Civil Surgeon. The Secretary MLGRDC officially launched the initiative.

This initiative more than doubled the Civil Surgeon's CDD treatment capability in Dhaka and was arranged very smoothly at very short notice. In other municipalities, we seconded staff from clinics that had to be closed to the local Civil Surgeon, for use in the flood relief effort. Both initiatives cemented UFHP's relationship with GOB and the former also allowed us to introduce our capabilities both to the Dhaka City Corporation and the MLGRDC – who are progressively assuming responsibility for health care in the city.

Figure 6  
Sample UFHP MIS Clinic Card (Part)



অত্যাৱশ্যকীয় সেৱা কাৰ্ড

বেলিট্ৰেণ্ডনং নং	বেলিট্ৰেণ্ডনং তাৰিখ	কেন্দ্ৰৰ নাম
কাৰ্য্যমূৰেৰে নাম	বয়স	শিক্ষিত লক্ষ্যৰ সংখ্যা
পানী/বীজ/শিশুৰ নাম	বয়স	মেলে
বিষয়েৰে কাৰ্য্য	প্ৰতিভা	বৰ্তমানৰ বাৰৰত প.ন. পছতি

পৰিয়াল পৰিকল্পনা সংক্ৰান্ত সেৱা

ইনজেকশ্বন

এখন ইনজেকশ্বন প্ৰাপ্ত \_\_\_\_\_ বয়সৰে তাৰিখ

প্ৰেৰণৰ তাৰিখ									
ডি.টি. মেৰেৰে তাৰিখ									
সেৱাৰ প্ৰকৃত তাৰিখ									

স্বাৰ্হাইডি/স্বপ্ৰাগ্ৰাট

প্ৰেৰণৰ তাৰিখ	স্বাৰ্হাৰে তাৰিখ	মূল কেন্দ্ৰৰ তাৰিখ	প্ৰেৰণৰ তাৰিখ	স্বাৰ্হাৰে তাৰিখ	মূল কেন্দ্ৰৰ তাৰিখ
১			২		

প্ৰাৰ্থনাত বডি/কনডম

সেৱাৰ তাৰিখ					
প্ৰেৰণৰ তাৰিখ					
পৰিষ্কাৰ					

শিশু স্বাস্থ্য: টিকা (EPI) ও ডি.টি.মিন - এ

শিশুৰ নাম	মাতৃৰ নাম	বয়স	ডি.টি.মিন/পেপিক			পেপিক	ডি.টি.মিন-এ
			১	২	৩		

ডি.টি. টিকা প্ৰদান (১৫-৪৯ বৎসৰেৰে মহিলা)

স্বাস্থ্যৰ নাম (প্ৰেৰণকাৰী হলে মাতৃৰ নামেৰে 'প' পিন্ধুন)	বয়স	ডি.টি. টিকা প্ৰদানেৰে তাৰিখ

গৰ্ভৱাসীনি সেৱা

কোনো গৰ্ভৱাসীনিৰে সন্তান জন্ম হোৱা

গৰ্ভৱাসীনিৰে নাম	গৰ্ভৱাসীনিৰে বয়স	গৰ্ভৱাসীনিৰে শিক্ষা	গৰ্ভৱাসীনিৰে পেশা	গৰ্ভৱাসীনিৰে স্থান	গৰ্ভৱাসীনিৰে প্ৰতিভা				

গৰ্ভৱাসীনিৰে সেৱা

কোনো গৰ্ভৱাসীনিৰে সন্তান জন্ম হোৱা

গৰ্ভৱাসীনিৰে নাম	গৰ্ভৱাসীনিৰে বয়স	গৰ্ভৱাসীনিৰে শিক্ষা	গৰ্ভৱাসীনিৰে পেশা	গৰ্ভৱাসীনিৰে স্থান	গৰ্ভৱাসীনিৰে প্ৰতিভা				

\* স্বাস্থ্যৰে নামেৰে প্ৰেৰণ কৰাৰে পৰিষ্কাৰ কৰাৰে তাৰিখ

*f. Revolving Drug Funds*

We finished the year with a very well constructed and documented concept for revolving drug funds in all of the UFHP clinics. The funds will be financed and formally launched in December 1998. Previously, many of UFHP's NGOs had funds of their own but they were small and their internal discipline with respect to revolving the capital sums was fairly weak. We had also permitted some of the remaining NGOs to start small funds financed by revenues accumulated since July 1997. Both of these funds can be replaced by the newly designed funds in December 1998.

We believe that our experience with these new funds represents a major success of the first year for three reasons:

- Having adequate drug stocks is a key success factor for NIPHP clinics – and one of the quality shortcomings repeatedly mentioned in customer surveys in the past. We expect that the new funds will work well and have spared no effort in constructing a management system that will ensure that the capital sum (contributed by Social Marketing Company) remains intact.
- The design work was a model of teamwork within the NIPHP. RSDP and UFHP, as the main beneficiaries, created a joint RDF Management Group along with USAID for the project. RPM, the consultants, worked to the management group rather than to USAID, setting a further precedent. Many NIPHP partners, including FPLM, ORP, QIP and SMC, were involved throughout.
- RPM recommended, and the management group adopted, a innovative approach to training NGO staff for RDF management. Monitoring-Training-Planning (MTP) is essentially a self-teaching technique based on written documents prepared centrally and sent to the NGOs after translation and field-testing. One representative from each NGO was trained separately to facilitate the MTP process in his/her clinic. MTP now represents a potential new addition to the NIPHP training toolbox.

*g. Sustainability and Transition Planning with Partners*

UFHP launched separate strategic planning exercises with all three of its management partners. The BCCP plan was facilitated by an outside consultant but with active participation from both RSDP and UFHP; the CWFPP and PSTC plans were facilitated by UFHP. Although none were complete by year-end, all three made significant progress in three respects by September 1998:

- Sustainability – All three plans focus on making the partner organisations more sustainable. From prior experience, the first attempt at strategic planning at least focuses the minds of a broad swathe of staff on the future of the organisation and this seems to be true of all three partners.
- Scale – All three are relatively small organisations and need to find ways to grow in order to be sustainable. Organic growth is one route and is being planned. Working together under the 'UFHP' label is another, since it permits greater scale without investment. We

have had one success in the first year on this front, where all three partners are cooperating to put on two training courses together.

- Management transition – All three face management change at the top: BCCP as JHU moves offshore; CWFPP and PSTC as their long-time leaders contemplate retirement. We have successfully placed this issue on the planning agenda in all three organisations and there has been serious debate about how to plan the necessary transition – which should make the transition much smoother when it comes.

#### **4. Lessons Learned**

We have learned five principal lessons from the first year of the UFHP programme.

##### ***a. The Urban Health Care Market is More Challenging than Anticipated***

We expected that, as the only new player in the NIPHP, we would face a certain amount of resistance as we set up the UFHP and started clinic operations. That resistance materialised – largely from displaced field workers and NGOs unsuccessful in the bidding process. However, we have also discovered three other factors which have proved even more challenging:

- Absence of data – There is very little documentation of urban health care markets in Bangladesh, especially when compared with rural markets. This has made it difficult to establish a clear baseline for the project or to get solid agreement on catchment area size.
- Many other players in the market – UFHP has attempted from the outset to minimise the possibility of duplication of services. However, we are the only participant in urban markets who has such a clear policy on duplication. And there are many other players now interested in urban health as the significant national shift of population from rural to urban areas becomes more obvious. Furthermore, the private sector seems well entrenched in urban areas; in the absence of hard data, it seems that the private sector may account for well over half of the market. All this contrasts with near monopolies for either GOB or NGOs in rural areas.
- Massive institutional change – MOHFW is now in the midst of handing responsibility for primary health care in the City Corporations to MLGRDC and the City Corporation Health Officers. A similar process is under way in smaller municipalities, where the pourashava chairman is becoming responsible for primary health care. The Asian Development Bank's Urban Primary Health Care Project is further confusing the current picture in the City Corporations.

The implication of all this is that UFHP's growth potential is far from certain.

##### ***b. The Size of the Technical Training Task Was Under-estimated***

All relevant participants in the NIPHP, including UFHP, seem to have under-estimated the size of the ESP technical training task we face. Although the training is not too far behind schedule, the chances of basic training being complete by the end of the next work plan are

remote – and that is after diverting considerable extra effort into training and creating a new NIPHP partner to oversee the subject. The reasons for this under-estimation seem to include:

- A shortage of FWVs in the country, leading to UFHP's recruitment of many nurse-midwives who typically do not have formal FP training.
- A need to give doctors more training than previously assumed. This is partly because they are finding some aspects of the ESP new to them and partly because UFHP has been able to recruit mostly young, and therefore inexperienced, staff.
- Higher turnover than expected in both paramedics and doctors. As the GOB staffs up for the ESP under the aegis of the HPSP and the ADB urban programme gets under way, the problem will worsen and increase the need for both basic and refresher training.

The consequence of this is that clinics are going to remain frequently short-handed while a large block of staff are trained. This will constrain both growth and quality of service in the short term.

### *c. Teamwork Works*

The radical design of the NIPHP – built around interlocking partnerships instead of the traditional 'stove-pipe' structure (see Figure 7) – has worked better than expected. Under previous programmes, most relationships have been between USAID as the donor and its CAs or contractors. Lateral communication or cooperation between CAs/contractors was historically modest. Under the NIPHP, the nine partners are to some extent inter-dependent despite the continuing 'contractual' allegiance to USAID as the donor. We use joint task forces and working groups much more now, work plans are aligned between partners, there is much more lateral communication and teamwork.

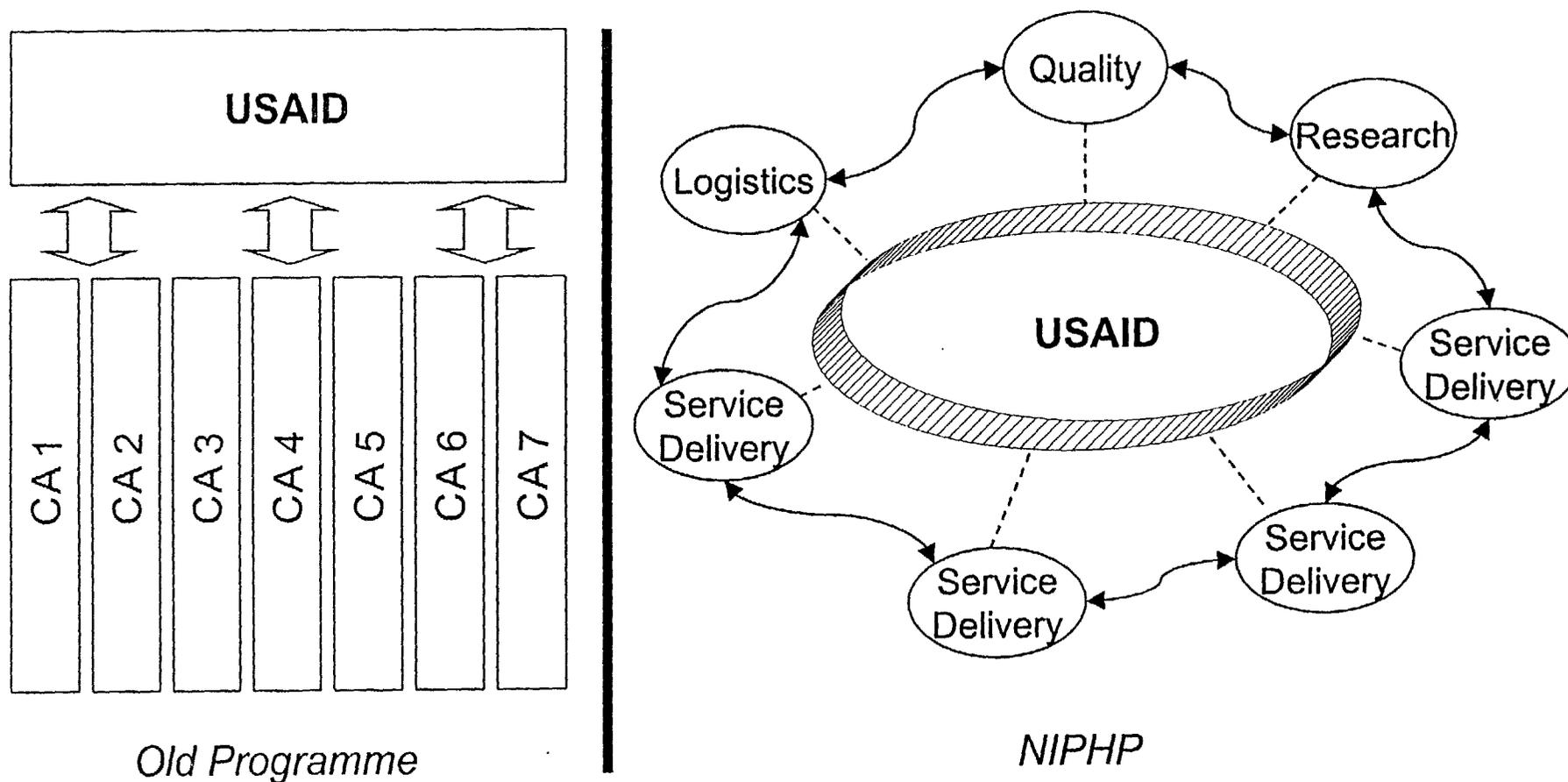
To date, NIPHP has collectively delivered on most of its performance objectives: the ESP has been widely rolled out; BCC programmes have flourished; quality has received a considerable amount of attention; institutional development initiatives are under way; cost recovery is already higher than in previous programmes. The team structure has not impeded: it has probably actively helped. There has been less re-work and less sub-optimisation than the old vertical structure would probably have encouraged.

Some dangers remain:

- The system depends heavily on personal relationships (CA/CA and CA/USAID) to resolve potential conflicts between partner performance and contractual obligations to the client. So far, the personal chemistry has worked.
- The system breeds too many meetings. Redefining teamwork, to move away from the current tendency to think it means everyone must do everything together, will help – but that requires more trust and that will take more time.
- A lack of delegation in management undermines teamwork and delegation is not a natural process yet in Bangladesh. This too will take more time.

Figure 7  
Design of the NIPHP Partnership Structure

The Population and Health partners adopted a radical approach to working together in the design of their programme.



**d. 'Marketing' Skills are Inadequate Throughout the System**

UFHP's NGOs are faced with the need to persuade customers to move from the doorstep to the clinic. At another level, sustainability requires UFHP's partners to persuade new clients that they have skills to offer and can perform well if given contractual responsibilities. At another level, in urban areas, service promoters need to be able to analyse the urban health care market and determine where best to put UFHP's resources to maximise public health impact.

Few of the necessary skills exist. Many NGOs understand the broad principles of BCC but the concept of marketing is foreign to them. As a result, they need much more help than anticipated in determining how best to move customers into clinics and analyse the markets they are serving. Many NGOs and partner organisations are familiar with the need to 'lobby' for new contracts but are generally unfamiliar with the practice because there was less competition for contracts in the past. At best, lobbying and marketing skills are concentrated in one or a handful of senior individuals in any organisation.

UFHP has reacted to this issue by doubling its in-house BCC and marketing staff, by conducting marketing blitzes at NGO level in the field, by putting a disproportionate amount of effort into national BCC and marketing initiatives and by mounting a new BCC and marketing training programme. More effort along similar lines will be needed in the coming year.

**e. Business Skills are Critical to NGO Performance**

In the first year, we have observed a wide range of performance between different NGOs in different areas. Many factors explain the range of outcomes. However, one factor seems to stand out and it is the amount and/or quality of business experience and skills represented on the Executive Committee. Such experience and skills are far from *sufficient* for an NGO to perform well but they do seem to be *necessary* in distinguishing good performance from weak performance. This is particularly true in the light of the increased scale associated with managing a UFHP cluster, which is much larger than most NGOs are used to.

In the day-to-day management of any organisation, there are few substitutes for the tried and tested conventions and procedures that have evolved over centuries in the private sector. These need substantial amendment when applied to the development sector but we conclude that it is a case of amendment not replacement. Among the most successful of UFHP's NGOs to date, we observe that most have a strong business sense represented in some form on the Committee. It is a finding we plan to encourage more widely among our NGOs in the coming year.

**B. Progress Against Selected Performance Indicators**

**1. Intermediate Result Indicators**

Figure 8 summarises UFHP's performance against selected IR indicators. The baseline data is a monthly average (for clinics only) for the period July to December 1996; the current data is monthly numbers for September 1998 (see Appendix C for full detail by ESP component).

Figure 8 – Selected Monthly Clinic Performance Indicators

<i>Indicator</i>	<i>Baseline</i> <sup>2</sup>	<i>Current</i> <sup>3</sup>	<i>Growth projection to 2004</i> <sup>4</sup>
<i>Child Health (contacts at clinics)</i>			
BCG	2,305	2,378	Medium
Measles	1,360	1,662	Medium
DPT 3	1,850	1,566	Medium
Vitamin A	4,275	4,659	Medium
ARI	1,740	11,375	High
CDD	1,720	18,611	High
<i>Reproductive Health (contacts at clinics)</i>			
ANC	3,025	9,355	High
PNC	1,180	1,522	High
TT	3,285	10,321	High
RTI/STDs	880	3,240	High
<i>Contraceptives (commodities issued)</i>			
Pills (cycles)	4,545	22,938	Medium
Condoms (pieces)	13,510	120,864	Low
Injectables (ampoules)	6,245	12,122	High
IUDs (pieces)	195	124	Medium
<i>Other Indicators</i>			
# ELCOs in UFHP catchment areas	na	2,016,850	>4% pa in urban areas
# satellite clinic sessions held	na	4,400	unlikely to expand beyond 5500 in next three years
% cost recovery	2.5	10.0 <sup>5</sup>	~15% after three years

<sup>2</sup> Average July to December 1996, clinics only

<sup>3</sup> September 1998, clinics only

<sup>4</sup> High/medium/low in relation to 5% per annum growth 'norm' (see text)

<sup>5</sup> Average August 1997 to September 1998

Individual months often produce unstable results because of the impact of national events: NIDs in December 1997 and January 1998, the Vitamin A drive in June 1998, the impact of the monsoon in July and August 1998 and the overriding impact of the floods in (at least) July, August and September 1998. The results in any one month like September 1998 should therefore be viewed with caution.

Comparing the September 1998 data with the 1996 baseline, UFHP's clinics are now performing well above baseline in all ESP components, except EPI and IUDs, where we are performing at the baseline level. However, the baseline data makes no allowance for doorstep delivery and so it is difficult to tell how good total progress to date is in the area of family planning. As mentioned above, we have four informal indications that suggest that performance has held up well in the face of the transition to the NIPHP service delivery approach:

- A rapid appraisal has been done in two municipalities to study pills and shows that less than three per cent of pill users may have dropped out of the national programme because of supply difficulties – which may include difficulty in obtaining access to supplies after withdrawal of urban field workers.
- The ICDDR,B's Urban Panel Survey in Dhaka shows CPR rising since launch of the NIPHP.
- ICDDR,B's as yet unpublished research on the impact of withdrawing field workers in urban areas shows virtually no impact on contraceptive prevalence.
- MOHFW's recent summary of CAR data for the year 1998 shows a continuing rising trend nationally.

In 1998/99, we plan to make a major effort in clinical methods of contraception. This is partly in reaction to the suspected market shift towards retail in non-clinical methods and partly because of the NIPHP's overriding need to boost clinical methods in pursuit of sustainability. Thus we expect all categories listed in Figure 8 to grow further but we shall be making special efforts, both in terms of new programmes and BCC/marketing, to promote injectables, Norplant, IUDs and vasectomies. We shall also be making a special effort on EPI – another strategic weakness in the NIPHP as the coverage rate is flat or falling. We expect all these efforts to be successful, although we acknowledge that:

- There is considerable churn right now in the EPI market – This is one area where the City Corporations and municipalities are showing signs of renewed activity. So long as UFHP can successfully cooperate with local government in this area, our activity level can grow further.
- A vast amount of ESP technical training will draw service providers away from the clinics, which will constrain growth throughout 1998/99.
- IUDs retain a strong image problem owing to actual or rumoured side-effects dating back many years. We shall be tackling this issue in our BCC programme but cannot predict the results in the coming year.

- PNC will be difficult to grow because we do not offer delivery services yet. UFHP clinics have been successful in building customer numbers and loyalty on ANC but we then lose customers once delivery occurs elsewhere.

In the longer term, the projections to 2004 presented in Figure 8 are order-of-magnitude estimates only. Seven year projections cannot be accurate in any circumstances and these are based on unstable data from the first 15 months of clinical operations. We expect that there will be three main drivers of growth:

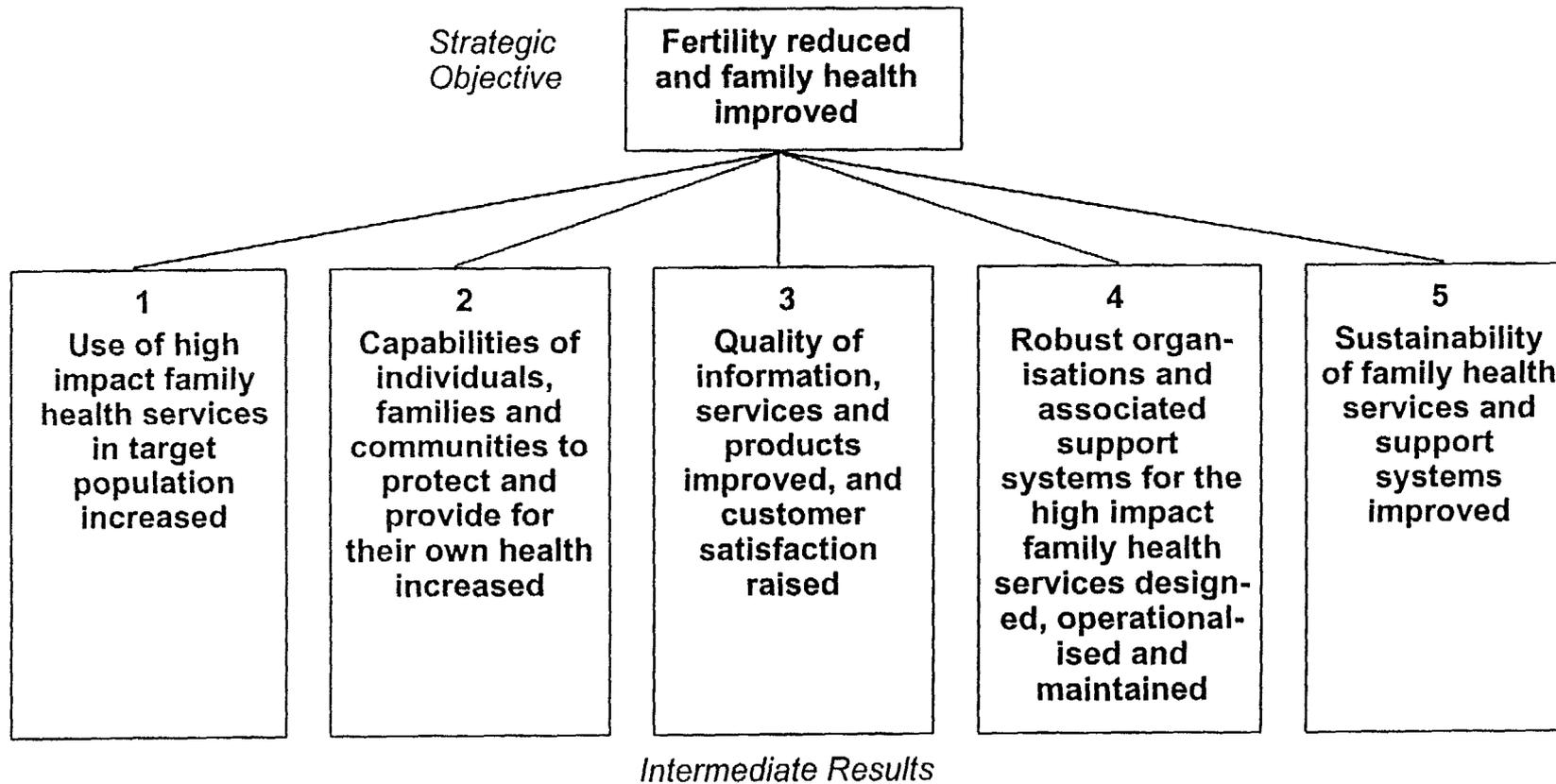
- Underlying growth of urban population – Anecdotal data suggest that urban population has grown at six per cent per annum in recent years. We believe this may be at least partly due to re-definition of municipal boundaries between censuses and have assumed a growth rate of 4.5 per cent per annum in our catchment population estimates. We expect the underlying population growth rate to slow as fertility falls but urban populations will continue to rise well above the national average as economic development continues to stimulate rural/urban migration. Thus we have assumed that urban population will rise by at least four per cent per annum over the period.
- Rising participation in health coverage – We expect participation rates in health coverage, defined as the proportion of the population exposed to ESP-related health risks who actually seek care from a service provider, to rise. In some segments, participation is already over 50 per cent – eg contraceptive prevalence and EPI coverage. In most others, it is below 20 per cent. Since participation rates tend to rise slowly, we have allowed an average of one percentage point per annum for this factor. Combining this with underlying population growth above gives a ‘norm’ of five per cent per annum. Obviously, ESP components with an already high participation rate will grow more slowly than those with a lower rate. Non-clinical components of modern FP use may actually fall from our clinics’ perspective, as customers switch to retail sources for pills and condoms.
- Rising NGO clinic market share – This factor is still impossible to predict at this early stage. NGO clinics historically have accounted for a very small share of ESP coverage (probably in the region of one per cent) and this is our baseline. Performance to date in urban clinics suggests market shares ranging from 1 to 5 per cent but the data remains highly unstable. If clinical quality can be raised further, if customers can be successfully persuaded to attach value to quality and more be attracted to our clinics, if we can start to penetrate the uncovered segments of the market (ie non-users of health care), if we can successfully launch new clinical FP methods like Norplant and NSV, etc – we can raise our market share over time. We expect to do this. However, we have conservatively made no allowance for growth from this source in these projections.

In Figure 8, ‘high’ growth therefore means above five per cent per annum; ‘medium’ means five per cent; ‘low’ means less than five per cent.

## 2. Long-term Objectives

UFHP’s long-term objectives are contained in the Strategic Objective and the Intermediate Results of the NIPHP. These are summarised in Figure 9. Measurement of UFHP’s performance against these long-term objectives is mostly dependent on the collective

Figure 9  
NIPHP Strategic Objective and Intermediate Results



performance of the entire Programme as measured by the periodic Demographic and Health Surveys (DHS). Appendix D reproduces the 34 NIPHP performance indicators and confirms that only eight of them (see Figure 10) are relevant in a report from UFHP alone; these can be grouped into four topics.

*a. Quality Assurance*

The proportion of clinics operating in accordance with protocols and standards and the percentage of NGO staff following those protocols and standards cannot be measured yet, since the quality protocols and standards have not yet been finalised by QIP and others. (We can say that all of UFHP static clinics are already offering at least four ESP services as defined in the performance indicator).

UFHP took an early initiative to get QA teams into the field in October 1997 and they have been working hard since then to visit all clinics in the network and study their operations against a standard checklist. By the end of the year, 77 per cent of UFHP clinics had received a two-day visit from a QA team. Appendix E shows the checklist that was used.

The main results from the QA visits to date have been:

- Customer flow management of many clinics improved as a result of better layout;
- Counselling process has improved through training and on-site orientation;
- Inadequate and improper equipment now replaced in almost all clinics;
- Training in CMT and CH has clearly started to improve the technical competence of service providers;
- Infection prevention practices have improved as a result of regular monitoring and TA visits;
- Customer follow-up and referral systems have improved somewhat through intensive BCC and marketing activities;
- Local supply problems for injectables are being continuously tackled through local level coordination with GOB encouraged by QA team members;
- Clinical supervision has improved as a result of frequent TA visits from UFHP;
- QA team member's participation in process observation has generally been useful in helping NGOs to take immediate remedial action through use of discussions, demonstrations, role play, etc.

The third quality assurance indicator refers to the proportion of clinics having appropriate personnel, equipment, supplies and facilities for delivering the ESP. Again, UFHP took an early initiative to work with QIP and develop a list of standard clinic equipment for both static and satellite locations. The list is included in Appendix F. By January 1998, UFHP had also finalised the standard staffing for clinics. This had been more or less finalised much earlier but in January we decided to add one Senior Service Promoter to each static clinic to improve BCC and marketing capabilities and we also confirmed the qualifications required for each job position in a clinic. The standard facility requirement, location and layout had been finalised within the first three months of the programme.

By the end of the year, our technical and management support visits to clinics were showing more or less universal compliance with personnel, equipment and facility guidelines. However, commodity supplies remained an issue with respect to injectables in particular. There appears to be a consistent shortage of this one contraceptive supply item in the country.

**Figure 10**  
**SO/IR Indicators Directly Relevant to UFHP**

<b>Relevant SO/IR</b>	<b>Indicator</b>
<i>Quality-related</i>	
IR1	Proportion of USAID-funded NGO clinics that offer at least four high impact services according to standards (clinical FP, non-clinical FP, EPI/Vit A, ARI, CDD, ANC, RTI/STD)
IR3	Per cent of service providers in USAID-supported areas complying with standards/protocols (for at least five priority services)
IR3	Per cent of service sites in USAID areas having appropriate personnel, equipment, supplies and facilities for a basic package of services
IR3	More customers who receive information, services, products they want (qualitative trend info)
<i>BCC-related</i>	
IR2	National FP/Health IEC strategy revised, implemented and evaluated
<i>Cost recovery-related</i>	
SO	Per cent of aggregate operating costs of USAID-supported NGOs covered by programme-generated revenues
IR5	Per cent of aggregate field costs of USAID-funded NGOs (not including contraceptives) covered by programme-generated revenues increased
<i>Capacity-related</i>	
IR5	Utilisation rates of static clinics (eg cluster sites, satellite clinics, fixed facilities) in USAID areas increased

*Source: Strategic Objective Agreement between the government of Bangladesh and the US, 9 May 1997.*

Both FPLM and GOB are consistently helpful when we point out a shortage but there have been a number of occasions in the first year when we had to turn injectable customers away from our clinics.

Finally, customer satisfaction has been measured informally throughout the year in the context of COPE exercises which UFHP conducted in most of its clinics by year-end. General satisfaction levels are high, although customers would (unsurprisingly) prefer a return to free service and they often regret the absence of delivery services at UFHP clinics. We present a fuller statement on customer feedback in section C of this report. A study of customer satisfaction with UFHP's clinical quality is planned for 1998/99.

*b. BCC Activities*

One indicator refers to BCC activities. BCCP has been working with GOB throughout the year to shape the national BCC strategy. However, reorganisation of the GOB service structure and all the intense planning leading up to launch of the HPSP made it a slow process, since there are many other GOB priorities at present. A national consensus-building workshop, facilitated by BCCP, was held in April 1998 and a workshop report prepared. That report was still awaiting GOB approval at year-end and detailed action planning needs to await agreement on the overall strategy.

*c. Cost Recovery*

As reported in Figure 8 above, UFHP has made good progress in its first year on cost recovery. Under the old programme, most clinics averaged around 2-3 per cent recovery on operating costs by the end of the programme in 1997; some enjoyed one-off community contributions which raised this average. By the end of the first year of the NIPHP, UFHP's clinics were achieving 9.9 per cent recovery on the same definition.

*d. Capacity Utilisation*

No detailed studies have been conducted to date on clinic capacity utilisation but UFHP has set a management objective of 100+ customers/day at a single static/satellite combination of sites, where more than 80 per cent of the customers must be for high priority services within the ESP. This objective was set with a capacity limit of around 100 customers/day in mind – given existing staffing and facility levels.

At the 100 customers/day target, we estimated that a paramedic in both a static and satellite location would be seeing around 35-40 customers/day; doctors would be slightly less busy. In a static clinic operating for eight hours, that equates to 12 minutes service time from a paramedic per customer if customers are evenly distributed throughout the day – or less if they are bunched. Experience to date suggests customers are bunched into the four hours from 9 am to 1 pm. In a satellite clinic operating for four hours per session, it equates to 7-8 minutes per customer. The paramedic is typically providing many 'quick' services – eg re-supply of an existing customer at a satellite clinic with condoms or an EPI shot – which take seven minutes or less on average. Thus far, she is not performing so many 'slow' services – eg pelvic examinations for new FP customers or IUD insertion – and counsellors are handling most of the lengthy advisory discussions on contraceptive methods. As this mix changes, so will capacity.

To date, as Figure 8 shows, UFHP is achieving around 40-45 customers/day in a single static/satellite combination. This suggests we are currently utilising about 45-50 per cent of currently available capacity. We therefore have considerable room for further growth at about the current cost level – implying greater efficiency and cost recovery are achievable if we can continue to raise customer numbers at the current rate. In the five months pre-flood in 1998 (ie February to June) customer numbers were growing at 16 per cent per month; in the last month of the year (ie September 1998, still somewhat affected by floods), customer numbers had grown again to 170,000 compared with 130,000 in June (equivalent to a monthly growth rate of nine per cent).

### **3. Training Conducted**

Figure 11 summarises training conducted in Bangladesh during the first year under UFHP auspices – ie UFHP NGO or HQ staff were trained or UFHP funded the course for third parties. The total number of trainees was around 4,200, including those who underwent formal training and those attending orientation sessions.

### **4. Publications Produced**

Figure 12 lists the 25 main publications produced by UFHP during the year, all for internal audiences and/or USAID consumption.

## **C. Recent Customer Feedback**

Although UFHP has not initiated any formal study to obtain customer feedback to date, our NGO Liaison Officers, QA Officers and other UFHP staff have gathered considerable informal feedback. This has been obtained either directly from customers – through informal discussion at the static and satellite clinics - or from service providers at the clinics or from community/opinion leaders at ad hoc meetings. The main messages are:

- UFHP clinics are better organised than other NGO clinics, clean and customer-friendly.
- Many customers want safe delivery, emergency support and limited specialist services at UFHP clinics. Some of them consider that the existing ANC, PNC and other related services are ineffective without facilities for safe delivery. Most referral centres do not give priority to the customers referred by another institution, including NGOs.
- All customers want an uninterrupted supply of medicine from the clinic, including FP commodities and particularly injectables.
- Many customers want UFHP clinics open during the evening hours.
- Some customers want a wider range of FP methods, particularly Norplant and sterilisation, to be available at UFHP clinics.
- In general, most customers consider that the static clinic fee rate for services is reasonable. Only a small percentage of customers expressed their concern about any pricing for services.

**Figure 11**  
**Training Conducted under UFHP Auspices within Bangladesh**  
**July 1997 – September 1998**

<b>Name/Description</b>	<b>Length</b>	<b>Date</b>	<b>No of Trainees</b>	<b>Type of Trainees</b>
<i>Training Courses</i>				
Clinical Management Training (CMT)	17 days	November 1997 – September 1998	186	UFHP NGO Paramedics
CMT for Physicians	5 days	January – September 1998	119	UFHP NGO Doctors
Advances in Family Health and Social Communication Workshop 1998	12 days	February 1998	31	UFHP NGO staff, UFHP Partner staff, GOB and Private sector participants
Child Survival Intervention Training	12 days	July – September 1998	159	UFHP NGO Paramedics
Rational Drug Use (RDU)	3 days	September 1998	33	UFHP NGO Doctors, UFHP HQ staff
Revolving Drug Fund (RDF) Management	2 days	September – October 1998	30	UFHP NGO Finance and Admin Managers, and UFHP HQ Staff
Improving Management and Performance of Delivery of ESP in Urban Areas	12 weeks	September – December 1998	29	UFHP NGO Project Directors, Medical Officers and GOB participants.
<i>Orientation Courses</i>				
A two-day orientation on Financial Management	2 days	August 1997	54	UFHP Project Directors, Finance and Admin Managers
Orientation on One Stop Shopping	1 day	October – December 1997	752	UFHP NGO Leaders and staff
Two Divisional Workshop-Orientation on NIPHP by PSTC	1 day	January 1998	205	GOB staff, UFHP NGO staff and RSDP staff

Figure 11 (cont'd)

<b>Name/Description</b>	<b>Length</b>	<b>Date</b>	<b>No of Trainees</b>	<b>Type of Trainees</b>
<i>Orientation Courses</i>				
One day budget orientation	1 day	January 1998	81	UFHP NGO Leaders, Project Directors, Finance and Admin Managers
A two-day Team Building and Motivation Workshop at each Clinic of NGOs	2 days	February – September 1998	1,100	UFHP NGO Staff
Municipal Level Orientation on NIPHP (65 Municipalities)	1 day	March – September 1998	2,253	GOB, UFHP Project Directors, UFHP NGO Leaders, Community Leaders, Private Sector Participants
A two-day workshop on UFHP Policy Guidelines and Performance Appraisal	2 days	June 1998	104	UFHP NGO Leaders, Project Directors, UFHP HQ staff
Message Development Workshop	5 days	June 1998	28	UFHP Sr Service Promoters, Service Promoters, UFHP NGO Leaders, RSDP, GOB and Private Sector participants
A two-day Strategic Planning Workshop at BARD, Comilla	2 days	July 1998	81	UFHP NGO Leaders, Project Directors and UFHP HQ Staff
BCC and Marketing Blitzes	4 days	July – September 1998	240	UFHP Sr Service Promoters and Service Promoters

**Figure 12**  
**UFHP Publications in the First Year**

<b>Name of Document</b>	<b>Month Issued</b>
A Profile of the Urban Family Health Partnership	August 1997
A Checklist for NGO Liaison Officers Visiting UFHP Clinics	September 1997
UFHP's 1997/98 Annual Work Plan	October 1997
A Standard Equipment List for UFHP Clinics	October 1997
UFHP Clinical Performance: 1 <sup>st</sup> Quarter (Aug – Oct 1997)	December 1997
UFHP Personnel Policy	January 1998
A Checklist for QA Visits to UFHP Clinics	February 1998
Catchment Areas for UFHP Clinics: Research Memorandum	February 1998
UFHP Clinical Performance: 2 <sup>nd</sup> Quarter (Nov 1997 – Jan 1998)	March 1998
UFHP Clinical Performance: 3 <sup>rd</sup> Quarter (Feb – Mar 1998)	April 1998
Policies and Procedures Manual for UFHP-funded NGOs	May 1998
Semi-annual Performance Report to USAID	May 1998
Guideline for NGO Performance Appraisal Systems	June 1998
UFHP Current Non-financial Policy Guidelines	June 1998
UFHP Teambuilding and Motivation Workshop – A Facilitator's Guide for NGO Staff	June 1998
BCC and Marketing – A Joint Plan ( <i>Bangla</i> )	
NIPHP's MIS: A User Manual for UFHP NGOs ( <i>Bangla</i> )	July 1998
UFHP Clinical Performance: 4 <sup>th</sup> Quarter (April – June 1998)	July 1998
BCC and Marketing: Developing a Joint Plan ( <i>Bangla</i> )	July 1998
Strategic Planning for NGOs	August 1998
A Facilitator's Guide to Strategic Planning for NGOs	August 1998
UFHP Clinical Performance: July 1998	August 1998
Rules and Procedures for Managing Revolving Drug Funds: Course Notes	September 1998
Rules and Procedures for Managing Revolving Drug Funds: NGO Manual	September 1998
Course Notes on Structured Communications	September 1998
Exercises Booklet on Structured Communications	September 1998
RDF/MTP Module 1 – Revolving Drug Funds and the Standard Drug List ( <i>English and Bangla</i> )	September 1998

- Many customers opined that the health problems of all family members, particularly elderly men and women and adolescents, should be addressed with equal importance.
- A few (affluent) customers advocated the need for a telephone connection at the clinic, for making appointments.
- Some customers indicated a market need for cost-effective diagnostic facilities, especially path lab services, at UFHP clinics.
- Some customers expected prescribed medicines to be provided within the consultation fee paid for the service provider's services at the clinics.

UFHP is taking these informal messages into account while designing its first formal customer feedback survey during 1998/99.

#### **D. Collaboration with GOB to Date**

UFHP has developed a close working relationship with GOB during its first year of operation. Areas in which we have found fruitful opportunities for collaboration include:

- UFHP clinic staff are attending routine coordination meetings with GOB and other stakeholders at thana, municipality and district levels.
- We have organised orientation meetings on ESP, NIPHP and one-stop shopping for GOB officials at divisional, district and municipality levels. NGO staff and volunteers also attend these meetings.
- NGOs have identified satellite spots through joint meetings at thana level with the TFPO and the Municipal Medical Officer. Many UFHP satellite clinics are now operating at GOB EPI centres.
- UFHP NGOs are collaborating and participating in NIDs and other national events.
- UFHP headquarters staff have both individual and joint meetings with the Mayor, Municipality Chairmen, Chief Health Officer, Medical Officers of City Corporation/Municipality, Civil Surgeon, Deputy Director Family Planning and their junior officers at thana and district levels.
- Based on a request from the Director General of the Directorate of Family Planning, UFHP has completed all the preparatory work to launch the BUSTTHI project (described in section A of this report). This project will provide ESP services to the urban slum population of Dhaka city and is expected to start from January 1999.
- UFHP, GOB and WHO are working together to develop the phased introduction of an urban TB programme through selected UFHP clinics. It is expected that the programme will be operational in the first quarter of 1999.

- During the recent devastating floods, UFHP collaborated with the Civil Surgeon in Dhaka to establish and manage 21 ORT Corners at its static clinics located in the DCC area. In addition, UFHP made its clinic staff available to the Civil Surgeons of affected districts for emergency relief work.
- To improve acceptance of clinical family planning methods in urban areas, UFHP has started a process of joint training collaboration on Norplant and NSV techniques with the Directorate of Family Planning. The training courses are expected to start in the fourth quarter of 1998.
- To raise awareness about the importance and availability of family health services, UFHP and RSDP have started to supplement the GOB efforts in the field of BCC/marketing by using mass media like television/radio.
- UFHP is conducting a 12 week course on “improving management and performance of delivery of ESP in urban areas”, involving NGOs and health, family planning, municipal health departments of the government. The course is expected to develop effective co-ordination and collaboration between GOB and NGO networks.
- UFHP clinics have also established referral linkages with GOB facilities for the services not currently offered by UFHP. This initiative will help us in establishing effective co-ordination among stakeholders.

#### **E. Strategic Issues to be Resolved**

There are five issues facing UFHP which we consider to be ‘strategic’ after one year’s experience of the programme. These all affect in some fundamental way our potential for development and success in the remaining years of the programme.

##### **1. The Grand Experiment**

Will the switch from doorstep service delivery to clinical delivery be a success? This is an NIPHP strategic issue not just affecting UFHP. There is insufficient data to lead us to any firm conclusion at this stage. Anecdotal evidence suggests that some customers switched from field-worker supply of contraceptives to retail supply (ie SMC) during the transition into the NIPHP in 1997. If true, it is very acceptable news for the programme, since customers remain well cared for and sustainability has improved. However, it may also re-define the role of clinics within the NIPHP.

The fact that UFHP is working in urban areas – which are largely undocumented and have many alternative NGO, retail and private sector supply sources – complicates the picture. For us, the grand experiment also needs to address the role of aid-funded NGOs in the urban environment. Only as data becomes available through the DHS and our own impact assessment research over the next 2-3 years, will these issues become easier to resolve.

##### **2. Institutional Relationships with GOB**

Can UFHP build a successful relationship with GOB in urban areas? This issue has many layers. At one level, we have made excellent progress in building a relationship with

MOHFW and its two Directorates. On another level, we have also made good progress in building field-level relationships. Our NGOs talk to local GOB representatives regularly and plan our development jointly with them. We cooperate together on national events and generally support each other well. Local difficulties remain – some NGO Project Directors and many doctors are shy in the area of GOB networking; some personalities on both sides are abrasive; the flow of information between the field and the Dhaka offices of both Directorates is intermittent, leading to occasional misunderstandings and confusion. At the end of the day, however, there is still no consensus on the role of the NGOs – are they to be viewed by GOB as a short-term gap filler or a long-term partner?

On another level, the playing field is changing radically because MOHFW is handing primary health care over largely to MLGRDC and the City Corporations. This ministry has little track record in, or resources for, health care management. The presence of the ADB Urban Primary Health Care Project should be helpful in terms of institution-building but that project comes with so many internal challenges of its own – including particularly its design, management structure and financing – that it represents a source of more confusion than much of a help at this stage. UFHP's strategy to date has been to cooperate as fully as we can as these changes take place, thereby helping to resolve the underlying strategic issue for us – but much uncertainty about the future remains.

### **3. ESP Pricing Policies**

What should UFHP be charging for its ESP services? UFHP has no basis on which to promulgate a formal ESP pricing policy yet – we do not know enough about our customers' ability or willingness to pay, the other providers of ESP and their pricing, our NGOs' unit costs or our own pricing strategy. We will be working hard on all of these issues during 1998/99. In the meantime, our NGOs charge what they believe is appropriate given their knowledge of local conditions.

Resolving this issue is relatively straightforward. We now have a card-based MIS which will give us a customer database and we can commission research to fill the other gaps. However, GOB is also starting to offer the ESP and GOB supplies many of UFHP's FP commodities for free. To date, GOB has largely taken a position of 'free service'. In two areas – EPI and TB – this position has caused some friction with UFHP. For instance, a few TFPOs, in the current confusion over what GOB's new attitude to ESP pricing will be, are insisting that they should control UFHP's pricing policy through supply of EPI vaccines. No free service, no vaccine. So far we have resolved this at the local level but the problem will persist until the GOB finalises its pricing policy in the context of its stated policy "to mobilise resources in the form of cost recovery".

### **4. CD/VAT**

When will UFHP be in a position to make necessary capital investments? The CD/VAT obligations of GOB under the NIPHP's SOAG have still not been funded. As a result, UFHP and its partners are still operating with inadequate capital equipment. For instance, UFHP has just three, second-hand vehicles on loan from TAF to transport a staff which has now grown to over 20 people. At least eight of these travel all over the country for 50 per cent of their time. We hope that USAID's efforts to resolve this issue will be successful soon.

## **5. Supply of Injectables**

Can UFHP get sufficient supply? GOB kindly supplies UFHP with free injectable contraceptives. Our own and external analyses of the supply situation show that, in contrast to other commodities which GOB supplies, injectables are in consistently short supply. We have had to turn injectable customers away from some clinics at various periods during the first year. Given that injectables are the fastest growing contraceptive method in the country, the problem is understandable but also one we cannot allow to continue. We are in discussion with USAID on this right now and expect to find a resolution during 1998/99.

**Appendix A**  
**Summary of Management Partner Activities**

## BCCP ACTIVITIES FOR UFHP FOR FY 1998

To fulfil the BCC needs of NIPHP/UFHP, Bangladesh Center for Communication Programs (BCCP) is principally responsible to conceptualize, develop, pretest and produce a variety of BCC materials in all media to address the local as well as national needs.

Research teams from BCCP visited the UFHP NGO's at the initial stage to conduct an IEC needs assessment. BCCP was able to draw upon the findings of this needs assessment to develop IEC materials for the service providers and customers. Besides collecting information on BCC needs, a half day workshop with the NGO staffs was conducted to orient them on the basic concept of BCC and how BCC materials are developed.

BCC materials to promote and market the Essential Service Package were produced during the first year. Besides producing the new BCC materials, existing BCC materials were collected from different organizations, some of which were distributed after discussions with the partners. A list of IEC activities conducted is attached.

BCCP staff visited several of the urban clinics to monitor the use of the BCC materials and promote their correct use. They also worked with the clinic administration to decorate the clinic waiting room.

During this period BCCP conducted two research activities - The 1998 National Media Survey and IEC Study. The purpose the National Media Survey was to examine media coverage and media habits of the target audiences in order to establish the relative importance of different media and to assist in determining the ideal timing/ placement of messages delivered to achieve their maximum reach and impact. The IEC study was conducted to collect information with which messages for NIPHP customers and service providers will be developed. The study primarily focuses on collecting information on the knowledge and attitudes of the customers which will help be to conceptualize, develop, pretest and produce appropriate BCC materials and to conduct other BCC activities as well.

BCCP held one Advances in Family Health and Social Communication workshop and one Message Development workshop in this year. The workshops' highly participatory approaches are designed to help develop the skill of the participants to follow a systematic communication approach to design BCC activities/programs.

BCCP staff in collaboration with UFHP also conducted BCC and Marketing blitz with a number of NGOs. The objectives were to orient the service providers on the concept of IEC, help them understand Marketing and Selling, develop local BCC activity calendar and discuss how these NGOs would survive in UFHP.

BCCP provided technical assistance to the development of the National Integrated Health and Family Planning BCC Strategy. As part of the process BCCP organized and held a one-day workshop with the stakeholders to build consensus in July 1998. Specific recommendations were made in the workshop. BCCP has been working in close collaboration with the government to assist in the development of the HIV/AIDS BCC strategy and is also providing technical input as a member of the National AIDS Advisory Committee, UNAIDS Technical Working Group and HIV/AIDS network. A Task Force made up of BCCP staff and other relevant persons with which the larger group will maintain liaison to coordinate activities. BCCP continued to provide technical support to various BCC committees of MOHFW.

## Accomplished BCC Activities from July 1997 - September 1998

BCC Activities/Materials	Target Audience	Purpose
All UFHP NGOs visited	Project Director, service providers and customers	Assess BCC needs and provide BCC orientation
Existing BCC materials collected, reviewed and distributed	NGO static clinics and service providers	Make best use of existing materials and avoid duplication
Green Umbrella tin signs, stickers and posters	NGO clinics, satellite clinics and service providers	Continuation of the green umbrella campaign to promote one stop shopping
ESP promotional leaflet printed and distributed	Customers	Promote ESP services and service sites
Satellite clinic banner produced and distributed	All UFHP satellite teams	Help customers identify satellite clinic
Counseling & Motivational Handbook distribution	Service Providers	Update and reinforce Counseling & Motivational techniques
Cassette players along with audio cassettes	NGOs static clinics	Use in the clinic waiting room
Standard clinic sign designed and distributed	Customers	Help identify state clinics
Modified satellite clinic directional sign	Customers	Help identify satellite clinics
Standard sign design promoting doctor and services available in the clinic	Customers	Inform about the doctors and available services
Prototypes of Press Ad.	Customers	Announce ESP service in the local news papers
BCC and Marketing blitz held in seven NGOs	Service providers	Orient on the concept of BCC, marketing & selling and quality performance
A poster on 'Quality'	Service providers	Remind elements of quality service
A desk top material on 'Quality'	Service providers	Remind elements of quality service
A loose leaf flipchart	Service providers	Help counseling and provide ready reference
Take-away brochures	Customers	Help customers to discuss with family to make informed choice
Video off takes from "Shabuj Shathi"	Clinic waiting room	Make best use of waiting time by educating thru entertainment
One laminated sheet on 'Management Objectives'	Customers	Constantly remind the objectives of management
One Generic TV spot	Customers	Promote one stop shopping & inform customers about available services
One Generic Radio spot	Customers	Promote one stop shopping & inform customers about available services
12 audio songs waiting room	Customers	Make best use of waiting time by educating thru entertainment
One UFHP specific TV spot	Customers	Introduce clinics with UFHP logo as quality services provider & remind available services
One UFHP specific TV spot	Customers	Introduce clinics with UFHP logo as quality services provider & remind available services
Advances in Family Health and Social Communication Workshop	Senior and mid-level decision-makers and program manager	Promote effective, state-of-the-art of communication to develop effective communication strategies /programs
Message Development Workshop	Senior and mid-level professional staff and program managers from Govt., NGOs and NIPHP partners agencies	Improve message development skills, pretesting techniques

## Work Plan of Concerned Women for Family Planning in UFHP

### **Adolescent Health**

A Working Group with members from each partner of UFHP was formed. Till date, the group has taken inventory of some of the existing adolescent programs of NGOs and GoB. Curricula and IEC materials have been collected. A concept paper with identified adolescent health package and implementation plan has been developed. The duties of the Senior Service Promoters and Medical Officers have been listed. The next step for the group is to prepare service provider's training curricula and develop IEC materials for adolescents.

### **Organizational Strengthening**

Strategic Planning process of CWFP started around March. The following activities have been completed:

1. Identification of SBUs and situation analysis of each SBU.
2. Finalization of the mission and vision statements of CWFP.
3. Draft base case projections
4. Preparation of the action plans of some of the SBUs
5. Financial projections
6. Corporate level planning

The next step is to finalize the action plans within each team.

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<b>Work Plan of Concerned Women for Family Planning in UFHP, 97-98</b>			
<b>Action Plan</b>	<b>Achievements</b>	<b>Additional Task</b>	<b>Immediate Next Steps</b>
<b>Adolescent Health</b>	<ul style="list-style-type: none"> <li>• A Working Group with members from each partner of UFHP was formed</li> <li>• The group has taken inventory of some of the existing adolescent programs of NGOs and GoB</li> <li>• Curricula and IEC materials have been collected</li> <li>• A concept paper with identified adolescent health package and implementation plan has been developed</li> </ul>	<ul style="list-style-type: none"> <li>• The duties of the Senior Service Promoters and Medical Officers have been listed</li> </ul>	<ul style="list-style-type: none"> <li>• To prepare service provider's training curricula and develop IEC materials for adolescents</li> </ul>
<b>Organizational Strengthening</b>	<ul style="list-style-type: none"> <li>• Identification of SBUs and situation analysis of each SBU</li> <li>• Finalization of the mission and vision statements of CWFP</li> <li>• Draft base case projections</li> <li>• Preparation of the action plans of some of the SBUs</li> <li>• Financial projections</li> <li>• Corporate level planning</li> </ul>		<ul style="list-style-type: none"> <li>• To finalize the action plans within each team.</li> </ul>

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**POPULATION SERVICES AND TRAINING CENTRE (PSTC)**  
**103, New Circular Road, Dhaka-1217**

Following activities have been performed by PSTC for the period from Sept '97 to Sept '98 in concert with and under UFHP funding:

Sl. No.	Activities	Events	Participants
1	<b>Attended UFHP Management committee meeting</b>	16	
2	<b>NGO Orientation on One stop shopping</b> (Participants were NGO leaders and staff)	26	867
3.	<b>Divisional level Workshop on NIPHP for Khulna &amp; Barisal, Sylhet &amp; Chittagong Division</b> (Participants were Division & District level govt officials of both the Directorate of Health and FP and NGO Project Director)	2	205
4.	<b>Municipal level orientation workshop on NIPHP</b> (Participants were District/Thana level govt. officials, Municipal Chairman and Commissioners, Community leaders, private sector representatives and NGO leaders including other NGOs).	65	2253
4.	<b>Team Building and Motivation workshop</b> Preparatory visit jointly made with Mrs Barbara Whitney, consultant and Ms Louisa B Gomes - 1st phase workshop held - 2nd phase workshop held - Follow up visits (Participants were the NGO Project staff)	4 17 17 3	  232 232
6	<b>Monthly publication of "Projanma"</b>	3 issues	18,000 copies
7	<b>Municipal Coordination</b> - Committee meeting held - # Municipalities selected for intervention - Information collected from # Municipalities - Project Designed, comments from Committee members & UFHP incorporated in the intervention design	6 6 4	
8	<b>Strategic Plan Development</b> - Worked for strategic plan development of PSTC under the guidance of Mr. Peter Connell, COP, UFHP		
9.	Provided Management & Logistic support for the Course on "Improving Mgt & Performance of ESP Delivery in Urban Areas" since July, 1998 - Course started from September '98	1	29



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**Appendix B**  
**Clinic Catchment Area Population Estimates**

**Clinic Catchment Area Population Estimates**  
(at 30 January 1998)

Cluster Number	NGO Name	Municipality	Clinic Name/Location	Estimated Catchment Area Radius (kms)	Estimated Catchment Area Population
1	Mamata	Chittagong	No 1/Ward 39	3.5	286,246
			No 2/Ward 24	3.0	129,536
			No 3/Ward 26	3.5	121,744
			No 4/Ward 9 (proposed)	1.5	72,730
2	Nishkriti	Chittagong	No 1/Ward 21	2.5	174,700
			No 2/Ward 29 (proposed)	3.5	58,419
			No 3/Ward 18	2.0	98,437
			No 4/Ward 33	3.0	83,446
3	Image	Chittagong	No 1/Ward 8	2.0	87,138
			No 2/Ward 2	2.5	125,667
			No 3/Ward 4 (proposed)	2.0	95,150
4	Proshanti	Cox's Bazar	Ward 2	3.5	52,343
		Chowmuhuni	Ward 3	4.0	52,059
		Feni	Ward 2 (to be moved)	4.0	34,944
		Lakshmipur	Ward 3	4.5	53,907
		Noakhali	Ward 1	4.5	79,568
5	CAMS	Brahmanbaria	Ward 1	4.0	84,630
		Chandpur	Ward 3	4.0	74,808
		Comilla	Ward 3	3.0	93,080
		Laksham	Ward 2	4.5	62,539
6	SSKS	Habiganj	Ward 3	4.5	39,934
		Moulvibazar	Ward 2	3.5	33,866
		Sunamganj	Ward 2	3.5	33,567
		Sylhet	Ward 3	3.0	62,972

Cluster Number	NGO Name	Municipality	Clinic Name/Location	Estimated Catchment Area Radius (kms)	Estimated Catchment Area Population
7	CWFP	Dhaka	Gandaria/Ward 81	1.5	161,938
			Lalbagh/Ward 61	2.0	378,442
			Rayerbazar/Ward 48	1.5	62,782
			Kayettuli/Ward 69 (proposed)	2.0	259,949
			Muradpur/Ward 88 (proposed)	1.5	91,045
8	PSTC	Dhaka	Circular Rd/Ward 53	1.5	227,623
			Golapbagh/Ward 85	1.5	148,635
			Bashaboo/Ward 28	1.5	159,443
			Green Rd/Ward 51	1.5	312,508
			Rampura/Ward 22	1.5	155,789
			Sayeedabad/Ward 84	2.0	119,571
9	UTPS	Dhaka	Baitul Aman/Ward 42	1.5	77,028
			Sheorapara/Ward 14	2.0	165,701
			Gabtohi/Ward 10	2.5	147,515
			Raja Bazar/Ward 40	1.5	132,339
10	PSKP	Dhaka	Mirpur-10/Ward 3	2.0	335,149
			Mirpur-7/Ward 7	2.5	223,745
			Manikdi/Ward 15	3.0	148,945
			North Badda/Ward 21	1.5	175,647
			Tejgaon/Ward 37	1.5	130,000
11	BMS	Tongi	ACORD/Ward 3	2.5	219,694
			Ward 1	4.5	55,083
		Munshiganj Narayanganj	Chandmari/Ward 3	3.0	55,098
			Paikpara/Ward 7	3.0	50,747
			Tanbazar/Ward 8	3.5	49,123
			Whilson Rd/Ward 1	3.0	97,605



Cluster Number	NGO Name	Municipality	Clinic Name/Location	Estimated Catchment Area Radius (kms)	Estimated Catchment Area Population
12	CWFP	Gazipur	Ward 1	4.0	125,951
		Gopalpur	Ward 3	4.5	47,110
		Mymensingh	Ward 1	4.5	117,236
		Netrokona	Ward 2	3.5	55,513
		Tangail	Ward 1	4.0	72,173
13	Malancha	Jamalpur	Ward 1	4.0	101,371
		Sharishabari	Ward 2	4.5	63,615
		Sherpur	Ward 2	4.5	81,021
14	VFWA	Faridpur	Ward 1	4.0	89,775
		Gopalganj	Ward 1	3.5	31,979
		Madaripur	Ward 2	4.5	59,894
		Rajbari	Ward 3	4.5	54,595
15	KAJUS	Barisal	Ward 10	3.5	53,301
		Bhola	Ward 2	3.5	44,786
		Patuakhali	Ward 3	4.5	55,527
16	Banophul	Khulna	No 1/Ward 29	3.5	275,769
			No 2/Ward 24	2.0	196,968
		Fultola	Bus stand/Ward 2	3.5	99,201
		Satkhira	Ward 3	4.5	69,728
17	FPAB	Khulna	No 1/Ward 12	3.0	58,170
			No 2/Ward 6	2.5	51,030
			No 3/Ward 3	2.5	48,174
		Bagerhat	Ward 3	4.0	42,263
18	PKS	Mongla	Ward 3	4.0	64,000
		Benapole	Durgapur Rd/Ward 2	4.0	49,706
		Jessore	Ward 2	4.0	29,386
		Magura	Ward 2	4.5	48,092
		Narail	Ward 2	4.5	35,135

Cluster Number	NGO Name	Municipality	Clinic Name/Location	Estimated Catchment Area Radius (kms)	Estimated Catchment Area Population
19	Dipshika	Chuadanga	Ward 3	4.5	76,860
		Darshana	Ward 3	4.5	32,242
		Jhenaidha	Ward 2	4.0	81,907
		Kustia	Ward 3	4.5	94,319
		Meherpur	Ward 6	4.5	34,786
20	PSSS	Bhairab	Ward 1	4.0	74,805
		Kishoreganj	Ward 1	4.5	47,015
		Narshingdi	Ward 1	4.0	128,067
		Ishwardi	Ward 1	4.0	57,089
21	ASKS	Pabna	Ward 3	4.0	65,470
		Shahjadpur	Ward 2	4.0	76,647
		Sirajganj	Ward 2	4.0	37,257
		Bogra	Ward 4	4.5	132,426
22	UPGMS/B	Gaibandha	Ward 1	4.0	52,646
		Joypurhat	Ward 1	4.5	41,258
		Hargacha	Ward 1	4.5	19,680
		Kurigram	Ward 2	4.5	75,780
23	UPGMS/R	Lalmonirhat	Ward 2	4.5	56,804
		Rangpur	Mulatola/Ward 2	4.0	165,416
			Babupara/Ward 4	4.0	58,209
			Ward 2	4.0	118,672
24	Tillotoma	Naogaon	Ward 2	4.0	38,581
		Natore	Ward 2	4.0	111,950
		Nawabganj	Ward 1	4.5	81,763
		Rajshahi	Ward 8	4.0	130,465
25	Kanchan	Dinajpur	Ward 4	4.5	23,219
		Hilli	Ward 2	4.5	38,816
		Nilphamari	Ward 2	4.5	65,520
		Saidpur	Ward 3	4.5	44,545
		Thakargaon	Ward 1	4.5	
<b>Total</b>					<b>10,406,257</b>

**Appendix C**  
**UFHP Clinic Performance Data, September 1998**

# Monthly Performance Report

Performance for : **UFHP**  
Cluster(s) 1-26

Month of September 1998

ESP Components			Static Clinic	Satellite Clinic	Total
<b>A. Child Health Contacts</b>			<b>14,977</b>	<b>35,346</b>	<b>50,323</b>
Immunisation	Age: 0-11 Months	BCG	1433	945	2378
		DPT/Polio 1	1450	910	2360
		DPT/Polio 2	1154	688	1842
		DPT/Polio 3	939	627	1566
		Polio 4	866	735	1601
		Measles	979	683	1662
	Age: 12+ Months	BCG	8	14	22
		DPT/Polio 1	5	10	15
		DPT/Polio 2	5	13	18
		DPT/Polio 3	1	1	2
		Polio 4	20	1872	1892
		Measles	16	1196	1212
Vitamin A	Age: 0-11 Months	1	1337	724	2061
		2	708	388	1096
		3	873	629	1502
CDD	Age: 12 + Months		225	873	1098
		Diarrhoea-no dehydration	1191	8659	9850
		Diarrhoea-atleast some dehydration	949	5620	6569
ARI	Dysentery		409	1783	2192
		Common Cold	1889	7648	9537
Disease Surveillance	Pneumonia		512	1326	1838
		AFP	6	2	8
	NNT	2	0	2	
<b>B. Reproductive Health Contacts</b>			<b>21,961</b>	<b>41,668</b>	<b>63,629</b>
ANC		1	2885	3106	5991
		2	1161	1208	2369
		3 +	412	357	769
		Referral	146	80	226
TT		Pregnant - 1	1382	803	2185
		Pregnant - 2	1118	488	1606
		Pregnant - 3	276	151	427
		Pregnant - 4	68	73	141
		Pregnant - 5	27	41	68
		Non-Pregnant - 1	910	2117	3027
		Non-Pregnant - 2	307	1419	1726
		Non-Pregnant - 3	145	625	770
		Non-Pregnant - 4	44	245	289
		Non-Pregnant - 5	29	53	82
PNC		1st Visit	486	780	1266
		Re-Visit	88	168	256
<b>Family Planning Service Contacts</b>			<b>10,520</b>	<b>27,529</b>	<b>38,049</b>
Family Planning		Pills	3314	13183	16497
		Condom	1886	6948	8834
		Injectable (2m)	284	192	476
		Injectable (3m)	4737	7190	11927
		IUD (insert)	122	11	133
		IUD (removal)	107	4	111
		Norplant	47	1	48
		Vasectomy	13	0	13
	Tubectomy	10	0	10	

# Monthly Performance Report

Performance for : **UFHP**  
 Cluster(s) **1-26**

Month of September 1998

ESP Components			Static Clinic	Satellite Clinic	Total
RTIs/STDs	Family Planning Referrals issued	Injectable	38	38	76
		IUD	4	22	26
		Norplant	8	11	19
		Sterilisation	6	19	25
	Contraceptive Side Effects	Pill	61	174	235
		Injectables	178	388	566
		IUD	134	36	170
		Norplant	9	3	12
		Sterilisation	1	12	13
		Female - VD	865	1257	2122
		Female - CD/LAP	395	309	704
		Female - GU/IB	142	93	235
		Male - GU/IB	67	27	94
		Male - UD/SS	49	36	85
<b>C. Communicable Disease Contacts</b>			<b>469</b>	<b>406</b>	<b>875</b>
	TB	55	152	207	
	HIV/AIDS	414	254	668	
<b>D. Limited Curative Care Contacts</b>			<b>16,751</b>	<b>35,216</b>	<b>51,967</b>
Curative care		Helminthiasis	934	1858	2792
		Anaemia	1115	2979	4094
		Menstruation Problem	1108	1154	2262
		ENT	471	392	863
		Skin Problem	1377	2428	3805
		First Aid	419	325	744
		Others	11327	26080	37407
<b>E. Total Contacts by Services</b>			<b>54,158</b>	<b>112,636</b>	<b>166,794</b>
<b>F. Contacts by age and sex</b>			<b>46,280</b>	<b>69,562</b>	<b>115,842</b>
	<5 yrs	Male	4819	4061	8880
		Female	4648	4558	9206
	5-8 yrs	Male	1247	1595	2842
		Female	1272	7125	8397
	9-19 yrs	Male	1555	1789	3344
		Female	3913	5501	9414
	20 + yrs	Male	4037	3892	7929
		Female	24789	41041	65830
<b>G. Commodities Distributed</b>			<b>44,503</b>	<b>111,558</b>	<b>156,061</b>
		Pill: SMC	128	550	678
		Pill: GoB	6112	16148	22260
		Condom: SMC	857	774	1631
		Condom: GoB	32343	86890	119233
		Injectable (amp/vial)	4937	7185	12122
		IUD (piece)	113	11	124
		Implants	13	0	13
<b>H. Community Health Meetings</b>			<b>267</b>	<b>2,906</b>	<b>3,173</b>
	Adolescents	Meetings	40	611	651
		Participants	709	4236	4945
	HIV/AIDS	Meetings	60	290	350
		Participants	767	2827	3594
	Newly Weds	Meetings	21	219	240
		Participants	242	1352	1594
	Others	Meetings	146	1786	1932
		Participants	2458	14691	17149

**Appendix D**  
**NIPHP SO/IR Performance Indicators**

*(Source: Strategic Objective Agreement between the  
Government of Bangladesh and the US, 9 May 1997)*

Strategic Objective: Fertility reduced and family health improved

INDICATOR	Source	Annual Measure	Baseline	Projected 2004*	Responsibility
Reduced Total Fertility Rate	DHS	none	3.3 DHS 96/7	2.8	GOB, USAID
Reduced Infant Mortality Rate	DHS	none	87 DHS 96/7	70/000	GOB, USAID
Reduced Child Mortality Rate	DHS	none	36 DHS 96/7	30/000	GOB, USAID
Increased proportion of pregnancies attended by trained provider (at least 1 ANC Visit during pregnancy)	DHS	nos. of reported ANC visits	26% DHS 96/7	40%	GOB, USAID
Percent of aggregate operating costs of USAID-supported NGOs covered by program generated revenues	CA reports	same	6%	25%	GOB, USAID, NGOs

\* These projections are based on the preliminary results of the 1996/7 Bangladesh DHS. Further revision may be made when the official results are available.

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Intermediate Result One: Use of high impact family health service increased

INDICATOR	Source	Annual Measure	Baseline	Responsibility <sup>2</sup>
Contraceptive Prevalence Rate (CPR) increased - all methods	DHS	# of IUDs, sterilizations and injectables DG/FP MIS	49% DHS 93/94	USAID
CPR increased - modern methods	DHS	same as above	41.5% DHS 93/94	USAID
Contraceptive method mix improved in favor of clinical methods (CPR for injectables, IUDs, sterilization, Norplant)	DHS	same as above	16.7% DHS 96/97	USAID
Proportion of fully immunized children by one year of age nationwide	Nation. EPI survey	EPI service statistics	51% EPI survey 1997	BASICS
TT2 coverage rate for women given birth in last year	Nation. EPI survey	EPI service statistics	72% EPI survey 1997	BASICS
Vitamin A capsule coverage for under 3 year olds in prior 6 months	DHS	UNICEF service statistics	48.8% DHS 93/4	BASICS
Proportion of diarrheal cases in prior 2 weeks in under 5 year olds treated with ORT	DHS	# of ORS packets sold by SMC and market share	62.6% DHS 96/97	SMC
Proportion of ARI cases in prior 2 weeks in under 3's treated by trained provider	DHS	# of pneumonia cases treated by CAs accord. standards	36% DHS 96/97	Urban and Rural CAs
Proportion of USAID funded NGO clinics that offer at least 4 high impact services according to standards (clinical FP, non-clinical FP, EPI/vit A, ARI, CDD, ANC, STI/RTI)	CA service statistics	same	0.00	Urban and Rural CAs

Intermediate Result Two Capabilities of individuals, families, and communities to protect and provide for their own health

INDICATOR	Source	Annual Measure	Baseline	Responsibility <sup>1</sup>
National FP Health IEC strategy revised, implemented, and evaluated	BCCP reports	same	plan needs revision	BCCP
Increased knowledge by men and women of risks and preventive measures for HIV/AIDS	DHS	none	TBD from 96/97 DHS	USAID
Number of condoms sold in proximity to targeted high risk populations	SMC and CA service statistics	same	21,000 /month SMC 96	SMC and Urban and Rural CAs

Intermediate Result Three: Quality of information, services, and products assured and customer satisfaction improved

Percent of service providers in USAID supported areas complying with standards/protocols (for at least 5 priority services)	CA service statistics	same	0	Urban and Rural CAs
Percent of service sites in USAID areas having appropriate personnel, equipment, supplies, facilities for basic package of services	CA service statistics	same	0	Urban and Rural CAs
% of EPI dropouts (BDG - fully vac./fully vacc.)	Nation. EPI survey	EPI service statistics	37% 1997 Nat EPI survey	BASICS
IUD discontinuation rate (12 months)	DHS	none	38% DHS 93/4	USAID
OC discontinuation rate (12 months)	DHS	none	37% DHS 93/4	USAID
Injectable contraceptive discontinuation rate (12 month)	DHS	none	57% DHS 93/4	USAID
More customers who receive information, services, products they want (qualitative trend info)	CA customer surveys	same	TBD in 1996 by PI and BCCP	Urban and Rural CAs

Intermediate Result 4 Local service delivery organizations strengthened and associated support systems for high impact family health services improved

INDICATOR	Source	Annual Measure	Baseline	Responsibility <sup>4</sup>
Stock out rate of FP commodities maintained at low level	FPLM stock survey	Same	4%	FPLM
Stock out rate of BPS commodity for USAID NGOs at field level	FPLM spot	Same	No system	FPLM
Percent of FP logistics activities performed by GOB without external TA	CA service statistics	Same	TBD in late 1996 by FPLM	FPLM
Number of OR findings/results replicated by other CAs	ICDDR,B MIS	Same	0.00	ICDDR,B
Number of OR activities conducted to operationalize the BPS	ICDDR,B MIS	Same	0	ICDDR,B
Completeness of Polio and NTT national surveillance reporting	Nat EPI MIS	same	Polio 10% NTT 2%	BASICS

Intermediate Result Five: Sustainability of family health services and support systems improved

Utilization rates of static sites (e.g., cluster sites, satellite clinics, fixed facilities) in USAID areas increased	NGO service statistics	same	TBD in sample of sites	Urban and Rural CAs
Proportion of FP users who receive services from other than doorstep delivery	DHS	NGO service stats	61.4% DHS 96/97	Urban and Rural CAs
Percent of aggregate field costs of USAID-funded NGOs (not including contraceptives) covered by program generated revenues increased	NGO service stats	same	6% NGO stats 1996	Urban and Rural CAs
Average total cost of a clinic-provided family planning CYP	Special cost studies every 3 years	none	\$5 per CYP 1996 JSI study	Urban and Rural CAs

**Appendix E**  
**Quality Assurance Checklist Used at UFHP Clinics**



**National Integrated Population and Health Program (NIPHP)**

**Quality Assurance (QA) Visit Checklist**  
(For UFHP clinics)

## QUALITY ASSURANCE (QA) VISIT CHECKLIST

Date of visit: \_\_\_\_\_

Name of the clinic: \_\_\_\_\_

Address : \_\_\_\_\_

Team members:	<u>Name(s)</u>	<u>Organization</u>
01.		
02.		

**1. PHYSICAL FACILITIES:**

Particulars	Observations	Recommendations	By Whom	ByWhen
<b>a) Clinic Sign:</b> The clinic has signboard indicating name, address, services, clinic days & timing, EPI days, and directing signs displayed prominently.				
<b>b) Basic Infrastructure:</b>				
• Clinic has electricity and running water supply.				
• Room arrangement/clinic setup done as per appropriate clinic layout.				
• Has adequate and appropriate <b>job aids</b> .				
• Has <b>service delivery guidelines</b> .				
ii. Rooms numbered.				
<b>c) Individual Service Areas/Space:</b>				
<b>i. Clients Reception/Waiting:</b>				
The reception/waiting area has:				
• Separate space.				
• Adequate and appropriate furniture..				
• Sufficient seating arrangement.				
• Protected against rain and sun.				
• Nearby toilet for customers.				

Particulars	Observations	Recommendations	By Whom	ByWhen
<ul style="list-style-type: none"> <li>• Safe drinking water.</li> </ul>				
<ul style="list-style-type: none"> <li>• Service costs displayed prominently.</li> </ul>				
<ul style="list-style-type: none"> <li>• Audio visual aid for client information &amp; education (framed posters, cassette players, TV &amp; VCP, appropriate audio and videotapes, etc.).</li> </ul>				
<b>ii. Counseling Room:</b>				
<ul style="list-style-type: none"> <li>• Separate room with auditory and visual privacy.</li> </ul>				
<ul style="list-style-type: none"> <li>• Appropriate seating arrangement for provider and customer.</li> </ul>				
<ul style="list-style-type: none"> <li>• Appropriate <b>counseling aids</b> [(e.g., contraceptive display board and tray, flipcharts, anatomical models (pelvic, penile), forms and registers, etc.).]</li> </ul>				
<b>iii. Paramedic's Room:</b>				
<ul style="list-style-type: none"> <li>• Has privacy (door closer, screen around exam table).</li> </ul>				
<ul style="list-style-type: none"> <li>• Has adequate and appropriate furniture.</li> </ul>				
<ul style="list-style-type: none"> <li>• Adequately clean.</li> </ul>				
<ul style="list-style-type: none"> <li>• Has appropriate <b>job aids</b>.</li> </ul>				
<ul style="list-style-type: none"> <li>• Has provision for physical and pelvic examinations.</li> </ul>				
<ul style="list-style-type: none"> <li>• Has nearby hand washing facility.</li> </ul>				
<ul style="list-style-type: none"> <li>• Has adequate source of light.</li> </ul>				
<ul style="list-style-type: none"> <li>• Has adjacent space for providing EPI services with supplies.</li> </ul>				
<ul style="list-style-type: none"> <li>• Has adjacent facilities for performing simple appropriate lab tests (Hb%, Urine for Albumin &amp; Sugar), etc.).</li> </ul>				
<b>iv. Doctor's Room:</b>				
<ul style="list-style-type: none"> <li>• Has privacy (door closer/screen around exam table).</li> </ul>				

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Particulars	Observations	Recommendations	By Whom	ByWhen
• Has adequate and appropriate furniture.				
• Adequately clean.				
• Has appropriate <b>job aids</b> .				
• Have provision for physical and pelvic examinations.				
• Has adequate source of light.				
• Has nearby hand washing facility.				
<b>v. Restricted Area:</b>				
• Demarcated from other areas (red mark & door closer).				
• Has rack for street shoes outside the restricted area.				
• Has changing room/space with cloth-hanger, shoe rack with OT sandals, etc.				
• Has proper scrubbing facility.				
• Procedure room/OT with:				
➤ Both way swinging door.				
➤ Closed ventilators/windows.				
➤ Pedastal fan/air cooler.				
➤ Appropriate equipment and MSR for providing IUD and other available clinical services.				
➤ Wall clock.				
• Recovery room with at least 2 beds, saline stand, etc.				
• Instrument processing area (with wash basin, running water, cleaning equipment, rack/table for drying instruments, gloves hanger, autoclave/sterilizer, boiling pot with lid, gas burner/heater, etc.)				
<b>vi. Laboratory at selected UFHP clinics:</b>				
• Has separate room/space for lab.				

Particulars	Observations	Recommendations	By Whom	By When
• Has trained Lab. technician/paramedic.				
• Adequate and proper furniture.				
• Refrigerator for keeping lab. Reagents.				
• Necessary equipment and reagents for selected laboratory tests.				
• Lab. tests presently done by the clinic.				

**2. COMPETENCE OF THE SERVICE PROVIDERS:**

Services/Activities	Observations	Recommendations	By Whom	By When
<b>a) Customer Flow Management:</b>				
Clinic maintains appropriate customer flow system (registration of customer with giving token, one customer at a time in provider's room, steps taken to reduce waiting time, etc.).				
<b>b) Client-Provider Interaction (Counseling in General):</b>				
• Counselor follows required steps of counseling.				
• Provides priority information that is tailored to the specific client's particular needs.				
• Staff have sufficient time to provide key information and cover client concern.				
• Communication between customers and providers <b>interactive</b> .				
• Providers attempts to minimize "social distance" between themselves and their customers.				
• Providers are sympathetic, polite, non-hierarchical, respectful, unbiased and attentive.				

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Services/Activities	Observations	Recommendations	By Whom	By When
<ul style="list-style-type: none"> <li>Appropriate <b>Counseling Aids</b> regularly used.</li> </ul>				
<b>c) Providers Technical Competence in Delivering ESP Services:</b>				
<b>i. Family Planning, RTI/STD and HIV/AIDS:</b>				
<ul style="list-style-type: none"> <li>Providers ask customers about reason for coming, previous contraception and reasons for switching/stopping.</li> </ul>				
<ul style="list-style-type: none"> <li>Tell about alternate methods available, their advantages, disadvantages, etc.</li> </ul>				
<ul style="list-style-type: none"> <li>Advise customers of special categories (e.g., breastfeeding women/suffering from RTI/STD) in selecting methods.</li> </ul>				
<ul style="list-style-type: none"> <li>Tell about post procedure care and return visit/follow-up.</li> </ul>				
<ul style="list-style-type: none"> <li>Advise customers appropriately during special circumstances (e.g., contraceptive related side-effects).</li> </ul>				
<ul style="list-style-type: none"> <li>Properly screen and provide Condom.</li> </ul>				
<ul style="list-style-type: none"> <li>Properly screen and provide Oral Pill.</li> </ul>				
<ul style="list-style-type: none"> <li>Properly screen and provide Injectable.</li> </ul>				
<ul style="list-style-type: none"> <li>Properly screen and provide IUD.</li> </ul>				
<ul style="list-style-type: none"> <li>Properly screen and provide Norplant/VSC (if available).</li> </ul>				
<ul style="list-style-type: none"> <li>Advise for prevention of RTI/STD and HIV/AIDS as appropriate.</li> </ul>				
<ul style="list-style-type: none"> <li>Provide syndromic management of RTI/STD according to good medical standards with emphasis on 4Cs.</li> </ul>				

Services/Activities	Observations	Recommendations	By Whom	By When
<b>ii. Child Health:</b>				
• <b>EPI and Vitamin-A:</b>				
➤ Check immunization status, Vitamin A deficiency and other diseases.				
➤ Provide EPI service delivery according to service delivery standard.				
➤ Provide Vitamin-A to infants, children (1-6 years) and postpartum mothers according to service delivery standard.				
➤ Ask and advice mothers about contraception.				
• <b>ARI &amp; CDD:</b>				
➤ Provide information and education about ARI and CDD.				
➤ Ask and advice about nutrition.				
➤ Provide ARI services according to service delivery standard.				
➤ Provide Plan A and refer/treat Plan B/Plan C as appropriate.				
<b>iii. Maternal Health:</b>				
• Providers tell about the importance of ANC and PNC (emphasize on and provide minimum 3 antenatal and 1 postnatal contacts).				
• Ask and advice about TT.				
• Tell about hygiene, nutrition and rest.				
• Advice about the importance of colostrum & breast feeding, and child immunization.				
• Advice about preparation for safe delivery.				
• Educate about danger signs of pregnancy.				
• Tell about postpartum contraception.				
• Ask mothers to bring their husband/in-				

Services/Activities	Observations	Recommendations	By Whom	By When
laws during at least one antenatal visit.				
<ul style="list-style-type: none"> <li>• Takes history, do physical exam., screen for anemia/albumin/sugar, advice for return visit, identify risk factors/early complication, do necessary referral, etc. according to good medical standard.</li> </ul>				
<b>iv. Communicable diseases:</b>				
<ul style="list-style-type: none"> <li>• Providers diagnose/treat/ refer and advice for Tuberculosis/Malaria according to good medical standard.</li> </ul>				
<b>v. Limited Curative Care for Common Ailments:</b>				
<ul style="list-style-type: none"> <li>• Providers ask &amp; advice about deworming.</li> <li>• Providers treat Scabies/Conjunctivitis/ Ringworm/Worms/Colds, provide first aid procedures according to medical standard.</li> </ul>				
<b>vi. Rational Use of Drugs:</b>				
<ul style="list-style-type: none"> <li>• Providers abide by the rational use of drug policy.</li> </ul>				
<b>d) Infection Prevention:</b>				
<b>i. Provider wash hands:</b>				
<ul style="list-style-type: none"> <li>• Before direct contact with a customer.</li> <li>• After handling soiled instruments, touching body fluids and mucous membrane.</li> <li>• After removing gloves.</li> </ul>				
<b>ii. Practice following IP practice appropriately:</b>				
<ul style="list-style-type: none"> <li>• All providers use clean personal towel for drying hands after washing hands.</li> <li>• Appropriate antiseptic solution available and used for cleaning vulva, cervix (1:20 savlon soln.), injection site (rectified spirit), other procedure sites.</li> </ul>				

Services/Activities	Observations	Recommendations	By Whom	By When
<ul style="list-style-type: none"> <li>• Procedure site prepared and draped properly.</li> </ul>				
<ul style="list-style-type: none"> <li>• Only sterile/HLD instruments, needles and syringes used for IUD, injectable, EPI, etc.</li> </ul>				
<ul style="list-style-type: none"> <li>• Sterility maintained throughout the procedure.</li> </ul>				
<ul style="list-style-type: none"> <li>• Appropriate (sterile/HLD) gloves available for pelvic exams, IUD insertion &amp; removal, Norplant insertion &amp; removal, VSC, etc</li> </ul>				
<ul style="list-style-type: none"> <li>• Gloves changed between procedure or if punctured.</li> </ul>				
<b>iii. Processing of reusable instrument/gloves:</b>				
<ul style="list-style-type: none"> <li>• Store bleaching powder in a non-transparent airtight container.</li> </ul>				
<ul style="list-style-type: none"> <li>• Can demonstrate how to prepare 0.5% chlorine solution properly.</li> </ul>				
<ul style="list-style-type: none"> <li>• Soak all soiled items in 0.5% chlorine solution immediately after use.</li> </ul>				
<ul style="list-style-type: none"> <li>• Decontaminate them for 10 minutes.</li> </ul>				
<ul style="list-style-type: none"> <li>• Clean soiled floor and top of the table using 0.5% chlorine solution between procedures.</li> </ul>				
<ul style="list-style-type: none"> <li>• Clean decontaminated items in running water, using detergent powder and gentle brushing.</li> </ul>				
<ul style="list-style-type: none"> <li>• Instruments and gloves are dried properly before autoclaving.</li> </ul>				
<ul style="list-style-type: none"> <li>• Properly maintain the following procedures for sterilization/HLD:</li> </ul>				
<ul style="list-style-type: none"> <li>➤ Check for autoclave valve and gauze working properly.</li> </ul>				
<ul style="list-style-type: none"> <li>➤ Autoclave wrapped items for 30</li> </ul>				

Services/Activities	Observations	Recommendations	By Whom	By When
minutes; and unwrapped instruments and gloves for 20 minutes.				
➤ Boil instruments in lidded container for 30 minutes after the boiling point.				
<b>iv. While handling clinic waste:</b>				
<ul style="list-style-type: none"> <li>• Dispose of sharp objects in puncture-resistant containers.</li> </ul>				
<ul style="list-style-type: none"> <li>• Use utility glove during handling contaminated waste.</li> </ul>				
<ul style="list-style-type: none"> <li>• Clinic has an working incinerator and use it appropriately for burning contaminated waste.</li> </ul>				
<ul style="list-style-type: none"> <li>• Pour liquid waste down a utility drain or non-septic toilet.</li> </ul>				
<b>e) Client Follow-up and Referral:</b>				
<ul style="list-style-type: none"> <li>• The clinic has established follow-up mechanism (e.g., follow-up card, column for follow-up in the register, etc.).</li> </ul>				
<ul style="list-style-type: none"> <li>• Complications recorded and discussed in the clinical meeting for future prevention, proper management/referral..</li> </ul>				
<ul style="list-style-type: none"> <li>• The clinic has established referral mechanisms (e.g., list of identified referral centers developed after personal contact, appropriate referral slip, etc.).</li> </ul>				
<ul style="list-style-type: none"> <li>• The providers have regular contact with the referral centers for getting information about the referred customers.</li> </ul>				
<b>i) Logistic Management:</b>				
<ul style="list-style-type: none"> <li>• FP and other commodities in regular supply with no disruption in stock (stockouts).</li> </ul>				
<ul style="list-style-type: none"> <li>• All supplies are in good condition (e.g.,</li> </ul>				

Services/Activities	Observations	Recommendations	By Whom	By When
not expired, no damage to cartons or individual units, labeling intact and correct, etc.).				
<ul style="list-style-type: none"> <li>Expired contraceptives and used EPI vaccines destroyed as per standard procedure.</li> </ul>				

**3. MEDICAL/CLINICAL SUPERVISION AND LOCAL LEVEL COORDINATION:**

Issues	Observations	Recommendations	By Whom	By When
i. All supervisory visits to/from the clinic are participatory, helpful and relevant.				
ii. Visitors always send written feedback/ recommendations and are those followed up.				
iii. The clinic obtained GOB approval to provide clinical contraceptive services.				
iv. Clinic has a checklist for satellite clinic organization.				
v. The PD/MO invited to local level coordination meetings.				
vi. Regular staff meetings held to discuss service delivery problems.				
vii. Date of COPE exercise conducted. Name (s) of the facilitators.				
<ul style="list-style-type: none"> <li>What percentage the problems identified are solved.</li> </ul>				
<ul style="list-style-type: none"> <li>COPE follow-up exercise conducted/ scheduled.</li> </ul>				
viii. The clinic focuses and responds to customers needs (customers asked about services both informally and through interview) and uses the information received.				

4. CLINICAL MIS:

Items/Issues	Observations	Recommendations	By Whom	By when
a) The clinic has a management information system (MIS) of NIPHP.				
b) Whether data collected are used to make decisions to improve quality of services.				

**List of Equipment/Supplies Available for Different ESP Services**

Equipment/Supplies Required (Service Wise)	Observations	Recommendations	By Whom	By When
<b>a) General Items:</b>				
• Stethoscope for each provider.				
• Enough Thermometers.				
• BP Instruments for each provider.				
• Enough Bathroom scales (weighing machine).				
• Measuring tape/scale for each provider.				
• Autoclave machine, equipment for HLD (e.g., sterilizer, boiling pot), heating source.				
• Enough surgical drum.				
• Enough instrument tray with lid.				
• Sufficient P/V exam equipment/ MSR like:				
➢ Graves/Cuscos bi-valve vaginal speculum of 3 different sizes.				
➢ Sponge holding forceps.				
➢ Gloves.				
➢ Gloves powder.				
➢ Gloves cover with pocket and double wrap instrument cover.				
➢ Antiseptic solution.				
➢ Cotton ball.				
• Lifter jar and lifter for each working station.				
• Enough kidney tray.				
• Enough Gully pots.				
• Proper IUD table.				
• Instrument trolley.				
• Saline stand.				
• Spotlight and or torch light for each exam. Facility.				
• Macintosh.				
• Apron for each provider & name tag.				
• Personal hand towel for each provider.				
• Sufficient Mask for each provider.				
• Soap case with soap for each washing facility.				

Equipment/Supplies Required (Service Wise)	Observations	Recommendations	By Whom	By When
<ul style="list-style-type: none"> <li>Others:</li> </ul>				
<b>b) Special items for Contraceptive Injectable Service:</b>				
<ul style="list-style-type: none"> <li>Adequate supply of injectables (DMPA).</li> </ul>				
<ul style="list-style-type: none"> <li>Sufficient MSR for Injection pushing.</li> </ul>				
<ul style="list-style-type: none"> <li>Disposable syringe crushing equipment.</li> </ul>				
<ul style="list-style-type: none"> <li>Cartoon/container for storing broken used syringes and needles.</li> </ul>				
<b>c) Special items for IUD Service:</b>				
<ul style="list-style-type: none"> <li>3 sets of IUD instruments containing (sponge holding forceps, speculum, tenaculum, uterine sound, artery forceps and scissors).</li> </ul>				
<ul style="list-style-type: none"> <li>Plastic sheet.</li> </ul>				
<ul style="list-style-type: none"> <li>Sanitary pad (one for each IUD acceptor).</li> </ul>				
<ul style="list-style-type: none"> <li>Two (red and blue) 17 liters Bucket with lids kept close to the insertion table (one for used decontamination of instruments &amp; the other for used cotton and other wastes)?</li> </ul>				
<b>d) Special items for EPI Service:</b>				
<ul style="list-style-type: none"> <li>EPI Steam Sterilizer.</li> </ul>				
<ul style="list-style-type: none"> <li>Timer.</li> </ul>				
<ul style="list-style-type: none"> <li>Vaccine carrier with thermometer.</li> </ul>				
<ul style="list-style-type: none"> <li>Sufficient ice packs.</li> </ul>				
<ul style="list-style-type: none"> <li>Syringe/needle Pickup Forceps.</li> </ul>				
<ul style="list-style-type: none"> <li>Items for hand washing (soap, soap case and brush).</li> </ul>				
<ul style="list-style-type: none"> <li>Blue plastic bowl for keeping and washing used syringes and needles.</li> </ul>				
<ul style="list-style-type: none"> <li>Sufficient sterile syringes and needles in two racks of the EPI Sterilizer.</li> </ul>				
<ul style="list-style-type: none"> <li>Sufficient supply of fresh Vaccines (BCG, DPT, Polio, Measles and TT).</li> </ul>				
<ul style="list-style-type: none"> <li>Ampoule file (for cutting BCG and diluent ampoule.</li> </ul>				
<ul style="list-style-type: none"> <li>Dropper for feeding vaccine.</li> </ul>				

Equipment/Supplies Required (Service Wise)	Observations	Recommendations	By Whom	By When
<ul style="list-style-type: none"> <li>Clean/sterile absorbent cotton (as per requirement).</li> </ul>				
<ul style="list-style-type: none"> <li>Small bowl (for keeping with distilled/boiled water).</li> </ul>				
<ul style="list-style-type: none"> <li>Boiled water (for cleaning injection site).</li> </ul>				
<ul style="list-style-type: none"> <li>Plastic bag (for keeping the used vials and other items).</li> </ul>				
<ul style="list-style-type: none"> <li>Plastic/cotton table cloth with the sign of MONI (for covering the immunization table).</li> </ul>				
<ul style="list-style-type: none"> <li>Pen, vaccine card, register and tally sheet.</li> </ul>				
<ul style="list-style-type: none"> <li>IEC materials (poster, leaflet, flyer, etc).</li> </ul>				
<b>e) Special items for IP Procedures:</b>				
<ul style="list-style-type: none"> <li>One 17 liters red bucket with lid (for chlorine solution), another 17 liters blue bucket with lid (for waste) and one 17 liter green bucket without lids (for clean/jet water).</li> </ul>				
<ul style="list-style-type: none"> <li>One plastic basket (strainer) to be used inside the chlorine bucket.</li> </ul>				
<ul style="list-style-type: none"> <li>One plastic mug (for keeping fresh chlorine solution).</li> </ul>				
<ul style="list-style-type: none"> <li>Fresh bleaching powder in an air tight non-transparent pot.</li> </ul>				
<ul style="list-style-type: none"> <li>Cup/Polar cup for measuring bleaching powder.</li> </ul>				
<ul style="list-style-type: none"> <li>Non-metallic (e.g., melamine, plastic) spoon with long handle.</li> </ul>				
<ul style="list-style-type: none"> <li>Wooden stirrer.</li> </ul>				
<ul style="list-style-type: none"> <li>Utility gloves.</li> </ul>				
<ul style="list-style-type: none"> <li>Detergent powder.</li> </ul>				
<ul style="list-style-type: none"> <li>Tooth brush.</li> </ul>				
<ul style="list-style-type: none"> <li>Vinegar.</li> </ul>				
<ul style="list-style-type: none"> <li>Separate sink with running water for cleaning decontaminated items before sterilization.</li> </ul>				
<ul style="list-style-type: none"> <li>Arrangement for drying instruments and gloves (e.g., rack and hanger with clips).</li> </ul>				
<b>f) For Vitamin -A:</b>				
<ul style="list-style-type: none"> <li>Sufficient supply of Vitamin-A.</li> </ul>				
<ul style="list-style-type: none"> <li>Sterile needle (e.g. EPI mixing needle) for piercing the capsule.</li> </ul>				
<ul style="list-style-type: none"> <li>Tally sheet/register for record keeping.</li> </ul>				

Equipment/Supplies Required (Service Wise)	Observations	Recommendations	By Whom	By When
<b>g) For providing CDD service:</b>				
• Sufficient stock of ORS Packets?				
<b>h) For providing ARI service:</b>				
• ARI timer.				
• Cotrimoxazole tablet.				
• Syrup Amoxicillin.				
• Tablet or syrup Salbutamol.				
• ARI Register.				
• ARI Case Management Chart.				
• ARI Tally Sheet.				
<b>i) Drug Supply:</b>				
<i>i. The clinic have revolving drug fund.</i>				
<i>ii. The clinic have the policy for procurement of essential drugs.</i>				
<i>iii. Following drugs for RTI/STD case management:</i>				
• Tablet Ciprofloxacin 500 mg.				
• Capsule Doxycycline 100 mg.				
• Tablet Metronidazole 400 mg.				
• Tablet Secnidazole DS 1000 mg.				
• Capsule Fluconazole 150 mg.				
• Injection Benzathine Penicillin 12 Lac IU.				
• Tablet Erythromycin 500 mg.				
<i>iv. Emergency drugs:</i>				
• Have supplies of Atropine/ Hydrocortisone/Antihistamine/ Adrenaline/Aminophylline injections/IV fluid with set to meet the emergencies.				
<i>v. Have sufficient supply of other essential drugs.</i>				
<i>vi. Others:</i>				

## QUALITY ASSURANCE REVIEW CHECKLIST FOR SATELLITE CLINIC

**A. General Information:**

- a. Location of the Satellite clinic:  
 School  Social Welfare Organization  Private House   
 Open Space  Other (specify): \_\_\_\_\_
- b. Distance from the static clinic in Km: \_\_\_\_\_
- c. Satellite clinic sessions organized per month: \_\_\_\_\_
- d. Signboard with schedule of service delivery available: Yes  No
- e. Banner/green Umbrella sign at Satellite Clinic: Available  Not available
- f. Sitting arrangement for provider: Acceptable  Not acceptable
- g. Sitting arrangement for client: Enough  No enough
- h. Services provided (specify): \_\_\_\_\_
- i. Preparation for Satellite clinic organization: Adequate  Inadequate
- j. Availability of equipment for service delivery: Adequate  Inadequate
- k. Supply of medicines/commodities & EPI logistics: Adequate  Not adequate
- l. Availability of contraceptives: \_\_\_\_\_  \_\_\_\_\_
- m. Customer flow/load at the site (mention average number/session): \_\_\_\_\_
- n. Information given to the community about the SC: Adequate  Inadequate
- o. Mechanism of publicity to improve customer flow of the SC: Adequate  Inadequate

**B. Observation of satellite session:**

- a. Customer counseling : Adequate  Not adequate
- b. Customer flow management: Satisfactory  Not satisfactory
- c. Privacy during counseling/examination: Acceptable  Not acceptable
- d. Provision of FP methods/other services: Satisfactory  Not satisfactory
- e. IP including waste disposal: Satisfactory  Not satisfactory
- f. Record keeping: Satisfactory  Not satisfactory
- g. Overall impression about the satellite clinic: Satisfactory  Not satisfactory

Observations and Recommendations of Services at the Satellite Clinic

Observations	Recommendations	By Whom	By When

Service Statistics

Facility	Services	Performances							Comments	
		Months						Six Months Total		Average Customer/ Month
Static Clinic	EPI									
	Child Health									
	Maternal Health									
	Family Planning									
	RTI/STD									
	Com. Diseases (TB/Malaria)									
	Common Ailments									
	<b>Month's Total</b>									
Satellite Sites	EPI									
	Child Health									
	Maternal Health									
	Family Planning									
	RTI/STD									
	Com. Diseases (referral)									
	Common Ailments									
	<b>Month's Total</b>									
<b>Number of Satellite Teams</b>		<b>Total Satellite Clinic sites</b>								
<b>Total Satellite Sessions per month</b>										

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**Staff Position, their Professional Qualifications and Training**

Name of Staff in Position	Designation	Qualification	Major Training Received	Year and Institution	Specific Training Needs
	Physician				
	Counselor				
	Paramedic				
	Sr. Service Promoter				
	Service Promoter				
	Service Promoter				
	Service Promoter				
	Service Promoter				
	Clinic Assistant/ Clinic Aid				
	Aya				
	Lab. Tech				
	Messenger/ Night Guard				

**Appendix F**  
**List of Standard UFHP Clinic Equipment**

## List of Equipment, Supplies and Lab. Tests etc. Required for Delivery of Essential Service Package (ESP) Under NIPHP

Service Level:            **Satellite Clinic + EPI Centers run by Paramedics**  
 Service Providers:        **Paramedic\* -1, and Trained assistant to the paramedic - 1**

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
1. Subsequent doses of injectable. 2. First dose of injectable and IUD would be given in very limited centers. 3. Non-clinical contraceptive services (pills and condoms). 4. Management of side effects of FP methods. 5. Prevention and management of RTIs/STDs. 6. Prevention of HIV/AIDS (educational IEC). 7. Antenatal, postnatal care and TT immunization. 8. Child Immunization and Vitamin-A supplementation. 9. ARI (treatment/referral) 10. CDD (Health education, advise, and ORS distribution) 11. Treatment of conjunctivitis and minor ailment, etc.	<p><u>Equipment/Supplies:</u>  <u>General items:</u></p> <ol style="list-style-type: none"> <li>1. Stethoscope – 1</li> <li>2. B P Machine – 1</li> <li>3. Thermometer - 3</li> <li>4. Bathroom scale (veighing machine) – 1</li> <li>5. Measuring tape - 1</li> <li>6. Instrument Tray with Lid - 1</li> <li>7. P/V exam instruments – 1 set:               <ul style="list-style-type: none"> <li>➤ Graves/Cuscos Bi-valve Vaginal Speculum – 1</li> <li>➤ Straight Long Artery Forceps/Sponge Holding Forceps – 1</li> <li>➤ Gloves – as per requirement</li> <li>➤ Cotton ball- as per requirement</li> <li>➤ Lugol's Iodine (for painting cervix) – in a small bottle</li> </ul> </li> <li>8. Lifter Jar – 1</li> <li>9. Lifter – 1</li> <li>10. Soap case with Soap – 1</li> <li>11. Mask – as per requirement.</li> <li>12. Apron/gown – as per requirement.</li> </ol> <p><u>For Injectable Service:</u></p> <ol style="list-style-type: none"> <li>1. DMPA/Noristerat injections – as per requirement</li> <li>2. MSR for Injection (<i>Appendix-3A</i>):               <ul style="list-style-type: none"> <li>➤ Disposable Syringes 2 cc and Needles (19-21 gauge) – 1 for each dose</li> <li>➤ Spirit – 1 lbs. for 500 injections</li> <li>➤ Absorbent Cotton – 450 Gm for 700 doses</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>1. Urine for Albumin and Sugar</li> <li>2. Hb% estimation (eye estimation preferred)</li> </ol>	<p><u>Equipment:</u></p> <ol style="list-style-type: none"> <li>1. Test Tube Stand - 1</li> <li>2. Test Tube Holder - 1</li> </ol> <p><b>For confirmation of Hb%:</b></p> <ol style="list-style-type: none"> <li>3. Shahli-Helliger Hemoglobinometer – 1</li> <li>4. Lancet (Sterile and Disposable) – 1 for each client</li> <li>5. Clean/sterile cotton – as per requirement</li> <li>6. Antiseptic solution (rectified spirit/ savlon) – as per requirement.</li> </ol> <p><u>Glass Ware:</u></p> <ol style="list-style-type: none"> <li>1. Test tubes - 6</li> <li>2. Reagent Bottles- 4</li> </ol> <p><u>Reagents &amp; Diagnostic Kits:</u></p> <ol style="list-style-type: none"> <li>1. Uristix - as per requirement</li> </ol> <p><b>For confirmation of Hb%:</b></p> <ol style="list-style-type: none"> <li>2. N/10 HCL - as per requirement.</li> <li>3. Distilled water/Normal Saline – as per</li> </ol>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment <sup>1</sup> Required
	<p>3. Used disposable syringe crushing equipment - 1</p> <p>4. Carton/container for storing broken used syringes and needles -1</p> <p><u>For IUD Services:</u></p> <ol style="list-style-type: none"> <li>1. Portable IUD Sterilizer in a bag -1</li> <li>2. IUD Instruments (<i>Appendix - 1</i>) - 3 sets</li> <li>3. Gully pot - 3</li> <li>4. Timer - 1</li> <li>5. Torch Light with batteries - 1</li> <li>6. Dressing Drum - 1</li> <li>7. Kidney Tray (small) - 1</li> <li>8. Plastic sheet - 1</li> <li>9. Table for insertion - 1</li> <li>10. Drugs and other MSR for IUD services (<i>Appendix - 2</i>)</li> <li>11. Bucket with lid (5 liter) red and blue - 2 (one for used instruments &amp; one for used cotton and other wastes)</li> <li>12. Sanitary pad - 1 for each IUD acceptor.</li> </ol> <p><u>For EPI Services:</u></p> <ol style="list-style-type: none"> <li>1. Steam Sterilizer - 1</li> <li>2. Timer - 1</li> <li>3. Vaccine carrier with thermometer - 1</li> <li>4. Ice packs - 4</li> <li>5. Syringe/needle Pickup Forceps - 1</li> <li>6. Items for hand washing (soap, soap case and brush)</li> <li>7. Blue plastic bowl for keeping and washing used syringes and needles - 1.</li> <li>8. Nylon bag for carrying (item # 1-7) - 1</li> <li>9. Sterile syringes and needles in two racks of the Sterilizer:               <ol style="list-style-type: none"> <li>a) 0.1 ml syringe (BCG) - 42</li> <li>b) 1.0 ml syringe (DPT, Measles, TT) - 42</li> <li>c) 5.0 ml syringe (for Mixing) - 4</li> <li>d) 26 gauge needle (BCG) - 50</li> <li>e) 22 or 23 gauge needle (DPT, Measles, TT) - 50</li> <li>f) 18 gauge needle (for Mixing) - 8</li> </ol> </li> </ol>		<p>requirement.</p>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
	<p>10. Vaccines (BCG, DPT, Polio, Measles and TT) – as per requirement</p> <p>11. Ampule file (for cutting BCG and diluent ampule) - 1</p> <p>12. Dropper for feeding vaccine - 2</p> <p>13. Clean/sterile absorbent cotton – as per requirement</p> <p>14. Distilled/boiled water (for cleaning injection site) – as per requirement.</p> <p>15. Small bowl (for keeping with distilled/boiled water) – 1.</p> <p>16. Pieces of cloth (for holding and keeping the hot Sterilizer, and cleaning the table) – as per requirement</p> <p>17. Plastic bag (for keeping the used vials and other items) – 1</p> <p>18. Plastic table cloth with the sign of MONI (for covering the immunization table) – 1</p> <p>19. Safety match – 1</p> <p>20. Pen, vaccine card, register and tally sheet – as per requirement</p> <p>21. Badge with MONI sign for the volunteers and the service providers – as per requirement</p> <p>22. IEC materials (poster, leaflet, flyer, etc) – as per requirement</p> <p>23. Hanging bag (for carrying item # 9-22) – 1</p> <p>24. List of MSR for EPI services (<i>Appendix-10</i>)</p> <p><u><i>For IP Procedures:</i></u></p> <p>1. Bucket with lid- 1</p> <p>2. Bucket without lid – 2</p> <p>3. Bleaching powder in a pot (non-transparent).</p> <p>4. Cup/Polar cup for measuring bleaching powder – 1</p> <p>5. Spoon - 1</p> <p>6. Utility gloves – 1 pair</p> <p>7. Wooden stirrer – 1</p> <p>8. Tooth brush – 1</p> <p>9. Detergent powder – as per requirement</p> <p>List of MSR for IP procedure (<i>Appendix-11</i>)</p> <p><u><i>For Vitamin A:</i></u></p> <p>1. Vitamin A Cap – as per requirement</p>		

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Section - 4

List of Equipment, Supplies and Lab. Tests etc.  
required for

Static Clinics run by Paramedics

for

*Delivery of Essential Services Package (ESP)  
under NIPHP*

## List of Equipment, Supplies and Medical Tests etc. Required for Delivery of Essential Services Package (ESP) Under NIPHP

**Service Level:** Static Clinics run by Paramedics  
**Service Providers:** Paramedic\* -1, and Trained assistant to the paramedic - 1

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
1. First and subsequent doses of injectable and IUD. 2. Non-clinical contraceptive services (pills and condoms). 3. Management of side-effects of FP methods 4. Prevention and management of RTIs/STDs. 5. Prevention of HIV/AIDS (educational IEC). 6. Ante-natal, postnatal care and TT immunization 7. Child Immunization and Vitamin-A supplementation. 8. ARI. 9. CDD (Health education, advise and ORS distribution). 10. Essential Obstetric Care (EOC) – First Aid. 11. Post-MR contraception. 12. Treatment of conjunctivitis and minor ailment, etc.	<p><b>Equipment/Supplies:</b>  <u>General Items:</u>  <b>Additional Items (Beyond Satellite Clinic ones):</b></p> <ol style="list-style-type: none"> <li>1. Electric Sterilizer – 1</li> <li>2. Exam Table – 1</li> <li>3. Exam Light/Spot Light – 1</li> <li>4. Kidney Tray (Large) – 2</li> <li>5. Kidney Tray (small) – 2</li> <li>6. Instrument Trolley/Table - 1</li> <li>7. Adult height Weight Scale – 1</li> <li>8. Baby Weighing Scale – 1</li> <li>9. Wall Clock – 1</li> <li>10. Rubber Catheter – 1</li> <li>11. Saline Stand - 1</li> <li>12. Bed with mattress for observation of post-procedure (IUD) clients – 1-3</li> </ol> <p><u>For Injectable Service:</u>  <b>Additional Items for keeping Vaccines (Beyond Satellite Clinic ones):</b></p> <ol style="list-style-type: none"> <li>1. Refrigerator (not more than 8.5 cft) – 1</li> <li>2. Voltage Stabilizer - 1</li> </ol> <p><u>For IUD Services:</u>            (Same as Satellite Clinic ones)</p> <p><u>For EPI Services:</u>            (Same as Satellite Clinic ones)</p>	<ol style="list-style-type: none"> <li>1. Urine for Albumin and Sugar</li> <li>2. Hb% estimation</li> </ol>	<p><u>Equipment:</u>  <b>Additional Items (Beyond Satellite Clinic ones):</b></p> <ol style="list-style-type: none"> <li>1. Spirit Lamp - 1</li> <li>2. Shali - Helliger Hemoglobinometer - 1</li> <li>3. Lancet (Sterile and Disposable) – 1 for each client</li> <li>4. Clean/sterile cotton – as per requirement</li> <li>5. Antiseptic solution (rectified spirit/ savlon) – in small bottle</li> </ol> <p><u>Glass Ware:</u>  <b>Additional Items (Beyond Satellite Clinic ones):</b></p> <ol style="list-style-type: none"> <li>1. Test tubes -12</li> <li>2. Reagent Bottles -6</li> </ol> <p><u>Reagents &amp; Diagnostic Kits:</u>  <b>ADDITIONAL ITEMS (BEYOND SATELLITE CLINIC ONES):</b></p> <ol style="list-style-type: none"> <li>1. Methylated Spirit for lamp – as per requirement.</li> <li>2. Distilled water or</li> </ol>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
	<p><u>For IP Procedures:</u> Additional Items (Beyond Satellite Clinic ones):</p> <ol style="list-style-type: none"> <li>1. Incinerator – 1</li> <li>2. Drum with tap and bucket (for running water, if no basin or other facility available) - 1</li> </ol> <p><u>For Vitamin A:</u> (Same as Satellite Clinic ones)</p> <p><u>For CDD:</u> (Same as Satellite Clinic ones)</p> <p><u>For ARI:</u> (Same as Satellite Clinic ones)</p> <p><u>Drug for STD, and other general illnesses.</u> (Same as Satellite Clinic ones)</p> <p><u>Emergency Clinical Supplies:</u></p> <ol style="list-style-type: none"> <li>1. IV Fluid (DNS/Dextrose in Aqua) – 2 bags</li> <li>2. IV set – 2</li> <li>3. Inj. Promethazine HCl 25 mg – 2 amp</li> <li>4. Inj. Atropine Sulphate – 2 amp</li> <li>5. Inj. Hydrocortisone – 2 vials</li> <li>6. Inj. Epinephrine/Adrenaline 1: 1000 – 2 ampoules</li> <li>7. Disposable Syringe 10 ml – 5 pcs</li> </ol>		<p>Normal Saline – as per requirement</p> <ol style="list-style-type: none"> <li>3. N/10 HCL – as per requirement.</li> </ol>

\* Paramedic: includes FWV, Nurse, Medical Assistant, Lab Technician trained to provide ESP.

## Section - 5

List of Equipment, Supplies and Lab. Tests etc.

required for

Static Clinics run by Physicians with Minimum Lab  
Facilities

*for*

*Delivery of Essential Services Package (ESP)  
under NIPHP*

## List of Equipment, Supplies and Lab. Tests etc. Required for Delivery of Essential Services Package (ESP) Under NIPHP

**Service Level:** Static Clinics run by Physicians with Minimum Lab Facilities  
**Service Providers:** Physician – 1, Paramedic\* -1, Laboratory Technician/ Paramedic trained in selected lab tests – 1,  
 and Trained assistant to the physician/paramedic - 1

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
1. Norplant (in selected clinics). 2. First and subsequent doses of injectable and IUD. 3. Non-clinical contraceptive services (pills and condoms). 4. Management of side-effects of FP methods 5. Prevention and management of RTIs/STDs. 6. Prevention of HIV/AIDS (educational IEC). 7. Ante-natal, postnatal care and TT immunization 8. Child Immunization and Vitamin-A supplementation. 9. ARI. 10. CDD (Plan - A). 11. Post-MR contraception. 12. Treatment of conjunctivitis and minor ailment, etc. 13. Tuberculosis (detection)	<p><u>Equipment/Supplies:</u>  <u>General Items:</u>            Additional Items (Beyond Static Clinic run by Paramedic only ones):</p> <ol style="list-style-type: none"> <li>1. Ryle's tube – 1</li> <li>2. Glycerin for Ryle's Tube – 1 small bottle</li> <li>3. Refrigerator (not more than 8.5 cft.) – 1</li> <li>4. Voltage Stabilizer - 1</li> <li>5. View Box for viewing x-ray plates - 1</li> </ol> <p><u>For Injectable Service:</u>            (Same as Static Clinic run by Paramedic only ones)</p> <p><u>For IUD Services:</u>            Additional Items (Beyond Static Clinic run by Paramedic only ones):</p> <ol style="list-style-type: none"> <li>1. Alligator forceps (to be used by trained physician only for removal of IUD with missing thread) – 1</li> </ol> <p><u>For Norplant Services (if provided):</u>  <u>For Implantation:</u></p> <ol style="list-style-type: none"> <li>1. Patient Table with arm rest - 1</li> <li>2. Instrument tray – 1</li> <li>3. Sterile Instrument Cover – 1 for each client</li> <li>4. Sterile surgical drape – 1 for each client</li> <li>5. pair for each client</li> <li>6. Sterile Sponge holder/Artery forceps (for giving Swab) – 1</li> </ol>	<p>Additional Tests (Beyond Static Clinic run by Paramedic):</p> <ol style="list-style-type: none"> <li>1. TC, DC</li> <li>2. ESR</li> <li>3. Wet Mount</li> <li>4. Gram Stain</li> <li>5. KOH test RPR</li> <li>6. Urine for R/E</li> <li>7. Stool for R/E</li> </ol> <p>Pregnancy Test</p>	<p><u>Equipment:</u>            Additional Items (Beyond Static Clinic run by Paramedic only ones):</p> <ol style="list-style-type: none"> <li>1. Hemocytometer (complete set) – 1 set</li> <li>2. ESR Stand (set of 3) – 1 set</li> <li>3. ESR Tube - 3</li> <li>4. Disposable Syringes - 3 cc (for collecting blood) – 1 for each client</li> <li>5. Tourniquet - 1</li> <li>6. Stainless Staining Tray - 1</li> <li>7. Cotton-tipped swabs - 100</li> <li>8. Droppers – 12</li> <li>9. Forceps – 1</li> <li>10. Blotting Paper</li> <li>11. Microscope (Binocular with 4 eye pieces &amp; 4 objectives) - 1</li> <li>12. Spot Light with stand for Microscope – 1</li> <li>13. Centrifuge Machine</li> </ol>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
	<p>7. Plunger with # 10 Trocar – 1 for 20 clients</p> <p>8. Other MSR for Norplant Services (<i>Appendix-3B</i>)</p> <p><b>For Removal (Additional Items):</b></p> <p>15. Dissecting Forceps – 1</p> <p>16. Mosquito forceps – 1</p> <p>17. Cryle forceps – 1</p> <p>18. Tweezers - 1</p> <p><b><u>For EPI Services:</u></b> (Same as Static Clinic run by Paramedic only ones)</p> <p><b><u>For IP Procedures:</u></b> (Same as Static Clinic run by Paramedic only ones)</p> <p><b><u>For Vitamin A:</u></b> (Same as Static Clinic run by Paramedic only ones)</p> <p><b><u>For CDD:</u></b> (Same as Static Clinic run by Paramedic only ones)</p> <p><b><u>For CDD:</u></b> (Additional Items beyond Static Clinic run by Paramedic only ones):</p> <p>1. Special bed with hole for collecting stool 2-5</p> <p>2. Measuring pot for measuring the volume of stool and vomitus – 2-5</p> <p>3. Intravenous fluid – as per requirement.</p> <p><b><u>For ARI:</u></b> (Same as Static Clinic run by Paramedic only ones)</p> <p><b><u>Other Supplies:</u></b> (Same as Static Clinic run by Paramedic ones)</p>		<p>(for selected centers)</p> <p>14. Calculator (for counting TC/DC, etc )</p> <p>15. Rotator for RPR test/Shaker Machine -1</p> <p><b><u>Glass Ware:</u></b> Additional Items (Beyond Static Clinic run by Paramedic only ones):</p> <p>1. Test tubes -12</p> <p>2. Reagent Bottles -12</p> <p>3. Glass slide – 1 box of 100</p> <p>4. Cover glass 22 x 22 mm – 1 box of 100</p> <p>5. Beakers - 2</p> <p>6. Conical Flask - 2</p> <p>7. Funnel - 2</p> <p>8. Measuring Cylinders - 2</p> <p>9. Graduated Pipettes - 6</p> <p><b><u>Reagents &amp; Diagnostic Kits:</u></b> ADDITIONAL FILMS (BEYOND STATIC CLINIC RUN BY PARAMEDIC ONLY ONES):</p> <p>4. Benedict Solution</p> <p>1. Glacial Acetic Acid (5%)</p> <p>2. ESR fluid (3.8% Na Citrate)</p> <p>3. Leishman Stain</p> <p>4. KOH Reagent 10%</p> <p>5. For Wet Mount: Saline</p>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
	<p><u>Emergency Clinical Supplies:</u> Additional Items (Beyond Static Clinic run by Paramedic only ones):</p> <ol style="list-style-type: none"> <li>1. Inj. Atropine Sulfate -0.6 mg – 2-5 amp</li> <li>2. Inj. Calcium Gluconate 10 ml 10% – 2-5 amp.</li> <li>3. Inj. Aminophylline 250 mg – 2-5 amp</li> </ol>		<p>in dropper</p> <ol style="list-style-type: none"> <li>6 For Gram Staining</li> <li>➤ Crystal Violet</li> <li>➤ Gram's Iodine</li> <li>➤ Decolorizer (50/50 mixture of 95% ethanol with acetone)</li> <li>➤ Safranin</li> <li>➤ Immersion oil</li> <li>6. RPR ready test kit</li> <li>7. Litmus Paper (Red &amp; Blue)</li> <li>8. Methylm Blue</li> <li>9. Carbol Fuchin</li> <li>10. Acid Alcohol</li> <li>11. Lugol's Iodine</li> <li>12. Pregnancy Test Kit</li> </ol>

\* Paramedic: includes FWV, Nurse, Medical Assistant, Lab Technician trained to provide ESP.

Section - 5

List of Equipment, Supplies and Lab. Tests etc.

required for

Static Clinics run by Physicians with Lab Facilities  
and Perform Sterilization

*for*

*Delivery of Essential Services Package (ESP)  
under NIPHP*

## List of Equipment, Supplies and Lab. Tests etc. Required for Delivery of Essential Services Package (ESP) Under NIPHP

**Service Level:** Static Clinics run by Physicians with Lab Facilities and Perform Sterilization  
**Service Providers:** Physician – 1, Paramedic\* -2/3, Laboratory Technician/ Paramedic trained in selected lab tests - 1, and Trained assistant to the physician/paramedic - 1

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
<ol style="list-style-type: none"> <li>1. Sterilization and Norplant (in selected clinics).</li> <li>2. First and subsequent doses of injectable and IUD.</li> <li>3. Non-clinical contraceptive services (pills and condoms).</li> <li>4. Management of side-effects of FP methods</li> <li>5. Prevention and management of RTIs/STDs.</li> <li>6. Prevention of HIV/AIDS (educational IEC).</li> <li>7. Antenatal, postnatal care and TT immunization.</li> <li>8. Child Immunization and Vitamin-A supplementation.</li> <li>9. ARI.</li> <li>10. CDD.</li> <li>11. Normal safe delivery.</li> <li>12. Essential Obstetric Care (EOC).</li> <li>13. Post-MR contraception.</li> <li>14. Post-abortion care.</li> </ol>	<p><u>Equipment/Supplies:</u>  <u>General Items:</u>                      (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p> <p><u>For Injectable Service:</u>                      (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p> <p><u>For IUD Services:</u>                      (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p> <p><u>For Norplant Services:</u>                      (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p> <p><u>For Sterilization Services:</u>                      (Additional General Items):</p> <ol style="list-style-type: none"> <li>1. Medium Sized Autoclave (in running condition) - 1</li> <li>2. Surgical Drum (Medium) – 3</li> <li>3. Sucker machine (manual/electric) in running condition – 1</li> <li>4. Ambu Bag with airway tubes of 3 sizes – 1</li> <li>5. Oxygen cylinder (with therapy set, 10 inch Slide Range/Spinner and Trolley) - 2</li> <li>6. Patient Trolley – 1</li> </ol>	<p>(Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p>	<p><u>Lab. Equipment:</u>                      (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p> <p><u>Glass Ware:</u>                      (Same as Static Clinic run by Physician with Minimal Lab facilities ones)</p> <p><u>Reagents &amp; Diagnostic Kits:</u>                      (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p>

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Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
15 Tuberculosis (diagnosis) 16 Malaria. 17 Treatment of conjunctivitis and minor ailment, etc. 18 Treatment of Leprosy and Kalazar.	7 Stretcher - 1 8. OT Table - 1 9. OT Instrument table - 1 10. Mayo trolley with tray/side table - 1 11. OT Light (with bulb and in running condition) - 1 12. Emergency Light/Charge Light/Torch Light (with 3 batteries & in running condition) - 1 13. BP instrument - 1 14. Stethoscope - 1 15 Wall Clock for OT -1 16. Air cooler for OT (optional)-1 17. Tubectomy Instruments ( <i>Appendix 4</i> ) - 6 sets 18. MSR for Tubectomy - ( <i>Appendix - 5</i> ). 19. No-Scalpel Vasectomy Instruments ( <i>Appendix - 6</i> ) - 2 sets 20. MSR for Vasectomy - ( <i>Appendix - 7</i> ). 21. Emergency Drugs and Equipment for Sterilization Centers - ( <i>Appendix - 8</i> ). 22. Laparotomy Tray: ( <i>Appendix - 9</i> ) 23. Saline Stand (extra)- 2 24. Lifter Jar (extra)-1 25. Lifter (extra) - 1 26. Bed and Mattresses for pre and Post-op clients -05  <u>For EPI Services:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)  <u>For IP Procedures:</u> (Same as Static Clinic run by Physician with Minimal Lab facilities ones)  <u>For Vitamin A:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)		

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
	<p><u>For CDD:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities ones)</p> <p><u>For ARI:</u> (Additional items beyond Static Clinic run by Physician with Minimal Lab Facilities ones):</p> <ol style="list-style-type: none"> <li>1. Oxygen cylinder (O<sub>2</sub> available for Sterilization may be used) - 1</li> </ol> <p><u>Other Supplies:</u> (Same as Static Clinic run by Physician with Minimal Lab facilities ones)</p>		

\* Paramedic: includes FWV, Nurse, Medical Assistant, Lab Technician trained to provide ESP.

## Section - 6

List of Equipment, Supplies and Lab. Tests etc.

required for

Comprehensive (Specialized) Clinics

*for*

*Services including Delivery of Essential Services Package  
(ESP)  
under NIPHP*

List of Equipment, Supplies and Lab. Tests etc.  
That would be Required for Comprehensive (Specialized) Clinics

Find list of the equipment, supplies and lab. tests. etc. for Comprehensive clinics on an individual basis. This should be worked out in consultation with appropriate technical people. Following table contains a preliminary DRAFT list.

**List of Equipment, Supplies and Lab. Tests etc. for Comprehensive (Specialized) Clinics including Delivery of Essential Services Package (ESP) under NIPHP**

**Service Level:** Comprehensive (Specialized) Clinics (with Sophisticated Lab and Facilities to Performs Sterilization, C-Section, and Treat Post-abortion Complications)

**Service Providers:** Physician – 2/3, Sono-grapher (Part-time) – 1, Paramedic\* -5, Laboratory Technician trained in specialized lab tests – 1, and Trained assistant to the physician/paramedic – 3/4

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
1. Sterilization and Norplant services 2. First and subsequent doses of injectable and IUD. 3. Non-clinical contraceptive services (pills and condoms). 4. Management of side-effects of FP methods 5. Prevention and management of RTIs/STIs. 6. Prevention of HIV/AIDS (educational IEC). 7. Antenatal, postnatal care and TT immunization. 8. Child Immunization and Vitamin-A supplementation. 9. ARI. 10. CDD (Plan –B). 11. Normal safe delivery. 12. Essential Obstetric Care (EOC) including: ➤ Forceps delivery ➤ Vacuum Extraction	<p><b><u>Equipment/Supplies:</u></b>  <b><u>General Items:</u></b>  <b>Additional Items:</b> (Beyond Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <ol style="list-style-type: none"> <li>1. Large Autoclave – 1</li> <li>2. Dressing Drum (extra) - 3</li> <li>3. Instrument Tray with lid (extra) –3</li> <li>4. Instrument Trolley (extra) -1</li> <li>5. ENT Diagnostic Set</li> <li>6. Instruments for C/Section.</li> <li>7. Incinerator (Large) - 1</li> <li>8. Bed &amp; Mattress (for Pre and Post-op. Cases) – 5</li> <li>9. Ultrasonogram Equipment – 1 unit</li> </ol> <p><b><u>For Injectable Service:</u></b>            (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <p><b><u>For IUD Services:</u></b>            (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <p><b><u>For Norplant Services:</u></b>            (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones )</p>	<p><b>Additional Lab. Tests</b>            (Beyond Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones):</p> <ol style="list-style-type: none"> <li>1. Blood Group and RH factor</li> <li>2. S. Cholesterol</li> <li>3. Blood Glucose</li> <li>4. Urea level</li> <li>5. TPHA</li> <li>6. Serum Bilirubin</li> <li>7. HbsAg</li> <li>8. Sputum for AFB</li> <li>9. Tuberculin test</li> <li>10. Ultrasonogram</li> <li>11. Urea level</li> <li>12. Other lab tests as per requirement</li> </ol>	<p><b><u>Equipment:</u></b>  <b>Additional Lab. Tests</b>            (Beyond Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones):</p> <ol style="list-style-type: none"> <li>1. Micro Pipette (5 micro-liter to 100 micro-liter) – as per requirement.</li> <li>2. Colorimeter/Photometer (for selected centers)</li> <li>3. Hot Air Oven (for selected centers)</li> </ol> <p><b><u>Glass Ware:</u></b>            To be added as per addition of lab tests.</p> <p><b><u>Reagents &amp; Diagnostic Kits:</u></b></p> <ol style="list-style-type: none"> <li>1. Serum Anti-A (for Blood group)</li> <li>2. Serum Anti-B(for Blood group)</li> <li>3. Serum Anti-D (for Blood group).</li> </ol>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
<ul style="list-style-type: none"> <li>➤ C-section</li> <li>13. Post-MR contraception.</li> <li>14. Post-abortion care, including:               <ul style="list-style-type: none"> <li>➤ Post-abortion complication management</li> </ul> </li> <li>15. Tuberculosis (diagnosis).</li> <li>16. Malaria.</li> <li>17. Treatment of conjunctivitis and minor ailment, etc.</li> <li>18. Treatment of Leprosy and Kalazar.</li> </ul>	<p><u>For Sterilization Services:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones )</p> <p><u>For EPI Services:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <p><u>For IP Procedures:</u> Additional Items (Beyond Static Clinic run by Physician with Minimal Lab facilities and perform Sterilization ones):</p> <ol style="list-style-type: none"> <li>1. Large Incinerator - 1</li> </ol> <p><u>For Vitamin A:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <p><u>For CDD:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <p><u>For ARI:</u> (Same as Static Clinic run by Physician with Minimal Lab Facilities and perform Sterilization ones)</p> <p><u>For Delivery:</u></p> <ol style="list-style-type: none"> <li>1. Arrangement for episiotomy</li> <li>2. Arrangement for ligation and cutting of the umbilical cord.</li> <li>3. Forceps</li> <li>4. Vacuum Extractor</li> </ol> <p><u>For C-Section:</u> Instruments and equipment as per requirements including facilities for GA.</p>		<ol style="list-style-type: none"> <li>4. Vintex HBsAg</li> <li>5. TPHA ready test kit</li> <li>6. Blood Glucose Reagent</li> <li>7. Blood Urea Reagent</li> <li>8. Serum Cholesterol Reagent</li> <li>Serum Uric Acid Reagent</li> </ol>

Service Delivery Component (Listed according to rank for NIPHP support)	Equipment/Supplies Required (Service Wise)	Laboratory Services	Laboratory Equipment Required
	<u>Other Supplies:</u> (Same as Static Clinic run by Physician with Minimal Lab facilities and perform Sterilization ones)		

\* Paramedic: includes FWV, Nurse, Medical Assistant, Lab Technician trained to provide ESP.

## Section - 7

*Appendices*

The attached lists are taken from the GOB approved and followed service delivery manuals on the 7 contraceptive methods available in Bangladesh

*Appendix - 1*Contents of IUD Kit

SI No	Name of Items	Quantity
1.	Graves/Cuscos Bi-valve Speculum (Small, Medium and Large size)	01 each
2.	Tenaculum 9.5 inches	01
3.	Sponge Holding Forceps	01
4	Straight Artery Forceps	01
5.	Uterine Sound 9.5 inches	01
6.	Scissors	01

**Note:**

1. Small and Large size Speculum of item # 1. and item # 3 are non-essential.
2. In most cases Straight Artery Forces replace Sponge Holding Forceps.

*Appendix - 2*MSR for 100 Cases of IUD

SI No	Name of Items	Quantity
01	Absorbent Cotton (500 Gm Pkt)	04 Pkts
02	Chlorhexidine-Cetrimide Soln.	01 Liter Jar
03	Paracetamol Tablet 500 mg (6 for each case)	600
04	Iron tablet (60 for each case)	6000
05	Metronidazole Tablet 400 mg (For 15% complicated case and 21 tablets for each case)	315
06	Doxicycline Capsule 100 mg (For 15% complicated case and 14 capsules for each case)	210
07	Anti-Inflammatory Tablet (For 15% complicated case: 15 for each case)	225
08	Surgical Gloves (1 pair for each case)	100 Pair
09	Kerosene (for each case)	01 Liter
10	For Soap and Other incidental Expenses (for 1 case)	Tk. 10.00

*Note: All items are essential ones.*

## Appendix – 3A

List of MSR for Injectable Services

SI No	Name of Medicine/Items	Quantity
1.	Spirit	1 lb. for 500 doses of injections
2.	Absorbent Cotton	450 Gm for 700 doses of injections
3	Disposable Syringe 2 cc with needle (19-21 gauge)	1 for each dose.

## Appendix – 3B

List of MSR for Norplant Services

(For 100 Norplant Implantation)

SI No	Name of Medicine/Items	Quantity
1.	Norplant Capsule Set (6 capsules in 1 set)	100
2.	Xylocaine/Lidocaine 1% without Adrenaline	15 bottle (50 ml)
3.	Scalpel Blade # 11 or 15	100
4.	Disposable Syringe 5cc with 4-4.5 cm Needle	100
5.	Gauze (20 Yard Than)/Bandage	1 Than
6.	Absorbent Cotton (500 Gm)	1 Packet
7.	Tablet Paracetamol (500 mg)	1000
8.	Capsule Ampicillin (250 mg)	200 Caps (only for 10% complicated cases)
9.	Surgical Gloves	100 Pairs
10.	Savlon – 5 liter jar or (Iodine/Spirit)	1 jar
11.	Leucoplast 3" roll or ( Butterfly or simple band aid )	3 rolls

Note: All items are essential ones.

## Appendix- 4

## Contents of Tubectomy Kit

Particulars/Descriptions	Unit	Quantity
1. Instrument Pan with Cover 310 x 195 x 63 MM	each	1
2. Forceps. Tissue Babcock 20 cm	each	1
3 Towel Clip. Jones 9 cm	each	4
4 Forceps. Dressing. Spring Type 150 MM	each	1
5 Forceps. Hemostat. Straight Rochester Pean - 160 MM	each	4
6. Forceps. Hysterectomy. Straight Pean - 220 MM	each	4
7. Forceps. Hemostat Curved Mosquito - 125 MM	each	2
8. Forceps. Tissue. Spring-type 1 x 2 teeth 145 MM	each	1
9 Forceps. Tissue. Fenestrated Jaw, Duvall 145 MM	each	1
10. Forceps. Uterine, Tenaculum. Duplay DBL-CVD. 280 MM	each	1
11. Needle Holder. Straight Narrow-Jaw. Mayo- 180 MM	each	1
12. Knife-Handle. Surgical for Minor Surgery # 3	each	1
13. Knife-Blade, Surgical for Minor Surgery # 10 PKT 5	Pkt	10
14. Suture Needle. abdominal, Keith, Straight	Pkt	2
15. Needles. Suture 3/8 Circle, Round Point # 12. Pkt of 6	Pkt	2
16. Retractor. General Operation, Langebeak 60 x 20 MM	each	1
17. Retractor. Abdominal. Richardson Eastman D-E set of 2	Set	1
18. Scissors. Surgical, Straight 145 MM	each	1
19. Scissors. Tonsil Curved, Metzenbaum. Baby 100 MM	each	1
20. Speculum. Vaginal. Bi-valve, Graves Small	each	1
21. Speculum. Vaginal. Bi-valve, Graves Medium	each	1
22. Surgical Gloves 6 1/2 "	Pair	12
23. Surgical Gloves 7"	Pair	24
24. Surgical Gloves 7 1/2"	Pair	12
25. Surgical Gloves 8 1/2"	Pair	4

Note: *Non essential items of Tubectomy Kit are: Item # 3, 4, and 6  
Items # 13, 14, 15, 20, 22, 23, 24 and 25 are included in Tubectomy MSR list.*

## Appendix - 5

## List of Medical and Surgical Requirement (MSR) for Tubectomy

(May be increased or decreased as per requirement. Substitute may be used.)

## a. List of MSR for 100 Tubectomy Cases (to be replaced):

Item Number	Particulars/Descriptions	Quantity
<b>Medicines:</b>		
1	Atropine Sulfate Injection - 1/100 Grain or 0.6 mg. 1 ml ampoule	110 amp
2	Promethazine Hcl Injection - 25 mg ampoule	110 amp
3	Pethidine Hydrochloride Injection - 50 mg ampoule	110 amp
4	Lidocaine/Xylocaine 1% Injection, without adrenaline (50 ml vials)	50 vials
5	Ampicillin Capsule (250 mg) 20 caps for each patient for 5 days	2000 caps and as required
6	Diazepam Tablet (5 mg)	250 tabs
7	Paracetamol Tablet	1000 tabs
8	Iron/Vitamin B-Complex Tablet	2200 tabs
9	Antispasmodic Tablet (if required)	300 tabs
10	Antihistamine Syrup (100-150 ml bottle)	300 bottles
<b>Other Items:</b>		
11	Absorbent Cotton	2 kg
12	Adhesive Tape (5 cm x 3 meter)	10 rolls
13	Catgut, Chromic '0' or 1. 60"	110 tubes/pcs
14	Chlorhexidine-Cetrimide Solution	1 of 5 liter jar
15	Cutting Curved, Needles	10 pcs
16	Cutting, Straight, Needles	5 pcs
17	Curved, Roundbody, Needles	10 pcs
18	Gauze (20 Yards than)	5 thans
19	gloves(Surgical), Size 6 1/2" and 7" (Re-usable or Disposable)	200 pairs
20	Gloves Powder	2 Pounds
21	Disposable Syringe - 10 ml	110 Pcs
22	Disposable Syringe - 5 ml	110 Pcs
23	Methylated Spirit - 1liter bottle	8 bottles or as required
24	Saree	100 Pcs
25	Shaving Blade	100 Pcs
26	Surgical Blade (Disposable)	110 Pcs
27	Silk Thread (For skin)	5 rolls
28	Uristix	100 Sticks
29	Test Tube	12 Pcs
30	Hemoglobin Talquist Book	2 Pcs
31	Disposable Lancet	100 Pcs

## Appendix - 5

## List of Medical and Surgical Requirement (MSR) for Tubectomy

(Listed according to requirement during provision of services)  
(May be increased or decreased as per requirement. Substitute may be used.)

## a. List of MSR for 100 Tubectomy Cases (to be replaced):

Item Number	Particulars/Descriptions	Quantity
<b>Medicines:</b>		
1	Atropine Sulfate Injection - 1/100 Grain or 0.6 mg. 1 ml ampoule	110 amp
2	Promethazine Hcl Injection - 25 mg ampoule	110 amp
3	Pethidine Hydrochloride Injection - 50 mg ampoule	110 amp
4	Lidocaine/Xylocaine 1% Injection, without adrenaline (50 ml vials)	50 vials
5	Ampicillin Capsule (250 mg) 20 caps for each patient for 5 days	2000 caps and as required
6	Diazepam Tablet (5 mg)	250 tabs
7	Paracetamol Tablet	1000 tabs
8	Iron/Vitamin B-Complex Tablet	2200 tabs
9	Antispasmodic Tablet (if required)	300 tabs
10	Antihistamine Syrup (100-150 ml bottle)	300 bottles
<b>Other Items:</b>		
<b>Items Required Before Procedure:</b>		
11	Uristix	100 sticks
12.	Test Tube	12 Pcs
13.	Hemoglobin Talquist Book	02 Pcs
14.	Disposable Lancet	100 Pcs
15.	Shaving Blade	100 Pcs
16.	Saree	100Pcs
<b>Items Required During Procedure:</b>		
17	Disposable Syringe - 5 ml	110 Pcs
18.	Disposable Syringe - 10 ml	110 Pcs
19.	Gloves(Surgical), Size 6 1/2" and 7" (Re-usable or Disposable)	200 pairs
20.	Gloves Powder	2 Pounds
21.	Absorbent Cotton	2 kg
22	Chlorhexidine-Cetrimide Solution	1 of 5 liter jar
23.	Methylated Spirit - 1liter bottle	8 bottles or as required
24	Surgical Blade (Disposable)	110 Pcs
25.	Gauze (20 Yards than)	5 thans
26	Catgut, Chromic '0' or 1. 60"	110 tubes/pcs
27	Cutting Curved. Needles	10 pcs
28.	Cutting. Straight. Needles	5 pcs
29.	Curved. Roundbody. Needles	10 pcs
30	Silk Thread (For skin)	5 Rolls
<b>Items Required After Procedure:</b>		
31	Adhesive Tape (5 cm x 3 meter)	10 rolls

## b. List of MSR for Routine Follow-up of 100 Tubectomy cases:

SI No	Name of Items	Quantity
1	Adhesive Tape - 5 cm x 3 Meter	5 rolls
2	Absorbent Cotton	1/2 Kg
3	Cap Ampicillin or any other Broad-Spectrum Antibiotic for 15% of cases. where routine antibiotic is not effective.	300 Caps or 200 tabs

Caution: Tetracycline should not be used for lactating women.

## c. List of MSR for 15% Post-Operative Complication Cases (to be replaced):

SI No	Name of Items	Quantity
1	Adhesive Tape - 5 cm x 3 Meter	2 rolls
2	Gauze	1 Than
3	Absorbent Cotton	1/2 Kg
4	Cap Ampicillin or any other Broad-Spectrum Antibiotic.	300 Caps or as required

## Appendix - 6

List of Necessary Instruments and other Special Items for Non-Scalpel  
Vasectomy (NSV) Procedure

Particulars/Descriptions	Unit	Quantity
1. Extracutaneous Vas Deferens Fixing Clamp (Ringed Forceps) 145 MM (with 3 or 3.5 or 4 mm ring)	each	1
2. Vas Deferens Dissecting Clamp (Dissecting Forceps) 135 MM	each	1
3. Straight Artery Forceps 5.5"	each	1
4. Straight, Small Scissors	each	1
5. Gully Pot with Chlorhexidine-Cetrimide Solution (1:20)	30 ml	1
6. Disposable Syringe 5 ml	each	1
7. Disposable Needle 20 Gauge x 1" or 25 Gauge x 1.25"	each	1
8. Black Silk Thread 3-0 (8" long)	6 pcs	1
9. Surgical Gauze Piece (@' x 2")	4 pcs	1
10. Surgical Drape sewed in two fold (Double Wrap) 26" x 26" (with 2.5" x 3.5" hole)	each	1
11. Surgical Drape sewed in two fold (Double Wrap) 26" x 26" (To be used as Trolley Cover/Instrument Cover)	each	1
12. Lidocaine 1% (without adrenaline)	5 ml	1

Note: Items # 6, 7, 9, and 12 are included in the list of MSR for Vasectomy.

## Appendix - 7

## List of Medical and Surgical Requirement (MSR) for Vasectomy

(May be increased or decreased as per requirement. Substitute may be used.)

a) List of MSR for 100 Vasectomy Cases (Out of order or used items/medicines to be replaced):

Item Number	Particulars/Descriptions	Quantity
<b>Medicines:</b>		
1	Lidocaine/Xylocaine Injection 1% (without adrenaline) 50 ml vials	10 vials
2	Ampicillin Capsule (250 mg) 20 caps for each patient for 5 days	2000 caps and as required
3	Paracetamol Tablet - 500 mg	1000 tabs
4	Vitamin B-Complex Tablet (if required)	1500 tabs
<b>Other Items:</b>		
5	Absorbent Cotton	2 kg
6	Adhesive Tape (5 cm x 3 meter)	5 rolls
7	Condom	2000 Pcs
8	Catgut. Chromic '0' or 1 x 30" (12 cm)	100 Pcs
9	Chlorhexidine-Cetrimide Solution	1 of 5 liter jar
10	Cutting. Straight. Needles	10 pcs
11	Gloves (Surgical). Size 6 1/2" and 7" (Re-usable or Disposable)	100 Pairs
12	Gloves Powder	2 Lbs.
13	Gauze (20 Yards than)	2 Thans
14	Disposable Syringe - 5 ml (initial supply)	100 Pcs
15	Methylated Spirit - 500-1000 ml bottle	1 liter (2 bottles)
16	Lungi/Saree	100 Pcs
17	Shaving Blade	100 Pcs
18	Surgical Blade (Disposable), Size - 10	100 Pcs
19	Silk Thread 000 (for NSV)	5 rolls
20	Uristix	100 Pcs
21	Test Tube	12 Pcs
22	Hemoglobin Talquist Book	2 Noose
23	Disposable Lancet	100 Pcs

Compiled by: AVSC International/Quality Improvement Partnership (QIP)

## Appendix - 7

## List of Medical and Surgical Requirement (MSR) for Vasectomy

(Listed according to requirement during provision of services)

(May be increased or decreased as per requirement. Substitute may be used.)

b) List of MSR for 100 Vasectomy Cases (Out of order or used items/medicines to be replaced):

Item Number	Particulars/Descriptions	Quantity
<b>Medicines:</b>		
1	Lidocaine/Xylocaine Injection 1% (without adrenaline) 50 ml vials	10 vials
2	Ampicillin Capsule (250 mg) 20 caps for each patient for 5 days	2000 caps and as required
3	Paracetamol Tablet - 500 mg	1000 tabs
4	Vitamin B-Complex Tablet (if required)	1500 tabs
<b>Other Items:</b>		
<b>Items Required Before Procedure:</b>		
5.	Uristix	100 Sticks
6.	Test Tube	12 Pcs
7.	Hemoglobin Talquist Book	02 Pcs
8.	Disposable Lancet	100 Pcs
9.	Methylated Spirit - 500-1000 ml bottle	1 liter (2 bottles)
10.	Shaving Blade	100 Pcs
11.	Lungi	100 Pcs
<b>Items Required During Procedure:</b>		
12.	Gloves (Surgical), Size 6 1/2" and 7" (Re-usable or Disposable)	100 Pairs
13.	Gloves Powder	2 Lbs.
14.	Absorbent Cotton	2 kg
15.	Chlorhexidine-Cetrimide Solution	1 of 5 liter jar
16.	Disposable Syringe - 5 ml (initial supply)	100 Pcs
17.	Surgical Blade (Disposable), Size - 10	100 Pcs
18.	Catgut, Chromic '0' or 1 x 30" (12 cm)	100 Pcs
19.	Cutting, Straight, Needles	10 pcs
20.	Silk Thread 000 (for NSV)	5 rolls
21.	Gauze (20 Yards than)	2 Thans
<b>Items Required After Procedure:</b>		
22	Adhesive Tape (5 cm x 3 meter)	5 rolls
23	Condom	2000 Pcs

## 2. List of MSR for 100 Vasectomy Follow-up Cases (to be replaced):

Sl No	Name of Items	Quantity
1	Gauze (20 Yard Than)	2 Than
2	Absorbent Cotton	1 kg
3	Cap Ampicillin 250 mg or any other Broad-Spectrum Antibiotic (NB: MO-MCH is entitled to buy. cannot be stocked).	300 capsules or as per requirement
4	Paracetamol Tablet (500 mg)	300 Tabs
5	Iron Tablet/tablet B-Complex (if required)	600 Tabs or as required
6	Adhesive Tape - 5 cm x 3 Meter	2 roll

## c) List of MSR for 15% Post-Operative Complication Cases (to be replaced):

Sl No	Name of Items	Quantity
1	Gauze	1 Than
2	Absorbent Cotton	1 Kg
3	Adhesive Tape - 5 cm x 3 Meter	2 rolls
4	Cap Ampicillin or any other Broad-Spectrum Antibiotic.	300 Caps or as required
5	B-Complex Tablet ( if required)	300 tabs

Special Note: Medicines, MSR and other expandable items mentioned in the appendices are procured/supplied as per probability of use. For re-procurement/re-supply of non-expandable items offer its initial supply, recommendations/loss statement of Survey/Condemnation Board is not required. For detail information concerned rules should be discussed.

## Appendix - 8

Emergency Clinical Items for Clinics Providing Sterilization  
(For Providing Tubectomy)  
(to be replaced)

Sl No	Particulars/Description of Items	Quantity
1	Inj Naloxone 1 ml ampoule (0.4 mg)	10 ampoule
2	Inj Promethazine Hcl 1 ml ampoule (25 mg)	10 ampoule
3	Inj Adrenaline 1 ml ampoule (1:1000)	10 ampoule
4	Inj Hydrocortisone 2 ml ampoule/vial (100 mg)	10 ampoule/vial
5	Inj Diazepam 2 ml ampoule (10 mg)	2 ampoule
6	Inj Aminophylline 10 ml ampoule (250 mg)	10 ampoule
7	Inj Calcium Gluconate 10 ml 10% - 2-5 amp	5 ampoule
8	Inj Sodium-bi-Carbonate 25 ml ampoules (7.5%)	6 ampoule
9	5% Dextrose in Normal Saline 500 ml	20 ampoule
10	5% Dextrose in Aqua 500 ml	10 bags
11	Oxygen cylinder filled with Oxygen with therapy sets (connecting tube and Face mask for supplying Oxygen) (Therapy set - 1 and Trolley - 1)	10 bags
12	Respiratory Resuscitator (Ambu Bag)	2
13	Airway Tube (3 sizes)	1 set
14	Suction Machine (Manual or Electric) -1	1
15	Disposable Syringe 10 cc	5
16	Disposable Syringe 5 cc	5
17	Disposable Syringe 50 cc	2
18	Rubber Catheter	2
19	Foley's Catheter	2
20	Venesection Set	1 set
21	Atraumatic Catgut	5
22	Three Battery functioning Torch with batteries	1
23	Autoclave Tape (3 cm x 2 meter)	1
24	Laparotomy Tray with Instruments - 1	1

## (For Providing Vasectomy)

(to be replaced)

Sl No	Name of Items	Quantity
1	Adrenaline Injection - 1:100	5 Ampoules
2	Atropine Injection - 0.6 mg	5 Ampoules
3	5% Dextrose in Normal Saline - 500 ml bags.	5 Bags
4	Promethazine Injection - 25 mg ampoule.	5 Ampoules
5	Hydrocortisone Injection - 100 mg	5 Vials
6	Catgut, Chromic 0 x 60 inch	5 Tubes (Pcs)
7	Disposable Syringe 10 ml B-Complex Tablet ( if required)	10 Pcs

## Appendix - 9

Contents of Laparotomy Tray (Set)

(Laparotomy set is required for emergency procedure. Contents of Laparotomy Tray should be as following)

	Name of Instruments	Quantity
1	Sponge Holding Forceps	4
2	Side Retractor	2
3	Doyen Retractor	1
4	Long Straight Artery Forceps	2
5	Mosquito Forceps	6
6	Allis Tissue Forceps	6
7	Babcock Forceps	2
8	Towel Clip	4
9	BP Handle	1
10.	Needle Holder	1
11.	Mayo Scissors	1
12	Cutting scissors	1
13	Plain Dissecting Forceps	1
14	Toothed Dissecting Forceps	1
15.	Syringe 10 cc	1
16	Curved Cutting Needles	2
17	Curved Roundbody Needle	2
18	Straight Cutting Needle	1
19.	Atraumatic Catgut '0'	6
20.	Rubber Catheter	1
21.	Foley's Catheter	1
22.	Ryles Tube	1
23	Tourniquet	1
24	Venesection Kit (including vein flow)	1
25	Butterfly needle	1

List of MSR for EPI Services

Sl. #	Name of Items	Quantity
1	Steam Sterilizer	1
2	Timer	1
3	Vaccine carrier with thermometer	1
4	Ice packs	4
5	Syringe/needle Pickup Forceps	1
6	Items for hand washing (soap, soap case and brush)	One each
7	Blue plastic bowl for keeping and washing used syringes and needles.	1
8	Nylon bag for carrying (item # 1-7)	1
9	Sterile syringes and needles in two racks of the Sterilizer:	
	a) 0.1 ml syringe (BCG) - 42	Total = 84
	b) 1.0 ml syringe (DPT, Measles, TT) - 42	
	c) 5.0 ml syringe (for Mixing)	4
	d) 26 gauge needle (BCG) - 50	Total = 100
	e) 22 or 23 gauge needle (DPT, Measles, TT) - 50	
	f) 18 gauge needle (for Mixing)	8
10.	Vaccines (BCG, DPT, Polio, Measles and TT)	As per requirement
11.	Ampule file (for curving BCG and diluent ampule)	1
12.	Dropper for feeding vaccine	2
13.	Clean/sterile absorbent cotton	As per requirement
14.	Distilled/boiled water (for cleaning injection site)	As per requirement.
15.	Small bowl (for keeping with distilled/boiled water)	1
16.	Pieces of cloth (for holding and keeping the hot Sterilizer, and cleaning the table)	As per requirement
17.	Plastic bag (for keeping the used vials and other items)	1
18.	Plastic table cloth with the sign of MONI (for covering the immunization table)	1
19.	Safety match	1
20.	Pen, vaccine card, register and tally sheet	As per requirement
21.	Badge with MONI sign for the volunteers and the service providers	As per requirement
22.	IEC materials (poster, leaflet, flyer, etc)	As per requirement
23.	Hanging bag (for carrying item # 9-22)	1

## Appendix - 11

List of MSR for Infection Prevention Procedure

Sl. #	Name of Items	Quantity
1	For all level of services:	
ii	Bucket with lid	1
iii	Bucket without lid	2
iiii	Bleaching powder in a pot (non-transparent).	As per requirement
v	Cup/Polar cup for measuring bleaching powder	1
vi	Spoon	1
vii	Utility gloves	1 pair
viii	Wooden stirrer	1
ix	Tooth brush	1
x	Detergent powder	As per requirement
xi	Water in bucket or bowl for cleaning of the used items	1
2	Additional requirements for Static Clinic:	
i	Basin or Drum with tap and bucket (for running water)	1
ii	Incinerator (small or large as per requirement)	1

## Appendix – 12

## List of MSR for Child Health Programs

*List of MSR for Vitamin A Capsule (VAC)*  
*(For all level of services)*

Sl. #	Name of Items	Quantity
1.	Vitamin A Capsule	As per requirement
2.	Small scissors (for cutting the capsule)	1
3.	Register for record keeping	1

*List of MSR for CDD Program*

Sl. #	Name of Items	Quantity
1.	For all level of services (providing Plan-A):	
	i) ORS Packets	As per requirement
2.	For Static clinic with Doctor (providing Plan-B):	
	i) Pot for measurement of volume of stool and vomitus.	2-5
	ii) Intravenous fluid	As per requirement
3.	For Specialized clinic (providing Plan-C):	
	i) Special bed with hole for collection of stool	2-5

*List of MSR for ARI Services*

Sl. #	Name of Items	Quantity
1.	For all level of services:	
	i) ARI timer	1
	ii) Thermometer	1
	iii) Cotrimoxazole tablet	As per requirement
	iv) Syp. Amoxicillin	As per requirement
	v) Tab. Salbutamol 2 mg.	As per requirement
	vi) ARI Register	1
	vii) ARI Case Management Chart	As per requirement
	viii) ARI Tally Sheet	As per requirement
	ix) Flipchart/IEC materials for ARI	As per requirement
2.	For special clinics with doctors:	
	i) Separate bed for ARI patient	2-5
	ii) Oxygen Cylinder with therapy set (O <sub>2</sub> Cylinder available for Sterilization may be used)	1

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**Appendix H**  
**Administrative Actions**

## 1. Training Conducted Outside Bangladesh

Trainee	Type of Training	Date
<i>UFHP Staff</i>		
None		
<i>UFHP-funded NGO Staff</i>		
None		
<i>BCCP Staff</i>		
Yasmin Khan	Advances Workshop – Baltimore	June 1998
<i>CWFP Staff</i>		
Tahmina Sarker	MPH – UNC Jaipur/North Carolina	August 1998
<i>PSTC Staff</i>		
None		

## 2. International Travel

Traveller	Purpose	Date
<i>UFHP Staff</i>		
Peter Connell	USAID regional conference – Chiang Mai	September 1997
Noor Mohammad	Conference on International Health – Ottawa	November 1997
Ahmed Al-Kabir	JSI orientation and NCIH – Boston/Washington	May 1998
Peter Connell	JSI COPs' meeting – Washington	June 1998
<i>JSI Home Office Staff</i>		
Amy Cullum	Assist with setting up financial systems	September 1997
Abul Hashem	Garment workers' study	September 1997
Amy Cullum	Financial systems review	May 1998
Ken Olivola	Assist with semi-annual review	May 1998
<i>UFHP-funded NGO Staff</i>		
None		
<i>BCCP/JHU Staff</i>		
Phyllis Piotrow	JHU - chair BCCP Board meeting	November 1997
Paul Bankerd	JHU - Board meeting; financial systems review	November 1997
Cathryn Wilcox	JHU – Advances Workshop	January 1998
Bob Karam	Consultant – strategic planning	February 1998
Joan Yonkler	Consultant – national BCC strategy	February 1998
William Carter	JHU – financial systems review	May 1998
Bob Karam	Consultant – strategic planning	May 1998
Yasmin Khan	BCCP – training, Baltimore	June 1998
Bob Karam	Consultant – strategic planning	June 1998
Esta de Fossard	JHU – drama serial design workshop	July 1998
Md Shahjahan	BCCP – PPD conference, Bangkok	September 1998
<i>CWFP Staff</i>		
Tahmina Sarker	Training – Jaipur	August 1998
<i>PSTC Staff</i>		
None		

3. Procurements over \$5000

Item Description	Unit Cost (\$)	Total Cost (\$)
<i>UFHP</i>		
Desktop computers X 18	2,200	40,000
Laserjet printers X 4	1,800	7,000
Uninterruptible power suppliers X 18	350	6,000
<i>All Others</i>		
None		