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**Urban Family  
Health Partnership  
Annual Report  
1998/99**

**Annual Report for October  
1998 to September 1999**

**Submittal to  
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**Strategic objective number 1:  
Fertility Reduced and Family Health Improved  
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Contractor: JSI Research and Training Institute, Inc.**

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## **A. Summary of Main Activities in 1998/99**

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

Progress against UFHP's 1998/99 work plan is best assessed with reference to the 51 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.

#### ***Action Programme 1 – NGOs' ESP Strengthening***

##### ***a. Adolescent health***

The Adolescent Health Programme was designed for piloting in 1999; 16 clinics were selected to participate in the pilot. The programme has 3 components: a schools programme, a community programme (including a peer education sub-component) and a clinic programme. Training for peer educators and clinic staff in the various aspects of adolescent health was designed, TOT started in April 1999 and training of 64 participating staff (medical officer, paramedics, SSPs and counsellors) was completed in May 1999. The programme was launched at clinic level in June 1999. OR support is come from Population Council as part of their global adolescent health OR project and UFHP's Adolescent Health Officer attended a design workshop in Washington for this purpose in May 1999. ORP and Pop Council between them are covering six of the selected sites for baseline research purposes, using Pop Council methodology. BCC/marketing materials in support of the programme have been conceptualised and some had been produced by year-end; the rest are expected to be available for use by November 1999.

##### ***b. Adult male involvement in FP***

Men's baseline knowledge and perception of their role and responsibilities in FP were extracted from the National IEC Survey, published in October 1998. Further work on this initiative has focussed in fact on launching a pilot NSV programme. Doctors in each clinic were trained through the GOB's training system and GOB also provided an initial set of NSV kits for use in some of the clinics. Development of BCC materials was still under way at year-end and permission from USAID to hire additional SP resources to support this and other expansion programmes was also awaited at year-end.

##### ***c. ANC/syphilis screening***

Twenty-six clinics from 18 NGOs were selected for ANC syphilis screening piloting in 1999. Paramedics of 26 clinics received one day training on RPR (ANC Syphilis screening) with ORH training. Twenty-three MOs have also now received the same training when they came for CH and ORH training. RTI/STDs and HIV/AIDS modules have also been included in the existing IPC/counselling curriculum. NGOs have been advised to buy the necessary equipment for RPR to start services immediately after training. ANC Syphilis screening programme rollout started from July 1999. The screening is being conducted in concert with ICDDR,B who have a research interest in syphilis prevalence. The screening procedures, equipment and training were all designed in concert with ICDDR,B and training was

completed by year-end. Permission from USAID to purchase the remaining equipment was still pending at year-end.

*d. HIV/AIDS*

UFHP's HIV/AIDS programme focuses mostly on community counselling – both in community groups and through peer education to more focussed high-risk groups (rickshaw pullers, CSWs, truckers, etc). The programme was designed and circulated for comment from stakeholders in November 1998. It was then finalised but stayed on hold through May 1999 awaiting completion of the NIPHP HIV/AIDS standards and protocols. Those protocols were agreed between QIP and USAID in June 1999 and sent to GOB for final approval. UFHP then proceeded to recruit HIV/AIDS Counsellors for each target location and a training programme was developed under Training Management Group auspices. That training was complete at year-end bar one batch. BCC/M materials have been developed and provided to the Counsellors in the field; more materials were under preparation at year-end.

*e. ICDDR,B – Child health*

A proposal was received after extensive consultation with ICDDR,B and was passed to USAID for approval in March 1999. Under the terms of the proposal, UFHP will provide approximately \$700,000 of assistance to ICDDR,B's child health programme and short-stay ward over a 3-year period in order to improve the sustainability of those programmes and protect an essential Bangladesh health resource. This assistance will include direct support to the 2 programmes plus development of a UFHP clinic on ICDDR,B's campus to handle Plan A and uncomplicated Plan B CDD cases. In addition, UFHP will fund around \$95,000 of technical assistance on a range of subjects, from strategic planning to transferring ICDDR,B's nutrition protocols to the community. Signature of the contract was delayed by repeated obstacles discovered to the UFHP clinic. ICDDR,B finally granted a firm site for the clinic in September 1999. Further negotiations regarding QA and franchising were on-going at year-end.

*f. FPAB – Comprehensive care clinics*

A phase 1 agreement with FPAB, covering the quality of clinical contraceptive services at its 4 City Corporation clinics, was signed in July 1998. The intention was to expand into further subsequent phases which would include all of the FPAB's other 16 clinics, to improve both their clinical contraception service quality and – more controversially – the quality of their general ESP services. The latter was subject to safeguards against duplication of UFHP's existing network of ESP services. The phase 2 proposal received from FPAB in January 1999 and received USAID approval after considerable re-negotiation of both scope and phasing. In the meantime, FPAB staff at field level had clearly misunderstood the purpose of the UFHP relationship, which they saw as a means of entry to broad ESP service delivery, causing much anxiety among and friction with UFHP's existing NGO partners. By year-end, FPAB clinics were showing good ESP performance but poor clinical contraceptive performance. UFHP duly suspended phase 2 contract and was poised to call in an independent consultant to assess true performance to date under the contracts.

*g. Referral mechanisms*

This project primarily aims to provide high quality referral centres for UFHP customers who cannot be satisfactorily handled by our own clinics. It has 3 components: identify the best

potential referral centre for each ESP component in each municipality we serve; pre-qualify each centre in terms of its quality; introduce agreed referral procedures so that UFHP can be sure that referrals are being successfully completed. The first of these components is now in place, with a full list of preferred referral centres available for all static clinics. The third component is partially complete with the design of referral slips and some initial workshops with referral partners on how the slips can be processed and followed up to ensure customer satisfaction. The second component remains largely intractable – virtually no referral centres in the GOB system meet UFHP's quality standards. At year-end, we were proceeding with the few (private sector) centres which we have pre-qualified and starting on the design of generic workshops with GOB centres to help them understand UFHP's needs in this area.

#### *h. NSV pilot initiative*

This project was combined during the year with (b) above.

### *Action Programme 2 – GOB Networking*

#### *a. BUSTTHI – 100 slums initiative*

The BUSTTHI project involves launching satellite service, in concert with DGFP and DCC, in 100 Dhaka slums not currently receiving health coverage. The original project design called for 25 FWVs to be seconded to UFHP together with DCC vaccinators so that, with UFHP recruited SPs, 25 satellite teams could be created to tackle 100 selected slums with ESP service delivery on a weekly basis. All UFHP aspects of the project were in place in December 1998 – ie on schedule. DCC eventually did not choose to participate but DGFP did agree to second 15 FWVs to the project in May 1999 and 12 of these subsequently reported for work. UFHP's four partner NGOs in Dhaka used this delay to conduct a detailed enumeration of the 25 target slums. Training is now complete and, by year-end, 12 teams were in the field and their contribution is now incorporated into UFHP's monthly MIS.

#### *b. ICDDR,B – Hospital franchising to DCC sites*

We abandoned this project in the second half of the year, in the face of ICDDR,B's difficulties in starting its child health project with UFHP and the DCC's pre-occupation with the UPHCP/ADB project. Franchising – the focus of UFHP's initial interest – will be achieved through the child health project but to UFHP sites rather than DCC sites.

#### *c. MOHFW – Urban TB initiative*

Discussions between UFHP and the WHO consultant assisting MOHFW on transferring the TB programme to urban areas resulted in selection of Chittagong as the pilot site. All 3 UFHP NGOs will be involved and 3 clinics have been selected for participation, based on local data on TB prevalence plus whether the UFHP clinic has an existing laboratory facility. WHO will fund any equipment needed; UFHP and WHO will jointly supervise quality; UFHP will provide BCC support through BCCP and will fund training, which MOHFW staff will provide. The selected clinics will provide DOTS care to TB patients. Given the ongoing volume of ESP-related training which UFHP staff are receiving, training on DOTS was not scheduled to start until June 1999 but, as at year-end, GOB has not been able to start the training.

#### *d. Local networking*

We have focused our efforts to date at both national and local levels. At the national level, routine briefing meetings were held with the Directorates of Health and Family Planning. These meetings were very useful in resolving issues relating to programme implementation. At the project/clinic level, NGO representatives have been encouraged to attend district and thana/municipality/city corporation coordination meetings organised by the government departments. UFHP staff are holding routine meetings with district and thana GOB officials as a part of their site visits. Networking has now become such a routine part of the UFHP programme that it will no longer receive 'project' status in the next work plan.

#### *Action Programme 3 – Private Sector Networking*

##### *a. Clinic franchising - pilot*

We held one internal brainstorming session on this topic in March 1999 and concluded that further progress would require substantial effort and maybe full-time additional staffing. In the light of this, we do not expect to launch any 'franchises' until the middle of 2000. The other conclusions from the brainstorming were:

- We do have a potentially franchisable concept available – "high quality ESP clinic".
- The conditions imposed on the franchisee will need to include adoption of the UFHP service delivery model in all its aspects (eg layout, protocols, staffing, training, etc), UFHP quality control, integration into our MIS, unique geographical boundaries, use of UFHP logo, possible payment of royalty or fee.
- In return, UFHP will provide to the franchisee central advertising and promotion, local BCC/M materials and training.
- Target franchisees include other NGO clinics, private sector clinics, doctors in chambers expanding into clinical services.
- Target areas for seeking franchisees include locations with low ESP coverage, markets with high income customers, individual ESP components which are high revenue, high cost or high volume – or some desirable combination thereof.

A detailed terms of reference for consultants will be prepared for USAID approval in October 1999. A successful study tour to examine midwife franchising in the Philippines was completed in August 1999 and will provide inputs to these terms of reference.

##### *b. Adamjee Jute Mills – ESP Delivery*

In January 1999, a sub-project agreement was eventually signed with SPADES, the NGO which is to provide ESP service at Adamjee through its own and the mill's clinics. The agreement specifies target ESP contact numbers related to UFHP's investment in improving the quality of the clinic facilities and services; Adamjee's contribution is also specified. UFHP will provide total funding of \$61,500 which is phased so as to decline annually over the 3-year agreement period as SPADES and Adamjee progressively develop a self-sustaining service. At year-end the project was proceeding on target and it will cease to be a separate 'project' in the new work plan.

*c. SMC – Expansion of commodity sales*

UFHP launched a programme to sell SMC pills, condoms and ORS on a pilot basis in early 1998 but the pilot fell victim to the SMC closure in the first quarter of 1998. The pilot was re-designed slightly, to involve a different mix of clinics and different payment terms, and was re-launched in March 1999 with 26 UFHP clinics. SMC completed the necessary sales training for UFHP staff during May 1999 and the pilot will last 6 months – until November 1999. At that time a joint SMC/UFHP evaluation will determine how to roll out a national sales programme through UFHP clinics.

*d. Industrial workers' health scheme*

Completion of the field research into industrial workers' morbidity patterns and costs of care was not completed and documented until March 1999. UFHP started to analyse the findings but rapidly found that the research left many questions unanswered. By year-end we had pieced together sufficient data to form the basis of the design for the scheme. The next step will be to recruit an external consultant with appropriate health insurance experience to help us design the scheme parameters.

*Action Programme 4 – BCC/Marketing*

*a-d. Four BCC/M campaigns*

Action Plans 4 a through d remained on hold pending recruitment of appropriate staff to BCCP. The findings of BCCP's strategic plan (see Action Plan 9a) revealed major skill gap in the organisation and a separate consulting study was commissioned to determine how to fill the gaps. The report was available in late January 1999 and implementation started in February 1999. UFHP felt it would be unwise to launch major BCC/M campaigns until the necessary staff are in place at BCCP, since UFHP does not have the resources in-house to substitute even in the short-term.

New staff with appropriate skills were on board by June 1999 and had been oriented by July 1999. In August 1999, a workshop was held to discuss UFHP's urban BCC/M strategy; the workshop involved UFHP HQ BCC/M staff, BCCP staff and selected NGO staff. A separate strategy document was produced by the end of September 1999.

UFHP continued to produce BCC/M materials throughout this period using its quarterly marketing calendar. Materials included additional pages for the ESP flipchart, materials in support of the Adolescent Health and HIV/AIDS programmes and various materials in support of national events – eg NIDs, Vitamin A Week, the MNT campaign, National AIDS Day, World Population Day, World Health Day, etc. In addition, UFHP developed with BCCP assistance a successful TV advertisement promoting UFHP clinics. This was first broadcast in November/December 1998 and repeated in April/June 1999 as part of Project Jolt. Both airings were done under 'emergency' arrangements with USAID. Free GOB air-time provisions were finally secured by USAID in August 1999.

Project Jolt was also held over the April to June 1999. It was an integrated campaign aimed at re-focussing UFHP NGOs on the core FP business of the clinics, raising clinic contact numbers and increasing the effectiveness of community group meetings. The campaign

started on 7 April – World Health Day – and lasted 2 months. Prior to 7 April, clinics received centrally produced posters, leaflets, meeting scripts, sticker badges and miking scripts; the accompanying instruction pack included the design standard for locally-produced banners. Prior to 7 April, posters were put up in prime locations around each community, drawing attention to UFHP's services, the FP services in particular, and World Health Day. The banners (World Health Day and FP messages) went up at all clinics on 7 April and remained for one month. In the second two weeks of April, leaflets were distributed to all homes in each community served. The leaflets offered discounts on UFHP services and participation in a lucky draw. Throughout April and early May, community group meetings focussed on FP. Miking took place the second week of May, with the same messages as the leaflets (UFHP services and FP). Meetings with community opinion-formers took place in the second half of May. The lucky draw and attendant publicity took place in each clinic on 8 June. Partly as a result of Project Jolt, contact numbers rose 48% between March and July 1999.

*e. National BCC strategy*

The National IEC Committee met on 11 March 1999 and a Task force was formed. The Task Force subsequently reviewed two existing workshop reports, the National FP-MCH IEC strategy 1993-2000 of MOHFW and other relevant documents. A draft strategy was prepared by a working group drawn from the Task Force and a first draft was circulated in August 1999. That draft was subsequently withdrawn and amended and a revised draft is expected in October 1999.

*f. National HIV/AIDS BCC Strategy*

A Conceptualisation Workshop, organised by BCCP for MOHFW and DG Health, was held in December 1998. Subsequently, a second consultant was recruited by BCCP to prepare an implementation plan for the strategy and he ended up rewriting the strategy and preparing an implementation plan. A consensus-building workshop on the implementation plan was held in September 1999. A report on that workshop will be circulated in October 1999 and the next step will be a donors' meeting to line up funding.

*Action Programme 5 – Technical Supervision*

*a. Quality manuals dissemination*

All quality manuals had been promised in draft by December 1997; subsequently, the first 3 were firmly promised to be ready for dissemination by December 1998. UFHP received the first three manuals in May 1999. They were immediately distributed to the field and a series of dissemination sessions during July and August 1999 explained how they should be used for on-the-job training. The remaining three manuals are still awaited.

*b. Customer charter*

UFHP's customer charter is a component of our Quality Comes First campaign. With finalisation of the urban BCC/M strategy in September 1999 (see 4 a-d above), the charter has been scheduled for detailed development in the new work plan.

*c. Technical support visits*

The Quality Assurance checklist, for use by QA teams during their QA visits to clinics, was updated and reorganised. The objective was to document formally and in one place the facility, equipment and procedural aspects of quality – and to introduce a ‘scoring’ mechanism which can reduce all the quality indicators to a single overall assessment of clinical quality. The updating was more or less complete by end-March 1999 and the revised checklist was field-tested by QA teams during April and May and finally revised in June and July. It has been in use throughout the UFHP network from 1 August 1999. Checklists for doctors to use in supervising paramedics will be developed as an extract from the QA list.

*d. Management support visits*

The NGO Liaison Officer’s checklist has been revised to introduce a formal ‘scoring’ system for clinics as an input to the performance league tables (see Action Plan 8e). The new checklist was field-tested by NLOs during April and May and finally revised in June. It has been in use throughout the UFHP network from 1 July 1999. Checklists for project managers to use in supervising doctors as clinic managers will be developed as extracts from the NLO list.

*e. NGO self-assessment of performance*

We have abandoned this action plan. We still believe that COPE – the existing instrument – is outdated and based on total quality management concepts which were abandoned many years ago in the private sector. However, improving and replacing COPE will be a major task and there is no alternative we have been able to take off the shelf internationally.

*Action Programme 6 – ESP Technical Training*

*a. Child health course*

132 paramedics received training on child health during the year. So far a total of 291 paramedics have received the first round of training on child health from NIPHP approved training institutes. An orientation on CH and ORH for NLO and QAOs of UFHP was also organised with QIP’s participation. Another curriculum has also been developed for medical officers where ORH has been combined with Child Health. The duration of the course is 12 days and it was made available from April 1999. 106 medical officers had received the training by year-end.

*b. Other reproductive health course*

The course curriculum, which was developed with the active involvement of all the concerned key players of NIPHP, was not ready for use until December 1998. UFHP staff were scheduled for training promptly and, by year-end, 207 paramedics and 106 doctors had received ORH training.

*c. IPC/counselling course*

This course was successfully developed by the UFHP partners under the umbrella of the ‘UFHP training alliance’. The course was completed by all UFHP Counsellors on schedule in February 1999.

*d. HIV/AIDS course*

This course was delayed by the non-availability of the NIPHP HIV/AIDS standards/protocols (see Action Plan 1d). It was eventually designed in June 1999, with TOT starting in July 1999. By year-end, training was complete except for one batch and 104 UFHP NGO staff had been trained.

*e. Sterilisation course*

NIPHP Training Management Groups' working group on sterilisation developed an NSV training curriculum and materials at UFHP's request. These materials are used jointly by the government training institute Mohammadpur Model Clinic and AITAM for the training of doctors from UFHP NGOs. The first batch of UFHP doctors started training in late March 1999 and the last batch was completed in August 1999. By year-end, 21 UFHP doctors, 19 paramedics had been trained.

*f. Safe delivery course*

A concept development workshop for the whole safe delivery programme was held in May 1999 under the auspices of USAID and with the active participation of UFHP's Senior Technical Adviser from JSI Boston. The positive outcome of that workshop led to a draft safe delivery programme concept provided by the Senior Technical Adviser – which includes training issues to be included in the next work plan.

*g. RDU/MTP modules*

The three RDU modules of the MTP programme were scheduled for rollout in January 1999. However, neither RSDP nor QIP completed their draft modules on schedule and RSDP also had significant delays in rolling out its RDF modules, which had been scheduled for completion in December 1998. The remaining two RDU modules were eventually ready by June 1999 and UFHP scheduled rollout to commence following a series of dissemination sessions in July and August to remind our partner NGOs of the MTP concept. The first module went to the field in September 1999.

*Action Programme 7 – Management Training*

*a. CCC course*

To develop an effective co-ordination and collaboration between GOB and NGO networks, UFHP conducted a 12-week course on "Improving Management and Performance of Delivery of ESP in Urban Areas." A total of 29 participants from 8 municipalities attended the course and developed 8 action plans. A graduation ceremony was held during mid December and 8 action plans were handed over to Government, USAID and UFHP. The action plans are being implemented in the 8 selected (Feni, Narshingdi, Munshiganj, Sylhet, Moulvibazar, Satkhira, Kurigram and Barisal) municipalities.

UFHP subsequently agreed to coordinate design of a successor course with RSDP. Many meetings have been held to date to discuss the design concept. The broad consensus emerging is that any successor course should include revision of the curriculum, reduction of

the course duration and use of local resources and facilities for conducting the course. We now expect the curriculum for the successor course to be finalised by March 2000.

***b. BCC/marketing course***

The course was developed on schedule and all UFHP SPs and SSPs had received their initial training by the end of January 1999. This was another success for the UFHP training alliance. Further batches of the basic course will be scheduled as required to accommodate new SPs and SSPs as they are hired. A refresher course will also be developed for launch sometime in the next work plan year.

***c. Strategic plan facilitation/implementation***

NGOs' strategic planning is proceeding more slowly than hoped, both because the NGOs still have considerable routine work to accomplish to satisfy UFHP's management objectives and because some of the UFHP NLOs are themselves having difficulty in facilitating the process. Approximately two thirds of the NGOs had reached the vision development stage by year-end. However, a serious obstacle is now identified as a basic unwillingness of the NGOs to conduct strategic planning and our focus now is on that mindset problem. Given that none of the strategic plans were complete by year-end, we have made a credible plan a prerequisite for participation in the next round of contracts with UFHP.

***d. Teamwork seminars***

These seminars for NGO partners, building on the work developed by an external consultant in January, 1999, were completed by PSTC by June 1999.

***e. NGO personnel policy seminars***

The initial design of the seminar had been completed on schedule by end-March 1999. Rather than making a stand-alone seminar, we shall probably use this material as the basis for a one-day module in a clinic management course and as a one-day module in an NGO management development course. Both are scheduled to be held in the next work plan period.

***f. NGO financial management seminars***

Completion of the service delivery NGO audits was delayed beyond the end of 1998 and so therefore was the development of the financial management seminar. The broad content was finalised in April 1999 when the audit findings had been finalised during the visit to Bangladesh of the JSI backstopper. Thereafter, the seminars were held as the third day of the three-day dissemination sessions conducted in July and August 1999. A shorter module will be developed for doctors and will be included in the clinic management course to be held during the next work plan period.

***g. RDF management MTP modules***

The modules were developed and transferred to NGOs on schedule by end-December 1998. Revolving drug funds are also now in place at all NGOs. In March and April 1999, UFHP conducted a short survey of a sample of clinics to assess the impact of the MTP methodology. The returns from the survey showed mixed results and prompted UFHP to add an RDF

module to the July/August dissemination sessions. By year-end, we had concluded that the RDFs are in basically good shape – ie the drugs are being procured, stored, dispensed and accounted for safely – but that many management details remain poorly understood. An RDF module will be added to the clinic management course and we are considering other forms of refresher training for the coming year.

#### *h. MIS computerisation dissemination*

UFHP has re-designed MIS input formats so that they can be computerised at the NGO level. This will allow us to delegate MIS data input to the NGO level in future and eliminate the monthly bottleneck on data entry at the UFHP level. This change commenced implementation once the MIS progress review (conducted jointly by UFHP and ORP) was completed in May 1999. We also designed computerised MIS report formats for use by our NGOs to produce not only data for UFHP/USAID consumption but also GOB's Form 3 and graphic/tabular data for their own consumption. The new data entry routines, the report formats and new e-mail connections were disseminated in a series of personal NGO cluster visits by UFHP's Systems Administrator in July to September 1999.

### *Action Programme 8 – Research*

#### *a. NGO impact assessment*

Mitra and Associates was selected in a competitive bid for this work and appointed prior to the start of the reporting period. Field-work was considerably delayed by the impact of the 1998 floods but was completed by March 1999. The draft final report was delivered in May 1999 and was the subject of an extensive presentation made to the Strategic Change Committee in May 1999. The final report was delivered in September 1999.

#### *b. Quality definition/achievement survey*

It proved very difficult to get consensus between UFHP, RSDP, ORP and USAID on how and when to conduct this survey; the working group representing all parties was effectively not progressing from October 1998 to January 1999. However, by March 1999, a measure of consensus and progress had been achieved: we decided to combine the quality definition/achievement survey with the costing/pricing study (see Action Plan 8c); an outside consultant from Abt Associates had been selected to advise the working group; the terms of reference for a local consulting firm to conduct focus groups and exit interviews had been agreed. Given the initial lack of consensus, UFHP decided to conduct its own survey on existing pricing policies and this was completed in October 1998. UFHP also proceeded independently on studying its unit costing and two external consultants visited Bangladesh to put data collection routines and methodologies in place during May 1999. As a result of the delays experienced, a formal UFHP pricing policy will not now probably be finalised until February 2000. Work was ongoing on four or five fronts at year-end.

#### *c. Costing/pricing study*

Two consultants from USA have started the Patient Flow Analysis (PFA) study in June 1999 as a part of costing study. According to the consultant's plan, UFHP team has collected PFA information from 10 selected clinics throughout the country. PFA field data collection has been completed in July 1999. Subsequently data entries were made in Dhaka and along with

cost information sent to JSI/Boston in mid October. Now JSI/Boston office is processing PFA data with cost information in order to produce service unit costing report. We are expecting that unit costing task will be completed in November 1999. Simultaneously, other activities relating to costing/pricing study are in progress, which is reflected in Action Plan 8b above.

*d. New MIS evaluation*

This action plan in fact involved a joint progress review of the new NIPHP MIS, as applied to UFHP, conducted jointly by UFHP and ORP. ORP will conduct a formal evaluation only after the MIS has been in use for one year – ie in the second half of 1999. A joint review team was created and sample clinics visited; the clinic visits were completed in mid-April 1999. A report from the team was delivered in May 1999.

*e. NGO performance league tables*

We have delayed final design and production of the league tables so as to be able to combine elements from the revised/computerised MIS system, the revised QAO and NLO checklists and selected financial information. All data sources are now in place, although the QAO checklist remains somewhat experimental. We expect to start producing and interpreting the checklists before end 1999.

*f. Municipal coordination*

After slow progress on this topic throughout 1998, new impetus was achieved in early 1999. By the end of 1998, PSTC had led a UFHP working group in surveying 4 municipalities to assess the current state of municipal coordination. The working group's findings were generally critical but there was little internal consensus on the way forward. The working group has now been replaced by a Municipal Coordination Improvement Group (MCIG), consisting of UFHP, IOCH and ORP. The MCIG was formed in January 1999 on UFHP's initiative. It made considerable progress on defining the coordination 'problem' and integrating the earlier UFHP working group's findings into a work plan for achieving improved coordination. The MCIG commissioned PSTC to hold workshops with 6 pilot municipalities to assess their attitude towards coordination and the associated issues. A work plan for the MCIG was produced but implementation has been delayed by the difficulty of recruiting UPHCP/ADB involvement and the change of Secretary at MOLGRDC. A meeting with MOLGRDC Secretary is expected in November 1999 and the Urban Capacity Working Group can receive a presentation of the MCIG's work plan thereafter.

*Action programme 9 – Management Partner Strengthening*

*a. BCCP strategic plan implementation*

BCCP presented its strategic plan to its stakeholders in January 1999. As a result of that presentation, a consultant was appointed to assess the current skill gap within BCCP – an important determinant of BCCP's ability to implement the strategic plan. The consultant reported in February 1999 and set in train a major reorganisation and recruitment process at BCCP, which was not completed until July 1999. New core staff and skills were in place and had been oriented by July 1999, so that implementation of the plan commenced seriously at that point – and actions taken to launch UFHP's main BCC/M campaigns as well.

### ***b. CWFP strategic plan implementation***

CWFP presented its strategic plan to stakeholders in March 1999. The resulting discussion produced suggestions for change/improvement which were incorporated in a final draft of the plan by July 1999, when implementation commenced.

### ***c. PSTC strategic plan implementation***

PSTC's strategic plan was ready for presentation to stakeholders in May 1999 and, after incorporation of comments received, was finalised in July 1999, when implementation commenced.

## **2. Special Initiatives Undertaken**

Special initiatives are those initiatives involving significant effort which were not anticipated in the annual work plan. There are 4 of these:

- As part of the negotiations with ICDDR,B over the Child Health Strengthening project (action plan 1e), we have positioned UFHP to effectively take over a large part of the ICDDR,B hospital's Plan A and uncomplicated Plan B CDD cases. This led us to propose a new UFHP clinic facility on ICDDR,B's Mohakhali campus. This idea was accepted in principle and detailed negotiations regarding the site and start-up were almost finalised by year-end. Through this initiative, UFHP will become the second largest provider of CDD services in the country, after ICDDR,B itself.
- We believe that nutrition-related services, while being part of the ESP, represent a critical gap in the current NIPHP offering. This gap affects UFHP's effectiveness in both child health and maternal health. At the same time, UFHP is about the only national player in urban health currently capable of making a significant impact on this issue. We have started a project with ICDDR,B to take their in-patient nutrition improvement protocol to other hospitals and use the UFHP network to provide referrals into those facilities. We are also using this project to pilot various aspects of UFHP's own nutrition programme which will be formally launched during the next work plan.
- Project Jolt was conceived in February 1999 in response to a possible flattening of UFHP's clinic contact numbers. November 1998 through February 1999 was a difficult period in which to discern trends because of NIDs, hartals and Eids but, in case performance was prematurely flattening, Project Jolt was implemented in the period April to June 1999 with tremendous success. The Project is described in section 1 above.
- UFHP was asked to sponsor and lead an overseas study tour for senior GOB staff on HIV/AIDS. There is consensus among donors and NGOs that GOB needs to become more active on HIV/AIDS policy. The study tour was designed to demonstrate how bad an unanticipated HIV/AIDS epidemic can be (Zimbabwe) and the difference that a relatively progressive government response can make (Uganda). The tour was held over 10 days in August 1999 and involved the State Minister of Health, the Secretary of Health, the Technical chair of the National AIDS Committee and UFHP's COP. Participating in this tour was consistent with UFHP's objective of positioning itself as the only nationwide urban player in HIV/AIDS and, by year-end, it had yielded useful progress on the national HIV/AIDS effort and an enhanced image for UFHP in GOB circles.

### 3. Success Stories in 1998/99

We can identify seven particular successes during the year:

- Project Jolt – Not only did this project succeed in stimulating greater contact numbers but also it provided the service delivery NGOs with a practical example of a fully integrated BCC/M project, giving them local introductions to BCC production partners they had not necessarily met previously (eg banner production, miking) and to community leaders.
- External Audit – UFHP has conducted an external audit for all service delivery NGOs and 3 management partner organisations for the first 15 months of the project period in order to review the financial management of the sub-projects. These audits findings were very helpful in improving the financial management capabilities of our NGOs. Our finance team is conducting routine monitoring visits to ensure implementation of audit recommendations.
- NGO Dissemination Workshop – Four regional dissemination workshop were organised by UFHP for service delivery NGOs to cover a wide range of technical, programmatic and management issues. It was useful for developing a common understanding among NGOs on different service delivery issues and strategies.
- BUSTTHI – Although the project was slow in taking off, it represents an important first: GOB staff seconded to an NGO-led project. This breaks new ground in GOB/NGO teamwork and can hopefully be replicated in other cities.
- Revolving drug funds – The implementation has again not been perfect but the important outcome is that customers now have an additional and cost-competitive source of drug supply. As the proportion of UFHP prescriptions filled from UFHP RDF resources rises, the proportion of our customers who actually *buy* the drugs they need and then *consume* those drugs should also rise. These are highly desirable outcomes for Bangladesh. And this process is particularly important at satellite locations, where drug supplies from commercial sources are anyway restricted.
- UFHP's clinic at the ICDDR,B campus – Potentially this clinic will yield four times the average volume for a UFHP static clinic, at only a slightly higher cost than an average UFHP static clinic. This represents a very good deal for the NIPHP and reflects great credit on USAID for having engineered access for UFHP to this captive market.
- HIV/AIDS study tour to Africa – This investment has already yielded a strong change of mindset and sense of urgency among GOB leaders. In a very difficult and sensitive area of GOB policy, every little initiative helps. Furthermore, by introducing UFHP directly to top levels of government health policy-makers, it has enhanced the reputation of UFHP and strengthened NIPHP's overall reputation for being a very reliable development partner.

### 4. Lessons Learned

- Quality really matters – From the very beginning, we tried to establish clinics without compromising quality. We have equipped our clinics properly, choose the accessible clinic locations, exercised COPE at every clinic and above all established a customer

friendly clinic lay-out. Besides, we trained the service providers, particularly doctors and paramedics by ESP service technicalities. These all helped us building an image amongst the customers and thus our customer contacts increases day by day.

- Service marketing is a very challenging job – Likewise product marketing we have recognised that service marketing is a challenging task. Initially, we faced problems of getting customers at clinics with service fees. However, we have tried different ways to overcome the situation, which helped us taking off from previous ‘free service’ attitude of the customers. ‘Project Jolt’ was a good learning for us. During 2-months’ period from 7 April 99, UFHP clinics had undertaken extensive BCC activities under ‘Project Jolt’ programme for popularising clinics, as well as marketing services. As a result, tremendous increase in customer volume at UFHP clinics experienced in two months. UFHP has recognised the need for expanding local level BCC activities, which will be a focus in our future activities.
- Local level networking is useful – UFHP organised municipal level NIPHP orientation sessions for the municipal level government, non-government and local government leaders and local elites through its partner PSTC in each of the municipality. These orientations gave us the momentum to start with local support. Most of UFHP satellite clinic locations are in the premises of local elite’s house. These house owners basically help us promoting the clinics. Moreover, the participation of local level GOB officials in UFHP activities ensures higher level of GOB officials support to our activities.
- On the job training – Though we are providing training to the staff, but our technical officers’ visit and on-site training make the staff more confident. UFHP has recognised the need to provide on-site technical assistance support to the service providers is curicial for providing quality services. On site technical support at all levels is curicial for the professional development of clinics and its staffs.
- Management skills for doctors – UFHP clinic managers are doctors. Few of these doctors have necessary skill of management. Generally they are good at treating patients only. UFHP has taken this issue seriously and trying to develop management course for them very shortly.
- Working together with the UFHP Partners – BCCP, CWFD and PSTC have their own strengths and limitations in programme implementations. UFHP has identified one for their common strength as ‘training’ and all of them has identified ‘ training’ as an activity for their future-development. Accordingly, UFHP has used these organisations together in conducting few training activities for UFHP NGOs and the initial outcome is very positive. All these UFHP partner organisations are now working together to form a training alliance.

## **B. Progress Against Selected Performance Indicators**

### **1. Clinic Performance**

#### ***a. Past performance***

UFHP’s clinic performance in September 1999 is contained in Appendix A. Figure 1 summarises UFHP’s performance against selected clinic performance indicators. The

baseline data is a monthly average for the period July to December 1996 and covers clinic contacts only. The data for 1997/98 is the monthly average drawn from the last quarter of the year – ie July to September 1998; the data for 1998/99 is the monthly average for the last available 3 months – ie June to August 1999. Annual baseline data is not available; furthermore, all *annual* data thus far fails to give a good trend indication of clinic activity because:

- Monthly growth is still very high, making annual data a very poor predictor of future performance;
- Annual data includes special events like NIDs and Vitamin A weeks, both of which skew the data considerably towards their respective ESP components.

**Figure 1**  
**Selected Monthly Clinic Performance Indicators**

Indicator		<i>Baseline</i> <sup>1</sup>	<i>1997/98</i> <sup>2</sup>	<i>1998/99</i> <sup>3</sup>	<i>Long-term Growth Projection</i> <sup>4</sup>
<i>Child health (clinic contacts)</i>					
EPI	DPT/Polio3	1,815	2,331	4,489	} Medium
	Measles (0-11 months)	1,350	1,537	4,663	
Vitamin A <sup>5</sup>		4,260	5,754	7,090	Medium
CDD	No dehydration	na	8,040	10,267	} Low
	Some dehydration	na	4,284	4,350	
ARI	Common cold	} 1,735	7,095	15,292	} High
	Pneumonia		1,072	2,408	
<i>Reproductive health (clinic contacts)</i>					
ANC	1 <sup>st</sup> visit	na	6,608	14,488	} Medium
	2 <sup>nd</sup> visit	na	2,197	7,501	
TT	Pregnant women: TT1	na	2,910	4,787	} Medium
	TT2-5	na	3,361	5,820	
PNC		1,135	1,649	5,405	High
FP	Pill	1,216	17,266	37,652	Low
	Condom	531	8,862	16,151	Low
	Injectable	9,745	11,403	29,676	Medium
	IUD				} Medium
	Insertion	195	269	379	
	Removal	*na	79	176	} Medium
	Norplant	14	59	203	
	Vasectomy	0	7	79	Medium
	Tubectomy	9	8	38	Medium
	Side-effects				} Medium
	Pill	na	143	2,398	
	Injectable	na	317	3,430	
	IUD	na	100	554	}

<sup>1</sup> Average July to December 1996, clinics only

<sup>2</sup> Average July to September 1998

<sup>3</sup> Average July to September 1999

<sup>4</sup> See text

<sup>5</sup> Routine service only; for NIDs and Vitamin A Weeks, see Figure 2

**Figure 1 (cont'd)**  
**Selected Monthly Clinic Performance Indicators**

<b>Indicator</b>	<i>Baseline</i>	<i>1997/98</i>	<i>1998/99</i>	<i>Long-term Growth Projection</i>
<i>Reproductive health (clinic contacts – cont'd)</i>				
RTIs/STDs Female VD	875	2,479	21,506	High
Other		957	6,606	
Male UD		98	1,285	
GU		107	883	
<i>Reproductive health (referrals issued)</i>				
Injectable	31	231	59	Low
IUD		43	98	
Norplant		30	58	
Sterilisation		38	53	
<b>Other indicators (year-end)<sup>1</sup></b>				
# ELCOs in UFHP catchment areas	na	2,016,850	2,234,300	>4% per annum
# static clinics operating	75	114	123	unlikely to exceed 200
# monthly satellite sessions	na	4,392	5,788	unlikely to exceed 10,000
# clinic staff:				
Doctors	0	118	129	will increase in proportion to # clinics and # shifts added
Paramedics	75	342	396	
Counsellors	0	58	66	
Others	75	774	865	
Cost recovery: Service fees earned (Tk)	na	666,341	1,320,671	
Imputed cost of satellite facilities (Tk)	na	439,666	543,500	
Relevant programme cost (Tk)	na	10,822,855	12,495,477	
Recovery rate for year (%)	2.5	10.2	14.9	25-50%

<sup>1</sup> Year-end is September 1998 and September 1999

For reference, the data for the special events is given in Figure 2:

**Figure 2**  
**Estimated Clinic Contacts on Special Event Days,**  
**August 1997 to date**

Month	NID	Vitamin A Week
December 1997	28540	
January 1998	19030	
June 1998		127,206
December 1998	544,194	
February 1999	360,182	
June 1999		463,364*

\*Note: Not reported within UFHP MIS data

Current performance is well above baseline in all ESP components.

***b. Growth potential***

The time series is still too short and unstable to permit any sensible projections to be made, even at the Total Contacts level. In the 2 years to date, it is possible that the rapid physical expansion of the programme simply drowned out seasonality; other one-off events sometimes had a counter-intuitive impact. For instance, the monsoon had a marked early effect in 1998 but almost none so far in 1999; NIDs and Vitamin A weeks were included in the MIS data in 1997 and 1998 and severely distorted the trend; the severe floods had an impact in 1998 but it is not clear whether the net effect was up or down; Ramadan had a marked effect in 1999 but little visible impact in 1998; Project Jolt had a step-change effect in 1999.

For all these reasons, it is not clear where the programme is on the long-term 'S' curve. However, we do know that total contacts have grown at an average rate of 12% per month since start-up and that growth rate has been fairly evenly spread across all ESP components. We cannot expect this growth rate to persist: if it does, we shall either become a quasi-monopoly supplier in urban areas or we shall be converting unmet need to met need at a rate far in excess of market and population growth rates. We can find no rational basis at this point for predicting when the growth rate will start to decline significantly.

In Figure 1, we have indicated our best estimates of the *relative* growth potential for UFHP contacts under each of the indicators listed. These are long-term estimates; in the short-term we expect that our contacts under most ESP components will continue to grow. The long-term estimates take into account our growth to date (the higher it has been, the more positive we are about the future), the national coverage rate (the higher it is, the lower the further growth potential), the specific competition from the retail sector (which we will not resist because it is more sustainable) and specific constraints we face (eg commodity shortages, no further physical expansion of area within City Corporations, local reluctance to allow UFHP to undertake EPI).

*c. EPI coverage*

Figure 2 reflects UFHP’s contribution in NID and Vitamin A week. UFHP will continue strengthening its participation in these special events. EPI services are available in all UFHP static clinics. The frequency of EPI sessions varies widely based on local situations. UFHP’s policy is to encourage NGOs to conduct EPI as frequently as possible on a regular interval.

Of the 5,788 satellite sessions held per month at the end of 1998/99, 37% were with EPI service. This percentage is a function of not only whether EPI is offered but also of the frequency of sessions held at a particular satellite spot. UFHP’s policy is a *minimum* frequency of 2 sessions per spot per month. However, EPI is rarely offered more than once per month at most spots: customers are conditioned to a single “EPI day” each month; if we work with GOB vaccinators, the GOB system only has capacity for service once per month. Therefore the maximum achievable percentage of satellite sessions with EPI is 50%. The actual average number of sessions per spot is 2.8, which drives this percentage lower.

A more accurate indicator of EPI service coverage at satellites would be the percentage of *spots* where EPI is offered at least once per month. UFHP does not collect data by satellite spot. We do know, however, that UFHP does not offer satellite EPI service at all in 26 out of the 67 municipalities we serve (this excludes the City Corporations, where we have almost universal coverage). Those municipalities account for 496 out of the nationwide total of 2069 spots (24%), so UFHP’s maximum EPI coverage on a spot basis is 76%.

*d. Staff turnover*

Staff turnover rates in urban clinics are cyclical and most directly influenced by GOB recruitment campaigns. When GOB opens an active campaign to recruit paramedics or doctors – as it has done 3 times since the UFHP programme started – we lose staff. They are attracted by job security with GOB, not salary. However, Figure 3 shows that the turnover problem is not acute in urban clinics. At least one turnover in each position can be expected in a new programme like this and, by that standard, Counsellor and Doctor turnover rates are very modest: most Counsellors recruited to date are still in place and around 80% of the Doctors are still in place or their positions have turned over just once. Turnover problems are generally very localised and often attributable to peculiarities of the town or the NGO:

**Figure 3**  
**UFHP Staff Turnover Rates Since July 1997**

# times changed	# Clinics Reporting Change of Staff		
	Doctors	Paramedics	Counsellors
0	55	34	59
1	42	28	7
2	12	26	0
>2	14	35	0
	123	123	66

Paramedic positions turn over more frequently but have been exposed to 2 GOB recruitment campaigns to date. Thus far, we have not had many problems filling vacant positions in any cadre. This may possibly change if the GOB community clinic construction programme takes off quickly.

## 2. IR Indicators

There are 34 SO/IR indicators listed in the SOAG. Of these, 10 are uniquely relevant to clinic operations and would rely on UFHP data for monitoring purposes (see Figure 4).

### *a. Quality-related indicators*

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. As the remaining protocols and standards become available and UFHP's use of the revised QAO and NLO checklists with their associated scoring mechanisms takes shape, we shall be better able to monitor compliance with quality indicators – especially the first two listed in Figure 4.

The third indicator in Figure 4 focuses on physical inputs to quality and we can say with some safety that a very high proportion of clinics already meet this standard. If “appropriate” personnel is taken to mean staff satisfying the service delivery model guidelines, almost all clinics are now staffed to proper standard. Similarly, very few clinics can be found now to be lacking essential equipment or supplies. The facilities within which clinics operate are generally the best available in the municipalities they serve. A few are still going to have to move – eg because of persistent flood damage – but the numbers are small.

The fourth indicator addresses customer satisfaction. Both the Org-Marg Quest and the NIBS studies commissioned in 1998/99 suggest a relatively high level of customer satisfaction with UFHP's services. However, we plan to use the indicators developed and tested in those studies to drive our own internal customer satisfaction monitoring programme, which will be part of the ongoing BCC/M monitoring effort.

### *b. BCC-related indicator*

There is one indicator on BCC, which addresses the national BCC strategy. As reported in chapter A above, progress on the national strategy has been slow and lies well outside both UFHP's and BCCP's control in any event.

### *c. Cost recovery indicators*

Figure 1 reflects the good progress we are making on cost recovery. Under the terms of JSI's Cooperative Agreement with USAID, we have undertaken that service delivery operations will contribute over \$1.5 million of cost-sharing during the first 5 years of the 7-year programme. Current cost recovery rates – which rose to almost 15% by the end of the current year – suggest that this target is just achievable.

### *d. Capacity-related indicator*

UFHP clinic staff are now working at around 65-70% capacity. Assuming an average transaction time per contact of 7.5 minutes – ie 8 contacts per hour – and customer flow for around 5.5 hours a day (10-1 and 3:30-5), a static clinic with two service providers can

achieve a maximum of around 90 contacts a day. A satellite clinic can achieve no more than 55-60 (with one service provider, slightly shorter hours but shorter transaction times). Given UFHP's existing number of service providers and average hours worked per year, these assumptions equate to a capacity of around 6.4 million contacts per annum – or 530,000 per month. We reached 339,446 in September 1999, which is equivalent to 65% utilisation.

In practice, as RDU takes hold in UFHP clinics, transaction times will lengthen and reduce contact capacity. If we can spread the customer flow at static clinics more evenly throughout the day, we may be able to increase capacity somewhat to balance this. However, the conclusion after two years is that UFHP's investment in capacity is already being well utilised.

### **3. Long-term Objectives**

UFHP's longest term objective is to ensure that we play a full and valuable part in helping USAID meet its Strategic Objective for Bangladesh by 2004. Our intermediate objectives are tied to the Intermediate Results built into the NIPHP design; we reported on these in section 2 above. Still within the realm of long-term objectives, UFHP has three elements within its own vision for 2002 (see Figure 5):

- To build a strong NGO-based service delivery programme, which will evolve in three stages
  - quality improvement;
  - management strengthening;
  - financial sustainability.
- To develop a close working relationship with GOB and local government institutions which makes best use of our NGO programme as a reliable development partner for GOB. This will evolve in two stages
  - quality improvement;
  - institutional development.
- To forge a closer working relationship with the private sector as a more immediately sustainable channel for delivering the ESP, and which may represent a means of reducing USAID's strategic exposure to NGOs as its only form of development partner in Bangladesh. This will evolve in three ways
  - a closer relationship with Social Marketing Company;
  - a variety of partnerships with various other private sector delivery organisations;
  - development of franchising relationships with existing or new partners.

Our NGO programme is on schedule in terms of meeting its long-term objectives. Quality levels have been raised substantially, although mostly in terms of physical infrastructure and front-line customer service; there is still a way to go with regard to staff diagnostic and prescriptive skills. We are now in transition from a near-total preoccupation with quality to a more mixed focus on managerial capabilities as well. Financial sustainability, as measured by cost recovery, is progressing well.

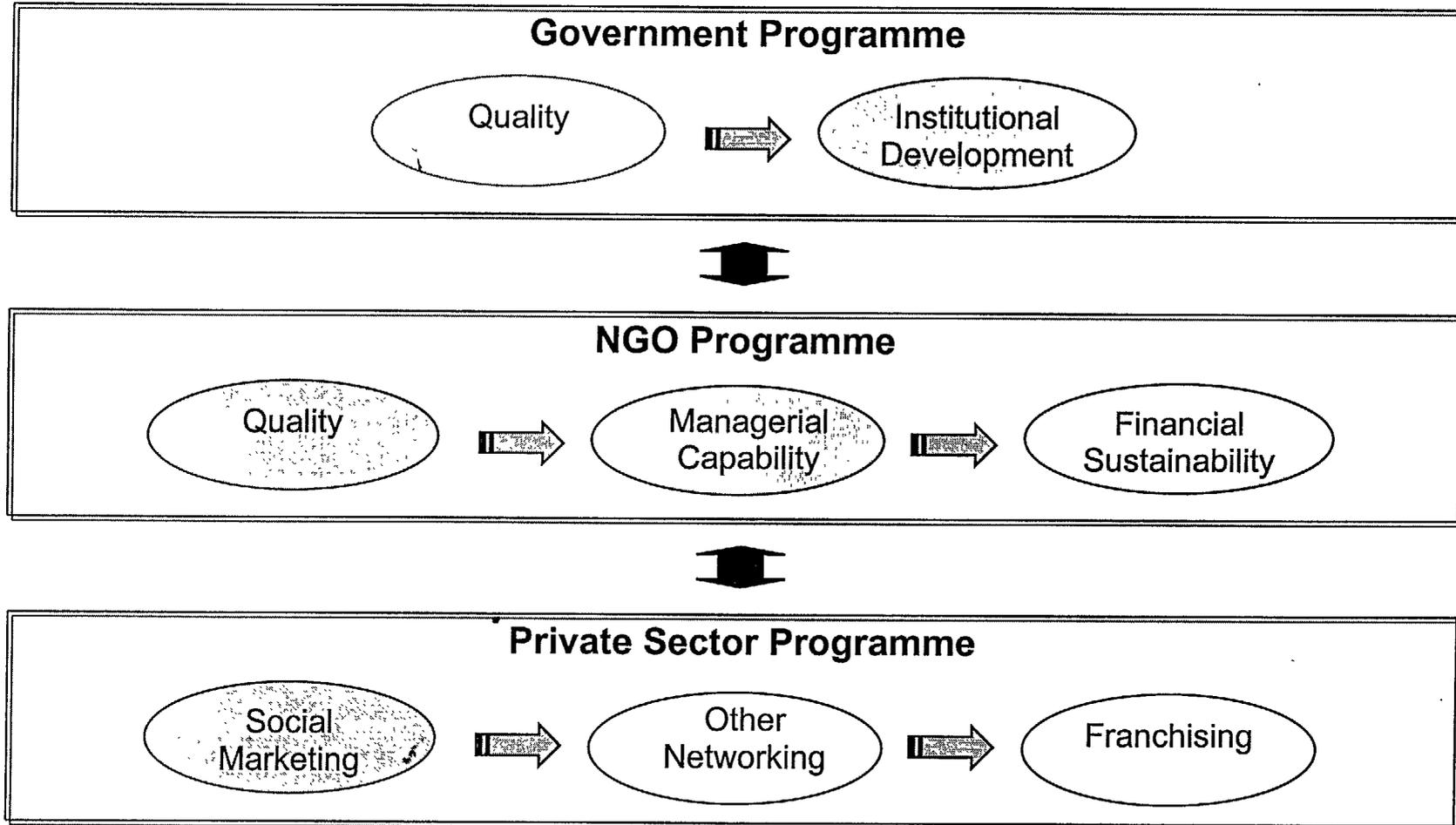
Figure 4

SO/IR Indicators Directly Relevant to UFHP

Relevant SO/IR	Indicator
<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	Percent of service providers in USAID-supported areas complying with standards/protocols (for at least five priority services)
IR3	Percent 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	Percent of aggregate operating costs of USAID-supported NGOs covered by programme-generated revenues
IR5	Percent 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: Strategy Objective Agreement between the government of Bangladesh and the US, 9 May 1997.

Figure 5  
UFHP's Vision for 2002



Our GOB programme has been slower to take off as the speed of the HPSP start-up has been slower than anticipated. We are working closely with GOB on BUSTTHI, have shared GOB training curricula on NSV and are actively involved in trying to improve municipal coordination. We are fully integrated into the GOB supply system for key commodities and networking between GOB and UFHP staff at local level is now routine and valued on both sides. We work together actively on national events. However, most of these initiatives fall under the heading of institutional development; we have had less success to date in allowing GOB to share in the lessons we have learned on quality improvement.

Our private sector programme is scheduled to start last and has, indeed, lagged the other two. Our first initiative to work with SMC, by selling their commodities, fell foul of the 1998 SMC strike/lockout. We re-launched the pilot sales programme in 1999 and have yet to determine whether it is successful for both parties. Our efforts to make UFHP clinics referral centres for SMC injectable customers have been weakened by the slow take-off of the SMC injectable programme. We have a list of possible other private or semi-private sector partners in mind but no programmes have been developed yet. We have investigated clinic franchising both through background research and a study tour to the Philippines and are now poised to conduct a detailed study.

#### **4. Training Conducted**

Figure 6 summarises training conducted in Bangladesh during October 1998 to September 1999 under UFHP auspices. The total number of trainees was around 2,053, including those who underwent formal training and those attending orientation sessions.

**Figure 6**  
**Training Conducted under UFHP Auspices within Bangladesh**  
**October 1998 – September 1999**

<b>Name/Description</b> <i>Training Courses</i>	<b>Length</b>	<b>Date</b>	<b>No of</b> <b>Trainees</b>	<b>Type of Trainees</b>
Clinical Management Training (CMT)	17 days	October 1998 – August 1999	125	UFHP NGO Paramedics, SPs, FWVs
CMT for Physicians	5 days	January 1999	13	UFHP NGO Doctors
Child Survival Intervention Training	12 days	October 1998 – August 1999	155	UFHP NGO Paramedics, SPs, FWVs
Other Reproductive Health (ORH)	10 days	November 1998 – September 1999	242	UFHP NGO Paramedics, SPs, FWVs
Child Survival Intervention	12 days	April – September 1999	106	UFHP NGO Doctors
Other Reproductive Health (ORH)	12 days	April – September 1999	106	UFHP NGO Doctors
NSV Training	8 days	February – August 1999	23	UFHP NGO Doctors
NSV OT Management Training	3 days	February – August 1999	19	UFHP NGO Paramedics
Norplant Training	5 days	November 1998 – June 1999	22	UFHP NGO Doctors
Norplant training	3/5 days	November 1998 – June 1999	22	UFHP Counsellors/Paramedics
BCC/Marketing	4 days	November 1998 – March 1999	328	UFHP NGO SSPs and SPs
IPC/Counselling	5 days	December 1998 – August 1999	54	UFHP NGO Counsellors

**Figure 6 (cont'd)**  
**Training Conducted under UFHP Auspices within Bangladesh**

HIV/AIDS Communication	4 days	August – September 1999	104	UFHP SSPs, SPs, HACs, Counsellors
Child Survival Intervention (CSI)	2 days	January 1999	9	UFHP NGOLOs, QAOs & CDO
Infection Prevention, Counseling & FP	2 days	January 1999	9	UFHP NGOLOs, QAOs & CDO
Other Reproductive Health	2 days	January 1999	9	UFHP NGOLOs, QAOs & CDO
Rational Drug Use (RDU)	2 days	January – February 1999	4	UFHP NGOLO, NGO Doctors
Advances in Family Health and Social Communication Workshop 1999	12 days	February 1999	29	UFHP NGO SSP, GOB and Private sector participants
TOT Adolescent Health	4 days	April 1999	9	UFHP Partners' staff
Training on Adolescent Health	4 days	April – May 1999 SSPs and Counsellors	64	UFHP NGO Doctors, Parmedics
Training on Writing Style	1 day	January 1999	20	UFHP professional staff
Structured Communication	2 days	October - November 1998	18	UFHP staff and UFHP partners' staff
Power Point Training	2 days	November 1998	21	UFHP staff

**Figure 6 (cont'd)**  
**Training Conducted under UFHP Auspices within Bangladesh**

*Orientation Courses*

Orientation on Facilitation Skills	1 day	January – February 1999	48	UFHP Professionals, UFHP Project Directors
Team Building and Partnership Workshop	1 day	February – June 1999	86	UFHP Professional, UFHP Project Directors and NGO Leaders
Team Building and Motivation Workshop	2 days	January – March 1999	60	Four FPAB Clinics staff
Message Development Workshop	6 days	June 1999	28	UFHP NGO SSPs, GOB, private Sector and other donor participants
Regional NGO Dissemination Workshop	3 days	July – August 1999	320	UFHP PDs, NGO Leaders, MOs, DOs FAMs, Counselors, SSPs, UFHP Professional

**Legend**

- NGOLO : NGO Liaison Officer
- QAO : Quality Assurance Officer
- CDO : Clinic Development Officer
- SSP : Senior Service Promoter
- SP : Service Promoter
- HAC : HIV/AIDS Counsellor

## 5. Publications Produced

We have produced 15 documents for publication within the UFHP network or further afield during the past year. These are listed in Figure 7.

**Figure 7**  
**Publications Produced During 1998/99**

<b>Document</b>	<b>Date</b>
UFHP 1998/99 Annual Work Plan	October 1998
UFHP 1997/98 Annual Report	November 1998
IPC/Counselling Training	November 1998
BCC and Marketing Course	November 1999
Achieving a Common UFHP Writing Style – Course Notes	January 1999
Achieving a Common UFHP Writing Style – Exercise Booklet	January 1999
Facilitation Skills – Presentation to UFHP NGO Project Directors	January 1999
Team and Partnership Development – Facilitator’s Resource Book	February 1999
UFHP Semi-annual Report to USAID	April 1999
Improving Coordination of Family Health Services in Urban Areas – Progress Report by the MCIG	May 1999
Adolescent Health Programme	May 1999
Guideline for QA Visits to UFHP NGOs 1999/2000	May 1999
NGO Liaison Officers’ Revised Checklist for NGO Management Visits	June 1999
HIV/AIDS Communication and Counselling	August 1999
UFHP BCC/Marketing Strategy 1999-2002	September 1999

### **C. Recent Customer Feedback**

From routine customer surveys by clinic staff and ad hoc contacts by NGO Liaison Officers and other UFHP staff, 4 messages are coming currently from customers:

- They want delivery services. This message has become louder and clearer as the year progressed. Customers feel there is a shortage of safe and cost-effective delivery services in urban areas. They appreciate the quality and professionalism of UFHP's ANC service; they are then forced to seek help with delivery elsewhere and know they are unlikely to get the same level of quality or the same value for money. UFHP also has resultant difficulty in motivating customers to use the less popular PNC service once the relationship is broken in this way.
- They want drug supply at satellite clinics especially. This is mostly a feature of rural municipalities where satellites are often far from the centre of town and/or the town is small. Drug supply is therefore less accessible. Most UFHP clinics have RDFs up and running but progress remains slowest at satellites, where staff already have to carry large amounts of equipment and supplies.
- They will pay for quality. As UFHP's questioning has become more sophisticated, so the apparent demand for 'free service' has been replaced by a more qualified response. Customers are beginning to recognise quality in our clinics – staff are on hand, the clinics are clean and well-presented, drugs are available; against that standard, they more readily acknowledge that prices are reasonable. Furthermore, we have received two formal customer surveys during the year (NIBS and OMQ) which send the same message on pricing: it is not a question of giving free service, which is often interpreted to mean inferior service; rather, it is a question of what the customer gets for that service.
- Generic drug names on prescriptions are not appreciated. Many customers report problems in having UFHP prescriptions filled outside UFHP clinics if generic names are used. Pharmacies often do not understand the generic name, there is confusion and irritated customers return to the clinic for the trade name. There is the clear possibility that many other prescriptions (which we do not hear about) are not filled accurately or at all. The solution lies partly in increasing the proportion of UFHP prescriptions filled at UFHP clinics – and we are working to achieve this. But the whole prescription philosophy may need to be re-examined.

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

UFHP has a good working relationship with GOB both at the centre and in the field. Our relationship with DGFP and his staff has strengthened markedly in recent months; we are working to replicate this growth among DGHS leadership and staff, although the change of incumbent DG Health will slow this process again. We also now have good working relationships with the Secretary of Health and the State Minister of Health by virtue of the HIV/AIDS study tour to Africa. Most NGOs – represented by project directors, doctors and SSPs – now give high priority to field-level relationships. The only irritation to this relationship remains commodity supplies: UFHP NGOs are often denied access to EPI vaccines; injectables remain in short supply everywhere.

Amongst UFHP's many ongoing areas of collaboration with GOB, we can identify 4 current priority activities:

- BUSTTHI – The project is now under way and we are beginning to see regular service from the satellite teams in the designated slums of Dhaka.
- Urban TB programme – Chittagong has been selected as the pilot site but UFHP is still awaiting confirmation of dates and arrangements for training to commence.
- HIV/AIDS strategy – During the current year, UFHP has moved to the forefront of the national HIV/AIDS programme; it is largely an urban issue and UFHP is the largest player in urban areas nationwide. We are working closely with GOB and BCCP on implementation of the national HIV/AIDS strategy. We helped to fund BCC materials used by the GOB programme on National AIDS Day 1998 and participated actively in local events organised by GOB as part of the National AIDS Day programme. We have helped alert senior GOB leaders to lessons to be learned from African countries wrestling with the AIDS pandemic. We have launched our own HIV/AIDS programme in 27 sites which is now starting to work in concert with local GOB structures.
- Injectable buffer stock – Injectable contraceptives are continually in short supply throughout the country; there are frequent stock-outs. DGFP staff have now kindly made available buffer stocks of up to 60,000 pieces on a one-off basis, which is being collected progressively by different clinics across the country.

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

There are six issues that UFHP still considers to be strategic after two years' experience of the programme that affect in some fundamental way of our potential for development and success in the following years of the programme.

- NGO Affairs Bureau's Approval – UFHP supported NGOs are registered with the NGO Affairs Bureau. But the NGO Affairs Bureau is asking for budget clearance from NGOs. We are in discussion with USAID on this issue and expect to find a resolution during 1999/2000.
- FP and Health Commodities/Institutional Reimbursement for Sterilisation Services – UFHP will continue be relying on MOHFW for all oral contraceptives, condoms, injectables, Norplant, IUDs, ORS sachets, EPI vaccines and Vitamin A capsules. All these commodities are essential to the success of UFHP's programme in particular and national programme in general. In addition, UFHP has already introduced NSV in selected clinics and has plans to expand NSV to additional clinics and introduce tubectomy in selected clinics. We anticipate supplies will be without interruption. Moreover, GOB will continue providing its reimbursement package for successful implementation of our sterilisation programme.
- The Grand Experiment – HPSP under the national programme has started from July 1998. However, the implementation status of HPSP is still in embryonic stage. As a result, switch over from doorstep service delivery to clinics in the context of NIPHP is still a strategic issue. There is still inadequate data to lead to any firm conclusion. This issue

will become easier to resolve over the coming years with the comprehensive implementation of HPSP and when full data becomes available through DHS.

- ESP pricing Policies – UFHP is charging for ESP services it offers to its customers and yet has no basis on which to promulgate a formal ESP pricing. However, UFHP is conducting a study on pricing to have a uniform policy for its NGOs. The existing problem will be resolved, as GOB has initiated pricing for ESP services. However, the steady and slow implementation of HPSP is affecting NIPHP ESP pricing. In case of EPI, UFHP has in most cases resolved the issue at the local level but GOB has to finalise its pricing policy in the context of its stated policy in terms of cost recovery.
- CD/VAT – Under the terms of the SOAG between the government of Bangladesh and the US, the MOHFW will arrange for payment of any customs duty and VAT obligations incurred by UFHP in the course of its programme. We hope USAID will provide continued efforts for CD/VAT payment for capital purchase made by UFHP.
- TV and Radio Airtime – Under the terms of SOAG, MOHFW will arrange provision of free television and radio airtime for UFHP’s BCC messages. Though the Ministry has agreed to secure the initial allocations of the airtime, however, we hope USAID’s efforts will help us to start availing of this resource on a regular basis.



**Appendix A**

**UFHP Clinic Performance Data, September 1999**

## Monthly Performance September 1999

ESP Components		Static Clinic	Satellite	Total	
<b>A. Child Health Contacts</b>		<b>36,703</b>	<b>51,299</b>	<b>88,002</b>	
Immunisation	Age: 0-11 Months	BCG	2,543	2,431	4,974
		DPT/Polio 1	2,986	2,945	5,931
		DPT/Polio 2	2,665	2,667	5,332
		DPT/Polio 3	2,415	2,156	4,571
		Polio 4	2,387	3,711	6,098
		Measles	2,362	2,560	4,922
	Age: 12+ Months	BCG	14	29	43
		DPT/Polio 1	16	44	60
		DPT/Polio 2	3	34	37
		DPT/Polio 3	4	35	39
		Polio 4	207	5,918	6,125
		Measles	147	2,438	2,585
	Sub Total		<b>15,749</b>	<b>24,968</b>	<b>40,717</b>
	Vitamin A	Age: 0-11 Months	2,310	2,530	4,840
Age: 12 + Months		758	1,006	1,764	
Sub Total		<b>3,068</b>	<b>3,536</b>	<b>6,604</b>	
CDD	Diarrhoea	No dehydration	4,656	6,395	11,051
		Some dehydration	1,578	2,437	4,015
		Dysentery	1,339	2,501	3,840
	Sub Total		<b>7,573</b>	<b>11,333</b>	<b>18,906</b>
ARI	Common Cold		6,973	8,518	15,491
		Pneumonia	1,393	1,082	2,475
	Sub Total		<b>8,366</b>	<b>9,600</b>	<b>17,966</b>
Disease Surveillance	AFP	-	3	3	
	NNT	1	5	6	
	Sub Total	<b>1</b>	<b>8</b>	<b>9</b>	
Referral		43	80	123	
Counselling only		1,903	1,774	3,677	
<b>B. Reproductive Health Contacts</b>		<b>72,930</b>	<b>120,993</b>	<b>193,923</b>	
ANC	1		6,110	7,830	13,940
			3,743	4,042	7,785
			2,683	1,600	4,283
		Referral	177	594	771
	Sub Total		<b>12,713</b>	<b>14,066</b>	<b>26,779</b>
TT	Pregnant	Pregnant - 1	2,445	2,410	4,855
		Pregnant - 2	2,148	1,767	3,915
		Pregnant - 3	756	831	1,587
		Pregnant - 4	256	206	462
		Pregnant - 5	119	165	284
	Non-Pregnant	Non-Pregnant - 1	2,010	6,219	8,229
		Non-Pregnant - 2	1,992	3,333	5,325
		Non-Pregnant - 3	764	3,093	3,857
		Non-Pregnant - 4	223	731	954
		Non-Pregnant - 5	134	277	411
Sub Total		<b>10,847</b>	<b>19,032</b>	<b>29,879</b>	
PNC	1st Visit	(registered)	1,498	2,398	3,896
		(non-registered)	254	576	830
		Re-Visit	323	474	797
	Sub Total		<b>2,075</b>	<b>3,448</b>	<b>5,523</b>
Delivery	Performed		-	-	-
		Referred	52	122	174
	Sub Total		<b>52</b>	<b>122</b>	<b>174</b>

**Monthly Performance**  
September 1999

ESP Components		Static Clinic	Satellite	Total
<b>Family Planning Service Contacts</b>		<b>30,011</b>	<b>63,136</b>	<b>93,147</b>
<b>Family Planning</b>	Pills	9,032	27,773	36,805
	Condom	4,920	11,359	16,279
	Injectable (2m)	19	25	44
	Injectable (3m)	12,073	18,667	30,740
	IUD (insert)	405	17	422
	IUD (removal)	151	8	159
	IUD (follow-up)	270	12	282
	Norplant (insert)	326	-	326
	Norplant (removal)	52	4	56
	Norplant (follow-up)	280	15	295
	Vasectomy	138	-	138
	Vasectomy (follow-up)	113	-	113
	Tubectomy	51	1	52
	Tubectomy (follow-up)	36	8	44
	<b>Sub Total</b>		<b>27,866</b>	<b>57,889</b>
<b>Referrals issued</b>	Injectable	13	103	116
	IUD	9	100	109
	Norplant	34	34	68
	Sterilisation	9	25	34
<b>Sub Total</b>		<b>65</b>	<b>262</b>	<b>327</b>
<b>Contraceptive Side Effects</b>	Pill	671	1,931	2,602
	Injectables	1,096	2,641	3,737
	IUD	223	279	502
	Norplant	69	83	152
	Sterilisation	21	51	72
<b>Sub Total</b>		<b>2,080</b>	<b>4,985</b>	<b>7,065</b>
<b>RTIs/STDs</b>	Female - VD	8,909	13,385	22,294
	Female - CD/LAP	3,398	3,565	6,963
	Female - GU/IB	157	102	259
	Female - ANC Syphilis	84	28	112
	Male - GU/IB	636	254	890
	Male - UD/SS	670	444	1,114
<b>Sub Total</b>		<b>13,854</b>	<b>17,778</b>	<b>31,632</b>
<b>Counselling Only</b>		3,378	3,411	6,789
<b>C. Communicable Disease Contacts</b>		<b>541</b>	<b>983</b>	<b>1,524</b>
	TB	32	31	63
	Malaria	505	728	1,233
	HIV/AIDS	4	224	228
<b>D. Limited Curative Care Contacts</b>		<b>23,114</b>	<b>31,128</b>	<b>54,242</b>
	Helminthiasis	2,317	3,388	5,705
	Anaemia	2,555	4,157	6,712
	Menstruation Problem	2,442	3,000	5,442
	ENT	803	777	1,580
	Skin Problem	2,208	2,645	4,853
	First Aid	385	308	693
	Others	12,404	16,853	29,257
<b>E. Lab.Test only</b>		1,708	47	1,755
<b>F. Total Contacts by Services</b>		<b>134,996</b>	<b>204,450</b>	<b>339,446</b>

ESP Components		Static Clinic	Satellite	Total
<b>G. Contacts by age and sex</b>		<b>134,996</b>	<b>204,450</b>	<b>339,446</b>
<5 yrs	Male	16,468	21,409	37,877
	Female	14,930	20,854	35,784
5-8 yrs	Male	2,649	3,320	5,969
	Female	2,438	4,814	7,252
9-14 yrs	Male	1,707	2,004	3,711
	Female	3,792	6,861	10,653
15-19 yrs	Male	2,234	2,675	4,909
	Female	14,896	21,448	36,344
20-49 yrs	Male	6,151	6,463	12,614
	Female	63,482	103,889	167,371
50 + yrs	Male	2,133	2,731	4,864
	Female	4,116	7,982	12,098
<b>H. Commodities Received from ...</b>		<b>-</b>	<b>-</b>	<b>-</b>
Pill (Cycle)	SMC	2,391	-	2,391
	GoB	49,684	-	49,684
	Other	3,247	-	3,247
Total		55,322	-	55,322
Condom (Piece)	SMC	2,001	-	2,001
	GoB	230,909	-	230,909
	Other	-	-	-
Total		232,910	-	232,910
Injectable (amp/vial)	Opening stock b/f	23,981	-	23,981
	Received from supplier	30,238	-	30,238
	Used	12,092	18,692	30,784
	Closing stock c/f	23,435	-	23,435
IUD (Piece)	Opening stock b/f	1,519	-	1,519
	Received from supplier	380	-	380
	Used	385	13	398
	Closing stock c/f	1,501	-	1,501
Implants (set)		230	-	230
<b>I. Community Group Meetings</b>		<b>1,279</b>	<b>3,603</b>	<b>4,882</b>
Child Health	Meetings	126	281	407
	Participants	1,910	3,633	5,543
IUDs	Meetings	70	267	337
	Participants	781	3,356	4,137
Injectables	Meetings	83	388	471
	Participants	1,204	4,654	5,858
NSV	Meetings	71	40	111
	Participants	330	423	753
Norplant	Meetings	21	64	85
	Participants	463	762	1,225
Male Involv.	Meetings	33	19	52
	Participants	503	230	733
Others	Meetings	181	276	457
	Participants	2,326	4,054	6,380
ANC/PNC	Meetings	105	358	463
	Participants	1,366	4,050	5,416
Newly Weds	Meetings	32	184	216
	Participants	374	1,678	2,052
Adolescents	Meetings	110	317	427
	Participants	1,845	4,215	6,060
HIVAIDS	Meetings	111	392	503
	Participants	1,537	4,172	5,709
Others	Meetings	336	1,017	1,353
	Participants	5,325	13,382	18,707

**Appendix C**

**Administrative Actions in 1998/1999**

## 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>		
Pijush Kumar Biswas	AID Rules and Regulation, India	March 1999
<i>CWFP Staff</i>		
Mubarra Matin	Planning and MIS training, USA	July 1999
<i>PSTC Staff</i>		
None		

## 2. International Travel

Traveller	Purpose	Date
<i>UFHP Staff</i>		
Nikhil Kumar Datta	JSI Orientation – Boston	November 1998
	AID Rules and Regulation, India	March 1999
Peter Connell	HIV/AIDS Study Tour, South Africa (Zimbabwe/Uganda)	August 1999
Hashina Begum	HIV/AIDS Workshop, USA	September 1999
Shamsun Nahar Ahmed	Strategic Planning Workshop, USA	September 1999
<i>UFHP-funded NGO staff</i>		
None		
<i>JSI Home Office Staff</i>		
Amy Cullum	Assist with setting up financial systems/ Garments worker's study/NGO Audit	April 1999
Sarah Littlefield	PFA Study	June 1999
Ellen Blair	Consultant – PFA Study	June 1999
Claudia Morrissey	TA to UFHP programme issues	June 1999
Joel Lamstein	To see UFHP Programme	November 1998
<i>BCCP/JHU Staff</i>		
Bob Karam	Consultant – strategic planning	November 1998 Jan/Feb 1999
Esta de Fossard	Consultant – design document workshop	May 1999
Mohammad Shahjahan	Pop and environment education, Philippines	December 1998
	BCCP Executive Board mtg, USA	January 1999
	Innovation of dev communication, India	March 1999
Jalal Ahmed	Advances Workshop, USA	June/July 1999
<i>CWFD Staff</i>		
None		
<i>PSTC Staff</i>		
Noor Mohammad	Youth Workshop, USA	May 1999
<i>Other (GOB official)</i>		
Major General Matiur Rahman	HIV/AIDS Study Tour, South Africa (Zimbabwe/Uganda)	August 1999
M M Reza	HIV/AIDS Study Tour, South Africa (Zimbabwe/Uganda)	August 1999
Prof Dr M Amanullah	HIV/AIDS Study Tour, South Africa (Zimbabwe/Uganda)	August 1999