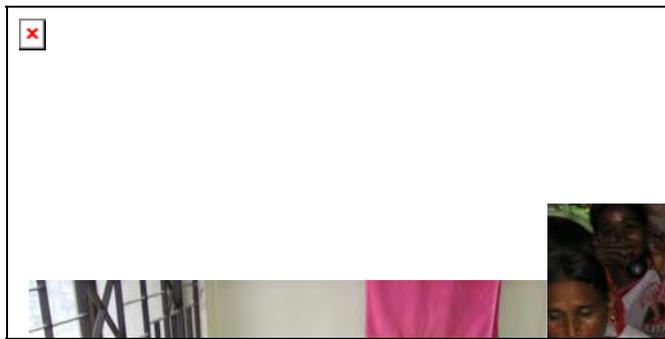




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# NGO Service Delivery Program Final Report



December 2007

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## **The NSDP NGOs**

BAMANEH

Bandhan

CWFD

CRC

DIPSHIKHA ANIRBAN

Fair Foundation

FDSR

IMAGE

JTS

Kanchan Samity

KAJUS

MALANCHA SEBA

MMKS

NISHKRITI

PKS

Proshanti

PSTC

PSF

PSKS

SGS

SHIMANTIK

SOPIRET

SSKS

SUPPS

SUS

Swanirvar

TILOTTAMA

UPGMS

VFWA

VPKA



## List of Acronyms

ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
BAMANEH	Bangladesh Association for Maternal and Neonatal Health
BCCP	Bangladesh Center for Communication Programs
BMS	Bangladesh Mohila Shangha
C-IMCI	Community Integrated Management of Childhood Illness
CR	Cost recovery
CWFD	Concerned Women for Family Development
CYP	Couple Year Protection
DGFP	Director General of Family Planning
DGHS	Director General of Health Services
DH	Depot holder
DOTS	Directly Observed Treatment Short course
DPT	Diphtheria, Pertussis, Tetanus
DSF	Demand Side Financing
EC	Executive Committee
EPI	Expanded Program on Immunization
ESD	Essential Service Delivery
FDSR	Family Development Services and Research
FP	Family Planning
GIS	Geographical Information System
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HR	Human Resource
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IMCI	Integrated Management of Childhood Illness
IPC	Interpersonal Communication
IUD	Intra Uterine Device
JTS	Jatiya Tarun Shangha
KAJUS	Kalikapur Juba Shangsad
M&E	Monitoring and Evaluation
MIS	Management Information System
MMKS	Madaripur Mohila Kallyan Sangstha
MOCAT	Modified Organizational Capacity Assessment Tool

MOHFW	Ministry of Health and Family Welfare
NIPHP	National Integrated Population and Health Program
NSV	Non-Scalpel Vasectomy
PAC	Post Abortion Care
PD	Project Director
PKS	Paribar Kallyan Samity
PLTM	Permanent and Long Term Method
PM	Project Manager
PNGO	Partner NGO
POT	Program Operations Team
PRA	Participatory Rapid Appraisal
PSF	Polli Shishu Foundation
PSTC	Population Services and Training Centre
QI	Quality Improvement
QMIS	Quality Management Information System
QMS	Quality Monitoring and Supervision
RDF	Revolving Drug Fund
RTI	Research Triangle Institute
STI	Sexually Transmitted Infection
SUS	Samannita Unnayan Sangstha
TB	Tuberculosis
UNICEF	United Nations Children Fund
UPHCP	Urban Primary Health Care Program
URC	University Research Corporation
USAID	United States Agency for International Development



## INTRODUCTION: ENABLING NGOS, CREATING HEALTHY COMMUNITIES, SERVING THE POOR

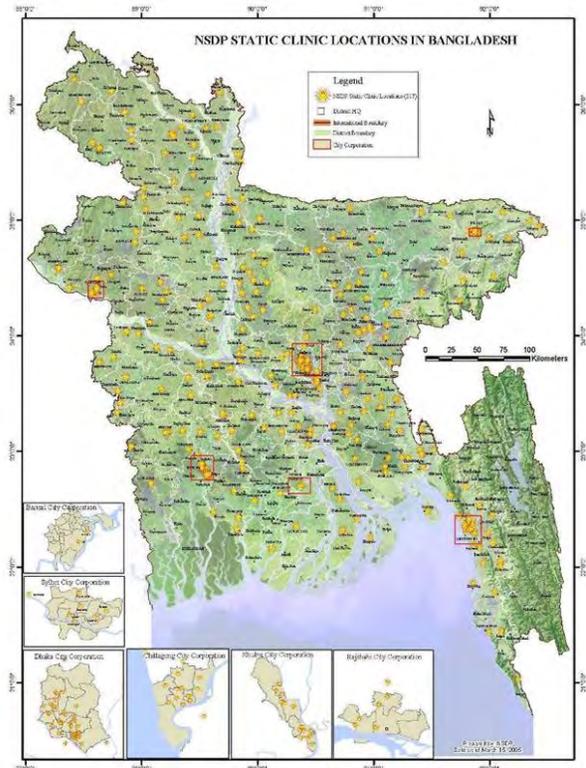
NSDP has been managed by Pathfinder International with the technical assistance of the Bangladesh Center for Communication Programs, CARE Bangladesh, Emerging Markets Group, IntraHealth International, Research Triangle Institute, Save the Children USA, and University Research Corporation. The Smiling Sun network of NGOs and clinics have served about 14 percent of Bangladesh's population, urban and rural, in 61 of 64 districts. The network includes 30 NGOs, 319 static clinics, about 8,000 satellite clinics, 5,000 staff, and 6,000 community workers called depot holders.

Smiling Sun clinics deliver the government's package of essential services. Family planning short-term methods are available at all clinics, as are IUDs, but other long-term and permanent methods are available at selected sites. IMCI is at every static clinic and community IMCI is at every rural clinic as well. Antenatal and postnatal care are available at all 319 clinics. Safe delivery services and EmOC have been introduced at selected urban clinics. NSDP works with the National TB Program in 56 urban Smiling Sun clinics today.

Providers at Smiling Sun clinics almost uniformly demonstrate they have the knowledge and skills to provide services to standard. External validation of self-monitoring has revealed NGOs' accuracy in reporting quality of care to NSDP.

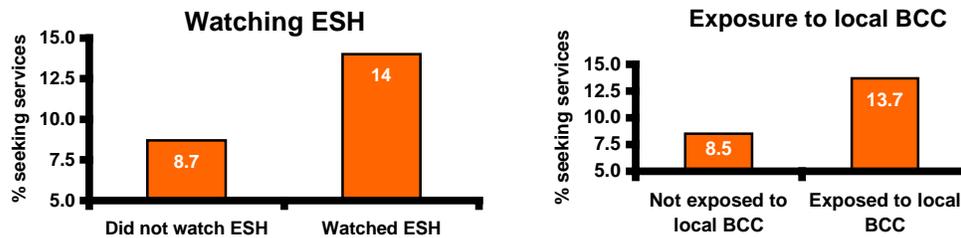
Smiling Sun clinics operate in underserved urban and rural areas where the least advantaged of the population dwell, in urban slums and hard-to-reach areas. The 2005 MEASURE survey funded by USAID showed that NSDP's catchment areas are considerably poorer than adjacent ones, and a majority of the very poor who receive health care in NSDP's catchment areas are customers of NSDP facilities. In urban areas, NSDP has maintained regular communications and coordination with the City Corporation Health Departments (CCHD), the Urban Primary Health Care Program (UPHCP), and all government and NGO stakeholders through round tables and other coordination mechanisms.

Over the life of NSDP, more and more customers used Smiling Sun services. Last year, there were 22 million customer contacts at Smiling Sun clinics, which accounted for 28 million service contacts. There were 10 million customer visits for family planning, which account for 1 million Couple Years of Protection. National childhood immunization coverage has increased significantly

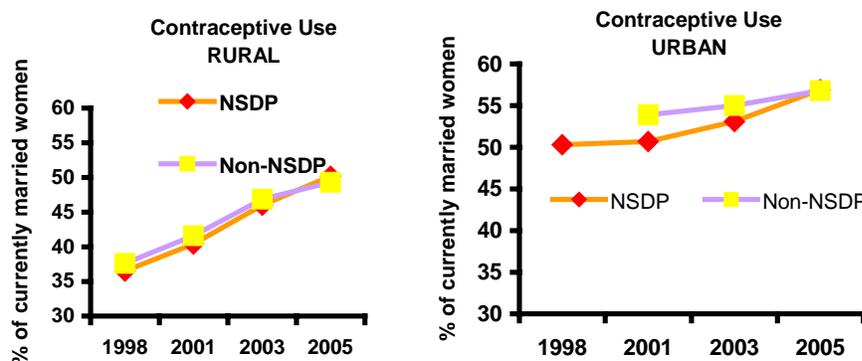


in the past few years and it did so in NSDP catchment areas as well. Smiling Sun clinics provided 3.5 million childhood immunizations last year.

Increasing customer volume these past 5 years could not have been accomplished without a comprehensive BCC and marketing program. A survey conducted by Mitra and Associates confirmed that our mass media and local BCC efforts have led to improved health seeking behaviors in our catchment areas. In addition, families living outside our catchment areas who watched *Enechhi Surjer Hashi* (“Bringing the Smiling Sun”) were also more likely to seek health care where available.



Contraceptive use at Smiling Sun clinics has increased over the past 5 years in both rural and urban areas as the 2005 MEASURE survey shows. However, increases come from short-term methods, especially oral contraceptives and injectables. Permanent and long-term method use has diminished in our areas. To curtail the decrease in the use of these methods, NSDP mounted a BCC and marketing campaign, and extensive counseling training. Preliminary results show modest increases in permanent and long-term method use. Collaboration with the government and EngenderHealth has also contributed to these gains. When NSDP’s clinics experienced stockouts and shortages of contraceptive supplies in the past year, SMC supplied and distributed 300,000 vials of Depo Provera.



Although NSDP’s catchment areas are more disadvantaged than surrounding ones, we are keeping pace with fertility declines in adjacent areas. Access to childhood immunizations is over 90 percent in Smiling Sun catchment areas and full childhood immunization coverage has climbed significantly. In rural catchment areas, full childhood immunization reached almost 70 percent in 2005 and 84 percent in urban ones. The Bangladesh Demographic and Health Survey of 2004

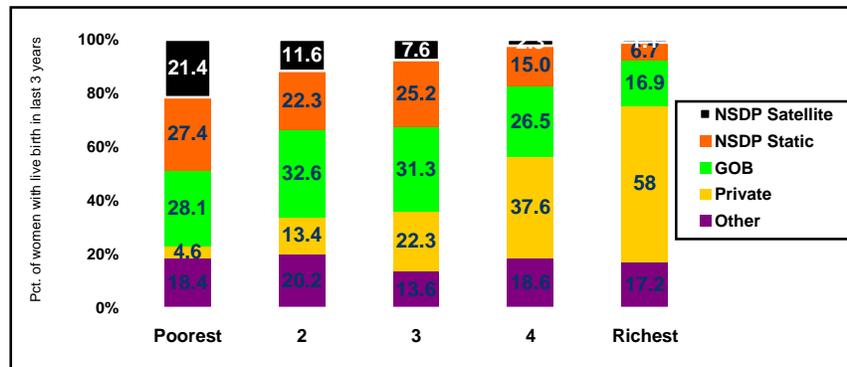


reported the national average as 73 percent. Among other major procurements in the past year, NSDP used clinic revenues to purchase 100 Ice-Lined Refrigerators for Smiling Sun clinics.

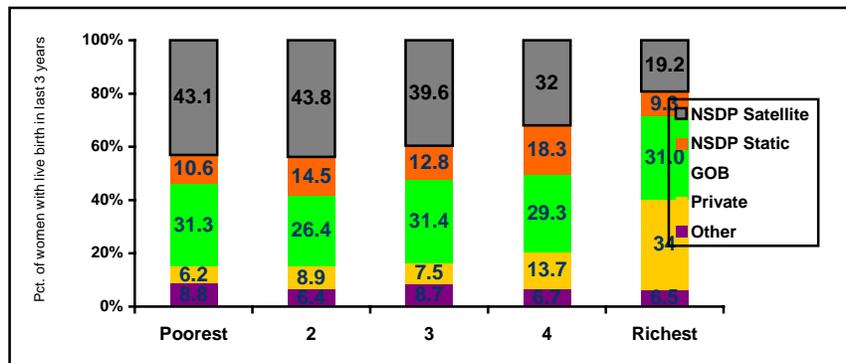
In both rural and urban areas, our NGOs' more disadvantaged catchment areas have had higher infant mortality rates in the past. Today, infant mortality rates are lower than in adjacent communities. Antenatal visits to Smiling Sun clinics have increased but the percentage of pregnant women making 3 or more antenatal visits is not increasing as fast as predicted. In Bangladesh, maternal mortality remains relatively high and neonatal deaths account for more than half of infant deaths.

NSDP's NGO clinics attract the poorest and the poor to their antenatal services. The poorer the family, the greater the likelihood of selecting Smiling Sun clinics or government clinics for antenatal care. Although the number of antenatal visits has increased and the poor choose Smiling Sun clinics for antenatal care, visits are still disproportionately low for poorer pregnant women. NSDP has introduced free health benefit cards to encourage the poorest families to attend Smiling Sun clinics for such essential services.

Antenatal Care Sources (previous 3 years): Market Share by Socioeconomic Group, Urban NSDP Areas



Antenatal Care Sources (previous 3 years): Market Share by Socioeconomic Group, Rural NSDP Areas



Socioeconomic status is not a predictor of family planning use. Whether poor or not, Bangladeshi families use contraception. In rural areas the poor choose NSDP or government and other NGO



clinics for family planning services, whereas the wealthier choose private practitioners. The relationship between socioeconomic status and choice of provider is even more pronounced in urban areas. The poorest and poorer families turn to Smiling Sun clinics or government and other NGOs' clinics for family planning services. The wealthy visit private practitioners.

The number of poor customers per clinic per day increased from 41 in the last fiscal year to 62 this year. While serving the poor who cannot afford to pay for services, NGOs have endeavored to cover their costs from paying customers such that customers who pay actually subsidize those who cannot afford to pay. At present, on average, NSDP's NGOs only recover 20 percent of their costs. Some urban comprehensive clinics recover as much as 80 percent, but small rural clinics only providing the essential services in very poor communities struggle to achieve higher cost recovery. The poorest cannot afford to pay, and customers who can sometimes only make partial payments for services priced well below the market and subsidized by USAID grants.

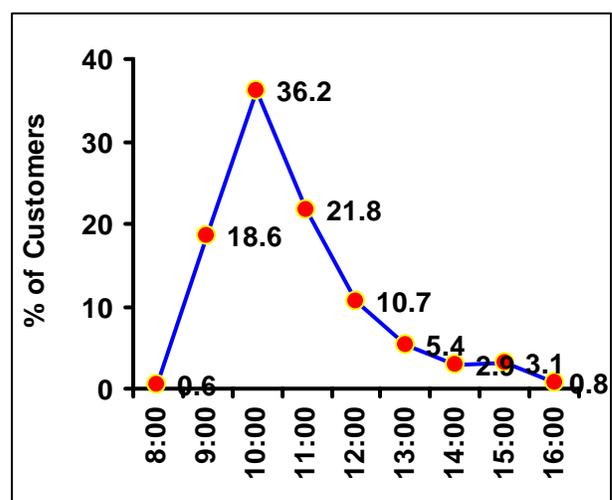
To continue serving the poorest of the poor, NGOs must become less dependent on donor funding, in particular funding from USAID. Costs recovered from user fees must increase dramatically in the immediate future. NSDP piloted a performance-based reimbursement scheme in 2005 and rolled it out in 2006 based on favorable pilot results. Results reveal that the scheme increases revenues and the number of poorest of the poor served. Clinics are being reimbursed for serving the poorest who are unable to pay, and NGO management and providers are receiving bonuses when they achieve such results.

While increasing customer volume and revenues, costs can also be curtailed. NSDP's costing study and Cost and Revenue model has made it possible to estimate the resources required to implement any program operations scenario. Smiling Sun providers are underutilized during much of the workday and spend time on tasks other than service delivery. Generally, about one-third of the day is spent seeing clients, while two-thirds of the day is spent on various administrative related tasks, normal daily breaks, or waiting for clients.

Clients prefer to visit clinics in the later morning hours each day. 58% of clients visit between 11:00 am and 1:00 pm. However, off-peak hours present an opportunity to be innovative by offering incentives, such as discounted service charges, to customers during off-peak hours. About 75% of urban clients and 80% of rural clients expressed willingness to visit clinics during off-peak hours.

Corporate sponsorship of health programs for the underprivileged and underserved is taking root in Bangladesh. Chevron funds 2 SSKS Smiling Sun clinics in the Sylhet region and is building 2 new clinics to expand coverage to more communities near the gas fields. BATB purchases health benefit cards for farmers and their families to

ensure they are provided basic health care. Standard Chartered Bank and Reckitt Benckiser have



financed airtime to market maternal care at Smiling Sun clinics and male involvement. Reckitt Benckiser also funded production of 10,000 posters.

In June this year, GrameenPhone's CSR program began its sponsorship of safe motherhood and infant care at Smiling Sun clinics. GrameenPhone's initiative is a nationwide project in the health sector representing the beginning of a long-term CSR strategy—a public-private partnership designed to utilize NSDP's existing infrastructure and expand it in the coastal region to further meet the needs of the poorest families in Bangladesh.

Recently, NSDP expanded services at many of its clinics to meet the needs of the communities and increase income from user fees. These new services include safe delivery, emergency obstetric care, ambulance services, ultrasonogram, laboratories, pharmacies, health care marts, and contracting specialists. Preliminary results show that the new services are increasing revenues, especially emergency obstetric care.

In Bangladesh, TB is one of the leading causes of death among adults. One person falls ill to the disease every 2 minutes while one person dies of TB every 10 minutes. Bangladesh ranks 6th among the world's 22 high-burden TB countries. Based on current estimates, 320,000 new TB cases and 70,000 TB-related deaths occur annually in Bangladesh. Since 2003, NSDP has worked with the National TB Program to expand screening and treatment. Last year, our clinics treated 3,930 cases and had an 88% treatment success rate the year before.

Any accomplishments of NSDP's 5 years would not have been possible without the support and cooperation of the government. The government donates contraceptives, vaccines, TB drugs, ORS, clinical training, and policy direction. Our NGOs collaborate with DGFP field offices nationwide.

Among other reports, NSDP published the following monographs, which were distributed during NSDP's Conference 2007 on May 23, 2007 at the Bangladesh-China Friendship Conference Centre.

#### Monographs

1. *Increasing Use of Health Services through Mass Media and Local Behavior Change Communication Campaigns*
  2. *Improving Child Health Through Community Involvement*
  3. *The Cost Efficiency of Health Care Services Provided by Smiling Sun Clinics*
  4. *Decreasing Maternal Mortality and Morbidity through Safe Delivery and the NSDP Home-based Delivery Initiative*
  5. *Improving Clinic Sustainability through Performance-based Reimbursement*
  6. *The Impact of Quality Monitoring and Supervision on NSDP Services*
  7. *Service Expansion: Adding New Services to Increase Sustainability*
8. *Private-Sector Collaboration: Diversifying NGO Funding While Serving the Poor*



**OBJECTIVE 1: EXPAND THE RANGE AND IMPROVE THE QUALITY OF THE ESSENTIAL SERVICES PACKAGE (ESP) PROVIDED BY NGOS AT THE CLINIC AND COMMUNITY LEVELS**

**1. Maternal Health**

Safe delivery expanded from 6 to 28 Smiling Sun clinics during NSDP, including facilities for caesarean sections (EmOC) in 20 of them. Service delivery guidelines were prepared on safe delivery, EmOC, and ultrasonogram services. NSDP advised NGOs with comprehensive EmOC services to install pharmacy, ultrasound and pathological lab services and on-call doctors paid on a per case basis to ensure availability of delivery services. Special attention was given to the poorest of the poor who are offered the services free of charge.

NGO managers were trained and mentored on NSDP's maternal health strategy and supervisory skills, and clinics with delivery services were equipped with ambulances and mini ambulances for home delivery. NSDP conducted other reproductive health training for 410 paramedics in antenatal, postnatal, newborn care and RTI/STI case management to build the capacity of service providers in reproductive health. In 2006, a workshop was organized on maternity care, "A Global, Evidence-based Update," for GOB personnel, NSDP staff (doctors), NGO project managers, and other development partners. The workshop was facilitated by Dr. Martha Carlough, a safe motherhood and newborn health advisor for the University of North Carolina and Intrahealth International, Inc.

As is the case in many other parts of the world, women in Bangladesh have restricted mobility even during obstetric emergencies to give birth to their children. Considering their restricted mobility and preference of Bangladeshi women to give birth at home, NSDP made the services available at their doorstep. A situation analysis was conducted to assess the need and willingness to pay for delivery services if offered at home. Almost 90% of respondents expressed their willingness to pay for such a service. An assessment was done for Smiling Sun paramedics to assess their current knowledge of delivery care and life saving skills during an obstetric emergency.

Considering the causes of maternal death in the country and international evidence, 23 paramedics from 10 Smiling Sun clinics were trained on use of partograph, active management of third stage of labor, and newborn resuscitation. Eventually, an additional 73 paramedics were trained and home delivery was expanded to a total of 61 clinic catchment areas in FY 2007. To support these trained paramedics with a functional referral system to nearby EmOC facilities, transport was provided by mini-ambulances or rickshaw vans.

NSDP also participated in the MOHFW's demand-side financing initiative which was launched in 21 selected Upazilas. Under this scheme an important trail introducing health vouchers for poor pregnant women to purchase health services started in Ramu Upazila and Daudkandi Upazila. NSDP's FDSR was selected in July 2006 as the service provider for this scheme in Ramu, and the GOB Upazila Health Center was designated the service provider in Daudkandi.



Evaluation of the services rendered revealed to the DGHS that FDSR is providing the services effectively. Based on this success, GOB assigned another nine upazilas to the NSDP partner NGOs of PSF, Swarnivar, Bameneh, and PSTC to initiate services under the Demand Side Finance program as of July 2007. NSDP Smiling Sun clinics upgraded their facilities and trained staff to participate in the maternal health voucher scheme.

## **2. Family Planning**

Throughout the life of the project, 431 NGO paramedics were trained in family planning clinical services (FPCSC), 195 doctors and 190 paramedics received Norplant training, 43 doctors and 39 paramedics were trained on NSV and 24 doctors and 21 paramedics received clinical training on Tubectomy. Trainers from affiliated training centers and selected NSDP staff received training to advance their “facilitation skills” to become trainers in reproductive health. In turn, all NGO project managers (clinical) were trained to improve their supervision of providers’ clinical skills. Guidelines for NGO project managers/supervisors were developed with sets of checklists for conducting post-training, follow-up visits for reproductive health services.

A new training methodology, on-the-job (OJT) training, in family planning was introduced to NGOs. 18 paramedics were trained as “preceptors” from 10 NGOs, and NGO project managers were oriented as OJT supervisors. The paramedics were updated on clinical skills for counseling, infection prevention and IUD insertion, and also trained on workshop facilitation. As a part of an OJT trainee handbook, trainer’s and reference manuals were developed on counseling, infection prevention and IUD insertion/removal. Training centers were also oriented on the OJT approach. FPCSC training was decentralized and NGO clinics were used as training venues for classroom and practical sessions. In decentralized training courses preceptors worked closely with trainers and they took the lead in conducting practical sessions. During the implementation stage of OJT the preceptors acted as OJT trainers. As a training aid, Zoe models were distributed to OJT sites (NGO clinics) and training centers.

A community-level follow-up guideline was developed with a checklist for PLTM customers, and introduced to NGOs in order to decrease dropout rates for family planning, particularly IUD dropouts. With the support of EngenderHealth and the GOB, NSDP established an implant training center at a NSDP-supported NGO clinic of PKS in Jessore, and a pool of trainers received TOT on Norplant. NSDP also supported the development of a training video on Implants (see Objective 2, section 29).

## **3. Child Health**

Availability and use of high-quality child health services were expanded and increased during NSDP respectively. An assessment of facility-based IMCI services was completed and the services were first introduced to 15 clinics. Expansion of facility-based IMCI services was in phases until IMCI services were available in all 319 Smiling Sun clinics. IMCI implementation guidelines were also developed, and the capacity of training institutions (Dhaka Shishu Hospital, Ad-din Hospital,



Radda, IMCH and the GOB's IMCI section) was strengthened. Facility-based IMCI training was decentralized to regional medical colleges at Rajshahi, Mymensingh and Rangpur.

789 Paramedics and 366 doctors received an 11-day clinical management course on IMCI during NSDP and 45 NGO managers (doctors) received 5-day follow-up training on IMCI. The IMCI mothers' card was adapted from the GOB's, printed and supplied to all Smiling Sun clinics. Formal follow-up visits were conducted at 106 randomly selected Smiling Sun clinics by NGO managers, thereby assessing clinic services of each other's NGOs. In addition, NGO managers conducted at least one IMCI follow-up visit to each of their NGO's Smiling Sun clinics, and facility-based IMCI was incorporated in the quality monitoring and supervision (QMS) system.

Community-based IMCI services were expanded to 156 Smiling Sun clinics' catchment areas—all the rural clinics. 156 paramedics and 156 service promoters were trained as trainers on community-based IMCI. About 6,471 depot holders were trained and equipped to provide IMCI services in their communities. Pediatric cotrimoxazole was purchased from Essential Drug Company Limited and was distributed to depot holders for community case management of pneumonia. (Depot holders already supply ORS.) About 2,500 ARI timers and 4,360 watches were distributed to depot holders to count the respiratory rate of under-5 sick children who were suffering from ARI.

About 60 village doctors (quacks) of 3 Smiling Sun clinics, Bhairob of Kishorgonj, Chagolnaiya of Feni and Debigonj of Panchagor, received community-based IMCI training. A checklist was developed and the village doctors of Chagolnaiya were followed-up after receiving their training.

One comprehensive model of community-based IMCI was implemented in Shahjadpur, Sirajgonj, with 37 government field workers (HA and FWA), 75 village doctors and 37 depot holders. These community-based IMCI service providers became skilled and equipped to manage under-5 children at the household level who were suffering from ARI, including pneumonia and diarrhea with no dehydration, and helped ensure proper referral for severe cases. The GOB plans to implement this comprehensive community-based IMCI model at 10 upazilas.

Community-based IMCI activities were reviewed in September 2006 by a competent team, guided by external consultant. Their findings included:

- there is a commitment to the strategy at all levels;
- depot holders are proud of their work, of being part of the Smiling Sun network, and have a strong commitment;
- there is a benefit by adding community-based IMCI to facility-based IMCI;
- depot holders offer counseling, prevention, and education, as well as curative care for common diseases;
- depot holders are closest to the community, particularly the poor; and
- the poorest people use the services, whereas the wealthier go elsewhere.

The supply of vaccines to Smiling Sun clinics and immunization services were improved throughout the Smiling Sun network. 33 clinics within Dhaka City Corporation received ice-lined refrigerators (ILR) from the GAVI program, and immunization services were expanded to the peri-



urban areas around Dhaka City Corporation. All Smiling Sun service providers received training on EPI from the GOB. During the life of NSDP, all 319 clinics also participated in all 15 National Immunization Days (NIDs) according to the GOB schedule. They also participated in other special campaigns, such as the MNT, Vitamin A, and Measles catch-up campaigns. In addition, NSDP supported the GOB in these campaigns by providing t-shirts and caps for the volunteers and published special supplements in newspapers.

#### **4. Tuberculosis**

NSDP signed an agreement with the Directorate General of Health Services in June 2003 to work with the National Tuberculosis Control Program (NTP) for TB diagnosis and treatment using the DOTS strategy in urban areas of Dhaka, Chiattagong, Rajshahi and Khulna divisions. 9 NGOs, namely PSTC, CWFD, Swanirvar, Bamaneh, Image, Nishkriti, Fair Foundation, PKS-Khulna, Tilottama participated. The total catchment population served by the 56 Smiling Sun clinics providing TB control services is 3.8 million. Operational guidelines for NSDP's NGOs conducting TB control services were developed in 2005 and introduced into practice in 2006. Close collaboration between the NSDP, NTP, BRAC/GFATM, WHO, and other stakeholders led to an uninterrupted supply of drugs, logistic support, reports, and BCC materials.

At the beginning of NSDP in 2003, the total number of TB microscopy centers was 18 (12 in Dhaka, 1 in Chittagong, 1 in Rajshahi and 4 in Khulna). The number of microscopy centers has increased to 32 (21 in Dhaka, 5 in Chittagong, 4 in Khulna and 2 in Rajshahi) based on client volume, quality of care, and NSDP supervision. 14 new microscopy centers were added in 2005 and 2006.

The first External Quality Assurance (EQA) center monitoring NSDP was established in July 2005 in Dhaka to ensure the quality of TB microscopy at Smiling Sun clinics in Dhaka. It was among 22 National EQA centers in the country. The microscopy center of Chittagong was brought under quality assurance in 2004, whereas quality assurance for TB microscopy came to Rajshahi and Khulna in 2005 and at the beginning of 2006. All microscopy centers are now cross checked by EQA centers.

Case detection rates of new smear positive TB cases is a principal indicator of the progress of the national TB Control Program. Case detection rates for NSDP NGO partners was 23.0% in 2003 with rates gradually increasing to 33%, 40% and 48 % in the years 2004, 2005, and 2006, respectively. In the first quarter of 2007, the detection rate was 62%.

Treatment success rate is another important indicator of the Program. Treatment success at the beginning of NSDP was about 80%, but also gradually increased over the years to the current treatment success rate of 88%. There have been 13,218 TB patient contacts from the program's inception in 2003 until March 2007.

444 NSDP clinic staff (129 graduate doctors, 92 paramedics, 38 lab technologists, 185 SP/SPOs/Counselors) were trained to screen and treat TB patients. Routine training was conducted by the NTP and need-based training was conducted by BRAC free of charge. On-the-job orientation was provided to staff as a continuous process throughout the project period to maintain high-quality



record keeping and reporting. Training information on all staff is available in NSDP's Human Resources Information System (HRIS).

In May 2006, community volunteers at NSDP's urban clinics providing TB control services were oriented to the program and 110 volunteers were recruited (2 volunteers per Smiling Sun clinic providing TB control services) to extend services to the community. Volunteers were oriented by the NGOs following the NTP's guidelines and orientation guidelines of BRAC.

NSDP and its partner NGOs contributed to developing a country proposal for Round 5 of the GFATM in Bangladesh. In May 2006, NSDP partner NGOs received US\$216,000 for 14 months to strengthen current DOTS activities; involve the private sector in delivering TB/DOTS services; create demand for services by introducing comprehensive advocacy, communication and social mobilization; and strengthen supervision, monitoring and evaluation.

NSDP and partner NGOs contributed to 3 important documents:

- The Strategic Plan for TB Control: 2006-2010
- National Guidelines on Advocacy, Communication and Social Mobilization
- National Guidelines on Public-Private Partnerships.

## **5. Partnerships**

NSDP formed several partnerships to expand services to high-risk populations. A partnership was formed between NSDP partner NGO, CWFD, and FHI partners, CREA and DAM, in February 2006, to provide TB control services to Injectable Drug Users (IDUs). A total of 533 clients were served, 14 were diagnosed as TB patients, 10 patients completed treatment and 4 patients dropped out as of June 30, 2007.

NSDP partner, Nishkriti, and FHI partner, YPSA, signed an agreement in September 2006 to provide ESD from selected Smiling sun clinics to street-based sex workers and their family members. A total of 409 clients, of which 373 were female and 36 were children, received services from 2 Smiling Sun clinics in Chittagong. A total 247 poorest of the poor clients received free medicines as of June 30, 2007.

NSDP partner, PSTC, and FHI signed an agreement in May 2007 to provide Voluntary Counseling and Testing (VCT) services for HIV/AIDS to TB positive patients and high-risk groups from 2 selected Smiling Sun Clinics in Dhaka. As of June 30, 2007, 39 clients were tested for HIV, of which 20 were male and 19 were female. None were found to be positive for HIV.

## **6. STI/RTI Program**

NSDP trained 149 clinic staff on STI/RTI case management. Sixty-two were doctors and 87 were paramedics. Almost 4 million clients received STI/RTI services from 2003 until May 2007 from Smiling Sun clinics. Monitoring and supervision ensured high-quality services in 68 Smiling Sun clinics serving high-risk populations.



A successful pilot promoting dual protection among rickshaw pullers and high-risk customers in 4 Smiling Sun clinic catchment areas led to expanding the program to 35 new clinic catchment areas belonging to 10 partner NGOs.

NSDP and its partner NGOs contributed to 3 important documents:

- National Guidelines on HIV/AIDS
- National Guidelines on STI/RTI Management
- National Guidelines on BCC of HIV/AIDS.

## **7. Human Resources Information System**

HRIS was developed to record training received by NGO and clinic personnel. Maintaining an up-to-date database on staff trained is important for NGOs to deliver high-quality services. There is relatively high turnover of doctors and paramedics, and, as services expand, more training will be needed. The database stores personnel information on 3,900 staff from 33 NGOs. The system was installed at 7 NGOs and their MIS officers were trained on the system. The HRIS should be installed at other NGOs as they develop the capacity to use it.

## **8. Quality Improvement of the Essential Service Package**

A quality assurance program was introduced to the USAID-funded clinic network under the supervision of the National Integrated Population and Health Program (NIPHP) partners, RSDP, UFHP and QIP, in 1997. With the introduction of NSDP, the management of this function, ensuring quality of care, was moved to the NGOs themselves. NSDP followed a 4-pronged strategy to integrate quality assurance into NGO functions. At the heart of this strategy is the Quality Monitoring and Supervision (QMS) system.

The QMS was designed during the later part of the first phase of the NIPHP, in 2000. It was piloted in two urban and two rural NGOs, reviewed in November 2002, and subsequently modified and revalidated prior to NSDP-wide implementation. Community perceptions about quality of care were also assessed prior to finalizing the current QMS system.

NSDP's vision for quality improvement was to institutionalize the culture of quality among NGOs for the provision of Essential Service Delivery (ESD), and promote the importance of quality assurance among the implementing partners and stakeholders including the government, private providers and the community at large. With this vision in mind, NSDP set forth implementing its quality of care strategy in the following phases:

1. Quality Monitoring and Supervision (QMS)
2. QMS External Validation
3. Quality Improvement Audit
4. Customer Satisfaction Survey

## **9. Quality Monitoring and Supervision (QMS) system**



The QMS was designed as a NGO- and clinic-based monitoring system using quality assessment data. System development included establishing service delivery guidelines and standards; formalizing problem solving techniques; organizing technical and skills updates; and ensuring proper referrals and reinforcing follow-up to ensure that problems identified are adequately addressed. Piloted in 2001-2002, NSDP modified and implemented the QMS after the following series of activities, which were undertaken in coordination with the NGOs, the intended implementers of the system:

1. Rapid review of the QMS pilot
2. Modification of the QMS to comply with current service delivery guidelines
3. Validation of the revised QMS
4. Exploring the community's perception of quality of care and incorporating community views in the modified QMS
5. Finalization and implementation of the QMS.

The QMS is a set of tools used by NGO managers, and more specifically, those managers who are clinicians, and their clinic-based counterparts to work with staff and review compliance to service delivery guidelines, identify the gaps and their root causes, develop action plans on the basis of the findings and monitor their implementation. It is based on the principle of self-assessment and improvement in order to

- Strengthen coordination among clinic staff
- Establish a supervision system that is collegial and supportive
- Help managers and staff jointly identify their own problems and solve them.

## 10. QMS tools

During the life of the program, NSDP developed and updated Knowledge Quizzes, Records Review sheets and Skills Observation Checklists related to all services in the ESD package, along with their accompanying score sheets and Facilitator's Guide. NGO and clinic managers were trained on using these tools for monitoring and scoring service performance. The data generated were used for decision-making to improve service quality. The QMS comprises checklists for assessing service delivery quality based on 10 indicators related to the ESD package, including family planning, maternal health, child health, counseling, RTI/STI, infection prevention practice, clinic organization (equipment and logistics) and rational drug use.



## 11. Integrating QMS in NGO and Clinic Operations



Following the modification of the QMS tools and processes, NSDP trained all NGO- and clinic-based managers on the system. Although the original plan was to implement the QMS in a phased-in manner, implementation was done across the network, on recommendation from USAID.

Between February and April 2003, NSDP trained 342 NGO and clinic-based managers on the QMS system. The training modules were participatory and skills-oriented. The managers were also given the relevant technology (presentations, handouts, modules, handbooks and scoring sheets on CD-ROM) to cascade the training to the other staff. NGO-based managers were responsible for training the other NGO staff and orienting members of the Executive Committees, while the Clinic Managers trained service providers. The training included:



- Introduction to quality of care, supportive supervision, and monitoring, and linkages to performance improvement
- Introduction to the QMS tools and processes, including data management
- Role-play and skill-building in “supportive supervision” and problem-solving techniques
- NSDP training on a routine basis as new clinics entered the network and as new staff (managers at the NGO- and clinic-levels) came on board
- On-site mentoring and coaching.

To ensure quality of service delivery despite repeated staff turnover, NSDP staff conducted on-site QMS coaching for new recruits in the event that there was no training available in the near future. In addition, NSDP also provided on-site mentoring for trained staff who needed further skill development to implement the QMS properly.

As the part of the NGO mentoring plan, NSDP also developed a group of four QMS core trainers from the NGO managers to facilitate QMS training among their peers and new recruits at the regional level and at lower cost. Potential QMS facilitators were selected following intensive review and were trained on the concepts of quality of care and supportive supervision, adult learning, and how to successfully conduct a training event and facilitate training in QMS. These core trainers conducted QMS training for 63 doctors and NGO managers in two batches, in which NSDP played the role of observer.



## 12. QMS Implementation by NGOs

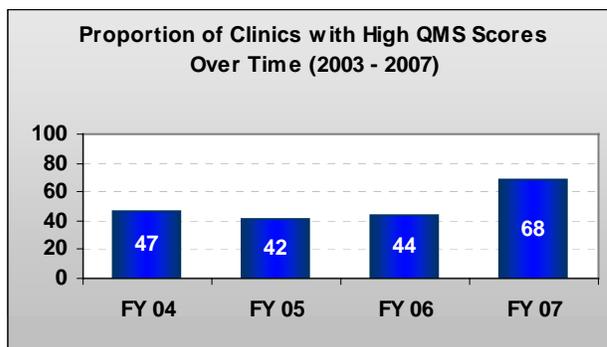
QMS implementation across the Smiling Sun network began in July 2003 and included semi-annual visits to the clinics. The QMS comprises checklists and scoring sheets for monitoring provider compliance to standard for counseling, family planning, RTI/STI, maternal and child health, TB, safe delivery, post-abortion care, and special STI services for clinics offering them, as well as for physical facility, logistics, infection prevention practice and rational drug use. At the end of each



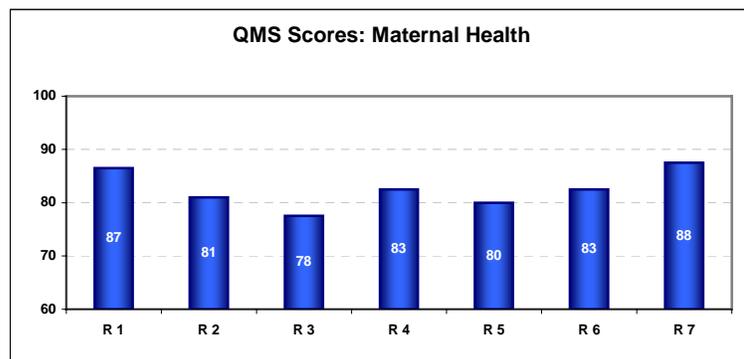
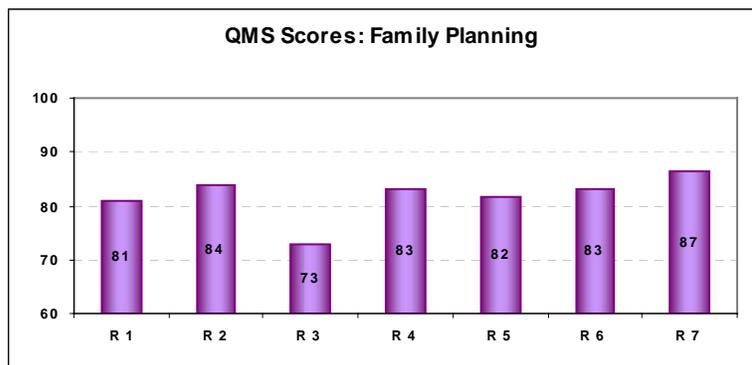
visit, staff work with the managers to apply rapid QI methods to develop an action plan for quality improvement, based on the findings of the visit. All gaps and problems resolved or unresolved at the NGO level are conveyed to NSDP for support and identification of common problems across a number of NGOs (for example, common problems that NGOs are trying to address, but which are outside their direct control and require support from external agencies such as the NSDP or GOB).

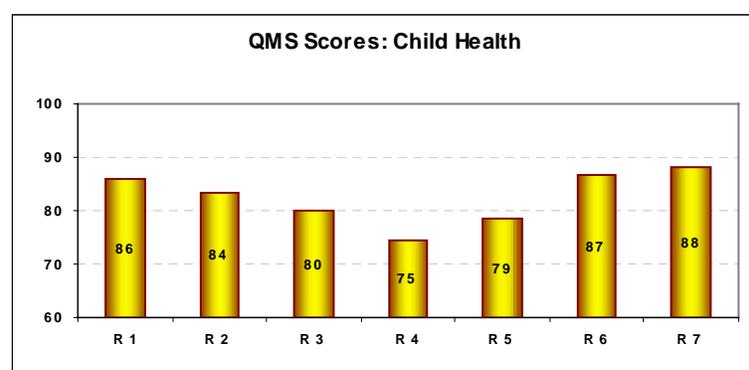
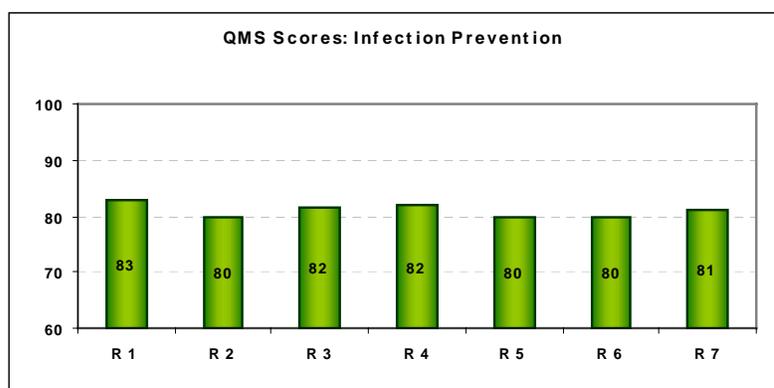
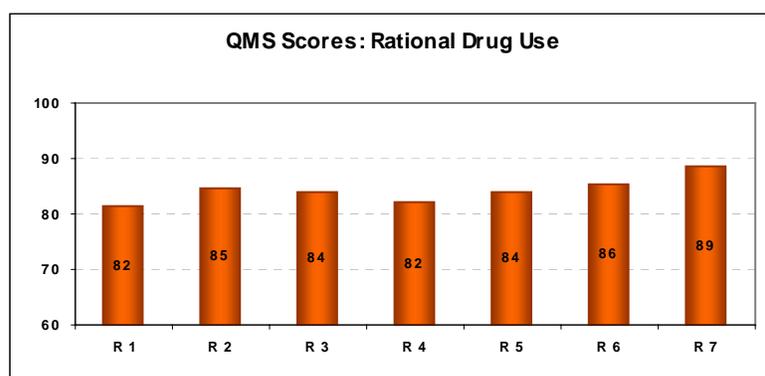
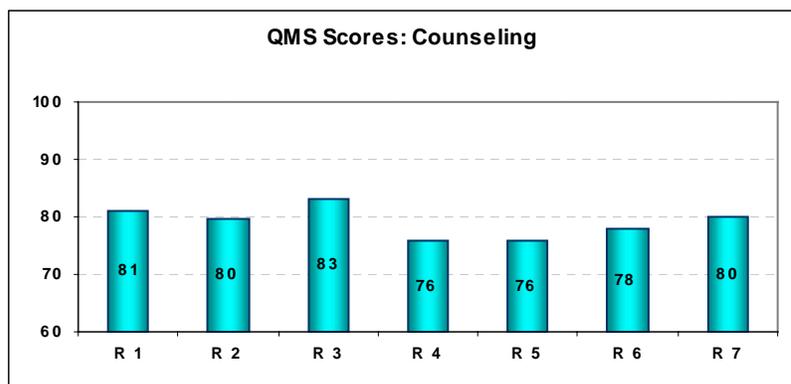
### 13. QMS Scores

Initiated in mid-2003, the NGOs have completed a total of 7 semi-annual rounds of QMS, with technical support and guidance from NSDP. The overall compiled QMS score across the network increased over time and the proportion of clinics achieving high scores between the first QMS Round in FY 2004 and the 7<sup>th</sup> in FY 2006 increased. In the beginning, less than half of the clinics met the requirements to be termed high quality. By 2007, the number of clinics of high quality increased to over two-thirds.



Scores for quality of service delivery increased over time with a slight decrease in scores for most services during Rounds 3 and 4 (2004 – 2005). This decrease may be attributed to more clinics being added to the NSDP network during that time, and also to staff turnover. The result of integration of a wider spectrum of services for maternal and child health by NSDP, such as making safe delivery and emergency obstetric care available at more clinics and integrating IMCI, is reflected by the subsequent increase in scores since 2005. In general, all NSDP clinics demonstrated moderately good compliance to service delivery guidelines, and the managers at the NGOs and clinic staff were always quick to adopt new strategies and updates to ensure service quality. Scores also increased for both maternal and child health. The increase was more pronounced between 2005 and 2007, and this may be linked to NSDP's accelerated efforts to improve maternal and child health, through more provider training, strengthened participation in maternal and child health activities, and better management. Overall, the staff learned to better organize their clinics, improve cleanliness, make available all necessary equipment and logistics to ensure that service delivery is smooth and uninterrupted, ensure appropriate client flow, and achieve a uniform appearance.





## 14. QMS External Validation

Following roll-out of the QMS across the network in mid-2003, NSDP introduced a system of external validation of the QMS data to ensure correct and appropriate provider scoring and QMS implementation. The validation served to compare the QMS scores generated by the NGOs and clinics on a wider scale and help the NGO managers and staff play an objective role in assessing their own quality of care. The QMS scores should reflect areas that need a coordinated effort for improvement, and the external validation by NSDP helped ensure accuracy.

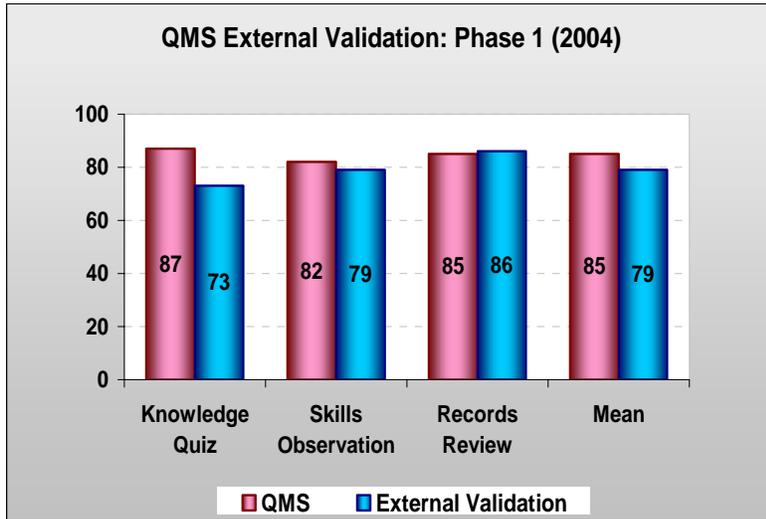


Clinics were selected randomly (10-20% of all NSDP clinics) for external data validation. NSDP staff scheduled external validation visits on the same day as the QMS visit, and worked side by side with the NGO and clinic staff to help them compare their own scoring with the scores of the validation team. This process helped them attain uniformity in measuring quality.

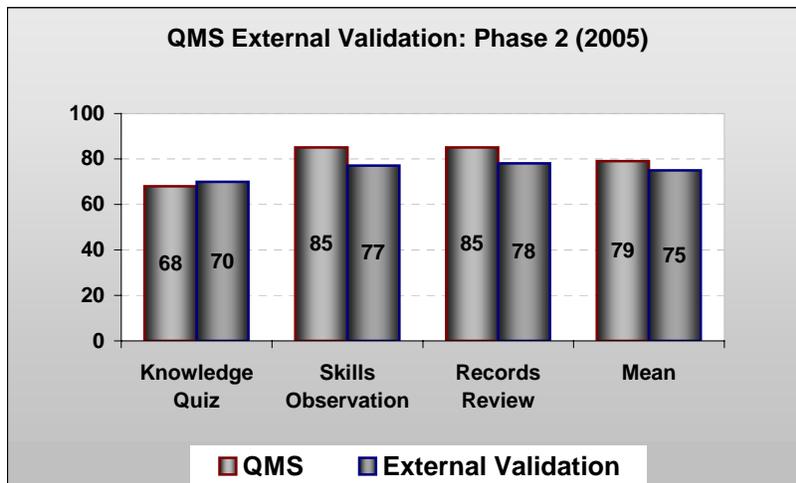


## 15. Validation scores

NSDP conducted three annual external validations of the QMS between 2004 and 2007. In the first phase, NSDP validated QMS scores of 18% of the existing clinics (54 clinics in 2004). There was comparatively greater variation in the scoring by the QMS facilitators from the NGOs versus that of the NSDP staff conducting the validations.



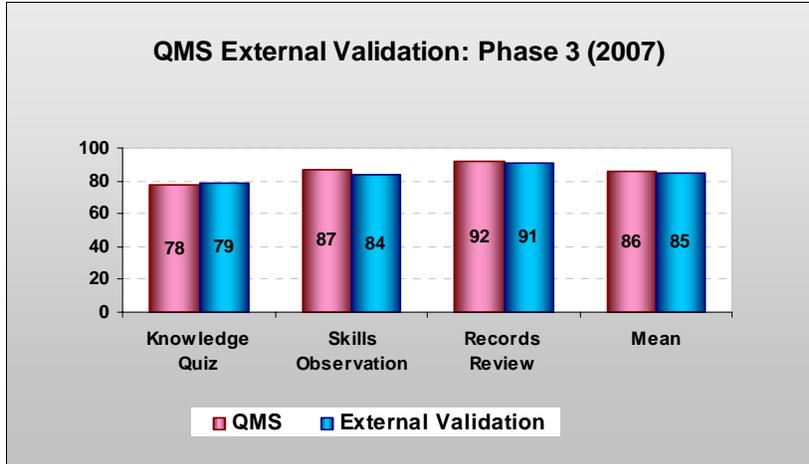
The second phase of external validation was conducted in 15% (40) of the clinics in 2005. The variation in scoring by the NGO managers and NSDP staff was more reduced by this time. Providers and managers became more tuned to the concept of scoring to identify and fix problems and thereby improve the quality of service delivery, which would make them providers of choice in their community.



By the time the third phase of QMS external validations was conducted in 10% (31) of the existing clinics in 2006, the variation between QMS scoring and validation had decreased markedly.



Providers and managers had begun to monitor more objectively and reduce their bias towards inflating scores while making facility and service assessments. The QMS is now perceived as a means to track and improve service quality and increase performance rather than for a regulatory function.



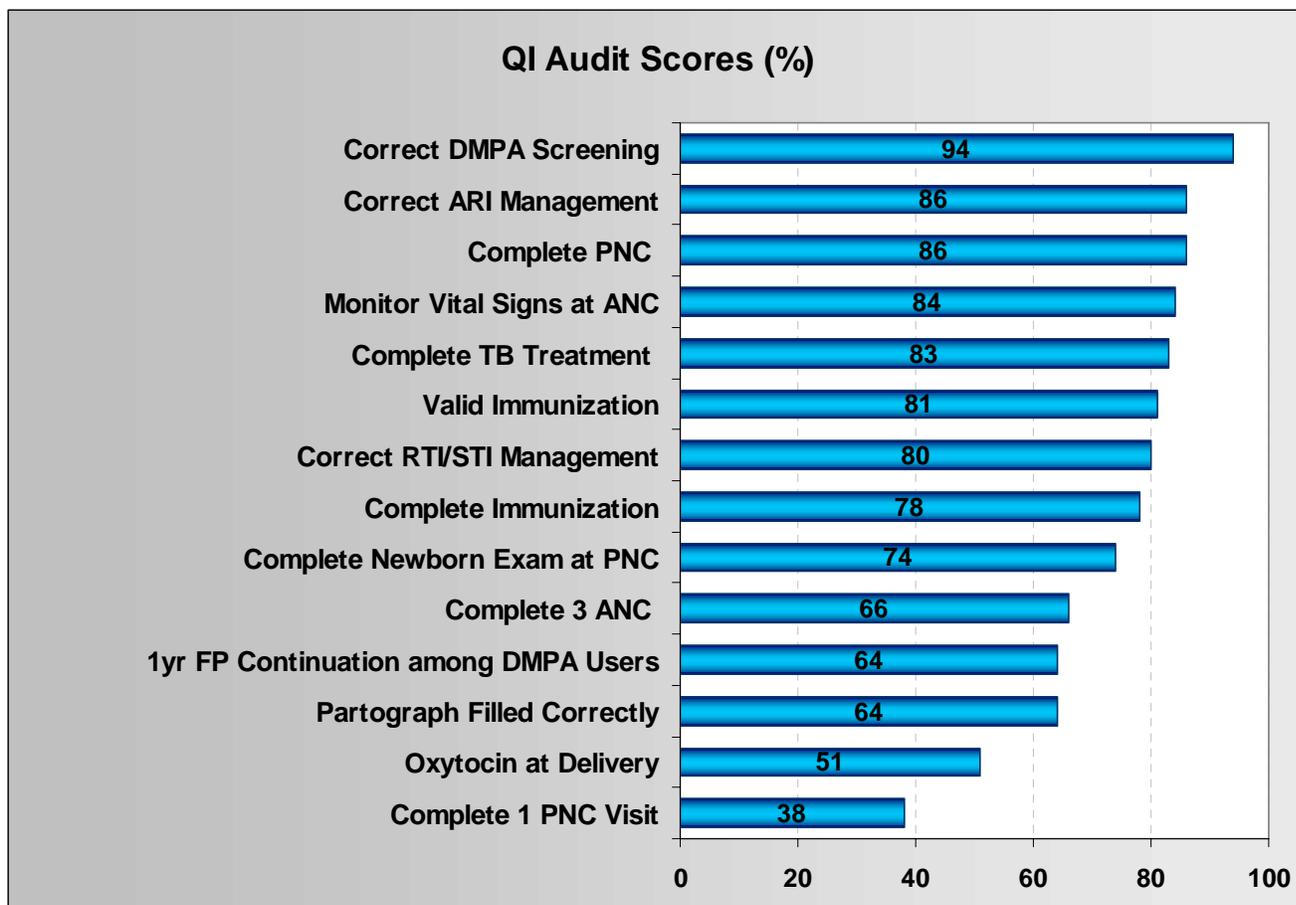
## 16. Quality Improvement Audit

The Quality Improvement Audit provides NGO and clinic staff with a longitudinal overview of quality of care at Smiling Sun clinics. The Audit is a retroactive review of clinic records using key indicators that track the continuum of care and customer drop out. The Audits are administered by NGO staff, irrespective of whether they are clinicians or not. Project Directors, Project Managers, Finance and Administrative Managers, MIS Officers or Monitoring Officers conduct the Audits. Each clinic is audited once in a year.

## 17. QI Audit Scores

The Smiling Sun clinics conducted one full round of Audits and the results demonstrated a wide range of scores from 94% for correct screening of DMPA customers to 38% completing 1 postnatal care visit. There are lower scores for skill sets related to services requiring follow-up visits, such as completion of 3 antenatal care visits and 1-year family planning method continuation among DMPA users. Other services that need more support include completing a partograph and administering oxytocin at delivery.





## 18. Customer Satisfaction Survey

Given that customer satisfaction is an important element of quality of care and programs need to address it to ensure a comprehensive package of high-quality services, NSDP conducted a customer satisfaction survey as part of its four-pronged quality of care strategy. The objectives of the study were to assess the level of customer satisfaction at NSDP service delivery outlets and identify areas for improvement to ensure a customer-driven service delivery system. This survey was conducted at four NSDP clinics (2 urban and 2 rural) in June 2007. Both clients and providers in the clinics' catchment areas were selected randomly for interviews.

Findings from the survey showed that the majority of customers (87%) were satisfied with the services at NSDP clinics. Most of them enjoyed the cordial clinic atmosphere, the TV drama serials during waiting time, providers' attitude during consultation (customer-patient interaction, counseling, advice for follow-up), use of safe and clean instruments, etc. Some of the customers expressed some concern about too many customers



flocking to the clinic at a particular time and a need for longer clinic hours in rural areas. Some also expressed the need for a wider range of services at the clinics, x-ray facilities and ultrasonogram services, for example, so customers would be able to access one-stop shopping for high-quality health care.

## 19. Improved Client-Provider Interaction

Increasing the delivery of Permanent and Long-Term Methods (PLTM) has been one of the major areas of focus for NSDP and is a high priority for the Government of Bangladesh. Effective family planning programming depends on appropriate utilization of methods for spacing and limiting, and the gradual decline in the use of PLTM nationwide has been a cause for concern. In light of the decline and QMS scores for family planning service delivery, NSDP conducted counseling training as part of a strategy, which included BCC and marketing activities, to increase the effectiveness of its family planning efforts.



NSDP provided special PLTM counseling training to all service providers (doctors, counselors, paramedics and clinic aides) in a select number of clinics through a series of participatory training events “strengthening provider capacity for counseling to potential PLTM customers.” The clinics were selected in areas with higher demand and acceptance of family planning, especially PLTM (Rangpur, Rajshahi, Jessore and Khulna regions, and urban clinics in Dhaka and Barisal regions). A total of 760 service providers from 157 Smiling Sun clinics of 24 NGOs received the

training, which focused on interpersonal communication and key messages to be communicated in conjunction with the provision of family planning service delivery.

## 20. Training on Rational Drug Use

NSDP trained 72 NGO and clinic staff on the principles of Rational Drug Use and drug dispensing. These included Project Directors, Project Managers, Monitoring Officers, as well as select Clinic Managers and Paramedics from some of the better performing clinics. The reason for selecting this varied range of participants was to ensure the smooth and efficient cascade of RDU training to all clinic staff within a short time.



The objective of the training was to improve the knowledge and skill of clinical service providers and drug dispensers, and to ensure high-quality drug therapy and cost effectiveness from NSDP clinics. NSDP also published the revised booklet on Essential Drugs during the training. RDU has been a weakness demonstrated by the clinics’ QMS scores. Some of the problems related to RDU include poor prescription practices, inappropriate prescription of antibiotics and vitamins, and incompatibility between diagnosis and treatment.



Some best practices related to packaging and dispensing of drugs by different NSDP NGOs were shared with the participants to sensitize them to the need for practical and marketing-friendly packaging of drugs.

## 21. Ensuring Appropriate Infection Prevention Practice

Correct disposal of biomedical waste is essential for the control and spread of infection, among providers, customers, and people in the community. NSDP provided guidance and support in this regard to the NGOs and clinics, so that they are able to maintain infection prevention practices and waste disposal as per the standard. The semi-annual Quality Monitoring and Supervision (QMS) scores in Infection Prevention Practice have demonstrated an overall improvement since 2003. From inception until the end of the project, NSDP provided several on-site and special infection prevention training modules and circulars.

Given the implications and importance of safe waste disposal in the Smiling Sun network, and given that a wider range of services are now being provided, especially safe delivery, emergency obstetric care, and comprehensive laboratory services, NSDP took steps to help ensure infection prevention and proper waste disposal. These steps included:



- distributing updated information on waste disposal procedures (disposal of sharp instruments, general waste, medical waste, hazardous waste, etc.) to all NGOs and clinics;
- ensuring the use of the infection prevention log, which is a matrix for ensuring practice of IP and waste disposal procedures and monitoring by the Clinic Manager;
- finalizing and distributing a Laboratory Operational Guideline to clinics. (The guideline provides specific and detailed information on disposal of laboratory waste.); and
- conducting special sessions on quality of care and waste disposal at the Laboratory Technicians' training organized by the HCDP of the Diabetic Association, Bangladesh.

## 22. Laboratory Technicians' Certificate Course

Laboratory service is an integral support function for the smooth implementation of ESD. NSDP conducted a needs assessment of the training status of laboratory technicians in the Smiling Sun network. The assessment found that a large portion of laboratory technicians in the network did not have any diploma in laboratory technology.



To standardize the skills of laboratory technicians across the Smiling Sun network, NSDP facilitated a one-month Short Certificate Course on Laboratory Services for technicians who did not have any diploma. The course was tailor-made for Smiling Sun clinics by the Health Care Development Project, an enterprise of the Diabetic Association of Bangladesh, in collaboration with the NSDP Quality Improvement staff. A total of 75 laboratory

technicians were trained. A Laboratory Operations Manual was also developed and distributed to them.

## **OBJECTIVE 2: INCREASE THE USE OF THE ESSENTIAL SERVICES PACKAGE, ESPECIALLY BY THE POOR OBJECTIVE**

NSDP raised awareness of and created demand for high-quality essential services by improving the knowledge of households on the value of family planning, reproductive health, maternal and child health, RTIs/STIs, HIV/AIDS, and tuberculosis. NSDP supported numerous initiatives to change health-seeking behaviors by disseminating information through mass media and local BCC activities.

### **1. NSDP/BCC Communication Strategy**

An integrated communication strategy was developed to meet the health needs of the poor. In developing the strategy, NSDP reviewed a large number of relevant documents, including the formative research on reaching the poorest, conducted site visits, reviewed NGO strategies, and interviewing members of different technical teams of NSDP. The strategic communication strategy addressed the most immediate challenges of NSDP by creating a unified, multi-media program that would work in communities, clinics, NGOs and national media environments and support NSDP program objectives, especially meeting the health needs of the poorest. The strategy strengthened the Smiling Sun as a genuine symbol of high-quality health services and created a platform for increasing the number of poor (non-paying customers), as well as increased the number of paying, regular customers. An implementation plan following the communication strategy was also developed.

### **2. National Media Survey 2002**

Sponsored by BCCP and SMC, the National Media Survey 2002 was the third of its kind in eight years. The survey was designed to provide information on people's exposure to various media and identify the media that are most effective in disseminating information. The survey covered 241 primary sampling units (PSUs) and included 10,850 male and female respondents between the ages of 15 and 49 years.

The survey revealed that 61 percent of the people in Bangladesh watch television, up from 42 percent in the second survey conducted in 1998. The number of television viewers had increased in both rural and urban areas from 24 percent in the villages in 1995 to 50 percent, and from 31 percent in 1995 to 83 percent in urban areas.

However, the proportion of people listening to radio in both urban and rural areas had declined. The survey also revealed that 60 percent of the people had seen the outdoor media displaying various health messages produced by SMC and NSDP on family planning methods or oral saline. Sixteen percent of the people went to cinema halls while 26 percent read newspapers and 8 percent magazines. Sixty-three percent of the population was literate, while 42 percent had electricity in



their homes. One-third of the television owners had cable and satellite connections. In rural areas a quarter of the viewers watched television run by batteries.

### 3. Evaluation of Smiling Sun BCC Campaign

In March 2003, an evaluation was conducted among 4,420 respondents (2,010 each between male and female and 400 service providers) in 134 primary sampling units (PSUs) between an equal number of urban and rural units.

The objective of the study was to evaluate the overall impact of the Smiling Sun Branding Campaign and to assess the levels of health knowledge, attitudes, and practices in relation to the campaign, which also included broadcasting the TV drama serial “Eyi Megh Eyi Roudra” (EMER).

65.4 percent of respondents identified the Smiling Sun logo. Of those who identified the logo, 43 percent cited recognition from television, 26 percent from billboards, 16 percent from clinic signboards, 9 percent from posters, and 8 percent from banners (multiple responses permitted). The majority of the respondents (79% were aware of Smiling Sun clinics) could mention the availability of different services of Smiling Sun clinics. The services mentioned were ANC, immunization, general health care and PNC.

### 4. Demand Generation Activities

Demand generation activities included Smiling Sun branding and marketing of service campaigns modified from the earlier UFHP and RSDP. Billboards and clinic signboards were re-designed, as well as BCC print materials.

- a) **Billboards:** a total of 87 billboards promoting Family Health Clinics with the Smiling Sun logo were re-designed at the initial stage of NSDP.
- b) **Smiling Sun Branding Campaign (TVC 20’/30’):** The television commercial promoting Family Health Clinics with the Smiling Sun logo was cut to 20- and 30-second versions. The commercials aired 103 times on three television channels-BTV, ATN Bangla and Channel I.
- c) **TV Commercials for Services:** Branding TVCs with four-scrolling messages were aired from February 26 to April 30, 2004. The campaign focused on the NID on February 29 to increase awareness and to inform people of EPI services at Smiling Sun clinics. Other messages were on family planning, and child and maternal health.
- d) **Print materials distributed to Improve Client-Provider Interaction and service use:** Print



materials were developed to reinforce clinic and community-based IPC and counseling. These materials helped the clinic and community workers explain ESD to customers and the community. The materials included brochures, leaflets, posters, flip charts, stickers, pictorial cards, Tiahrt posters, banners and danglers promoting maternal and child



health services, communicable disease control and limited curative care.

- e) **Weight for Age Campaign:** To mobilize communities to participate in growth monitoring and avail other child health services, a community-level campaign titled *Weight for Age* was implemented at Smiling Sun clinics. The campaign was conducted in 318 Smiling Sun clinics from December 9 to 14, 2006. The communities were informed of the range of child health services provided by the clinics, and BCC materials, such as posters, stickers and caps were distributed to the NGOs to support the promotional activities among the communities they serve.



## 5. BCC Capacity Building

NSDP conducted training courses on community mobilization, BCC and marketing, and IPC/Counseling from April to September 2003. The training on community mobilization was provided to project directors and clinic managers (or service promotion officers) and cascaded to service providers.

The BCC and marketing training introduced the latest BCC and marketing techniques and enhanced participants' practical knowledge and skills. The curriculum included social marketing, elements of Essential Services Delivery (ESD), perception of BCC, market analysis, potential markets, actual markets, market share, marketing of services, promoting community health and preparing, implementing, monitoring and supervising local-level BCC and marketing plans and activities.

IPC/Counseling training was pretested with 7 Counselors and 19 Paramedics from six NGOs. The training was designed to enhance IPC/C skills of frontline service providers by updating their knowledge of hands-on IPC/C techniques.

In addition, a Message Development workshop and Advances in Family Health and Social Communication workshop were held at BARD, Comilla in 2003 and 2004. Topics included advocacy, behavior change through social mobilization, message development and state-of-the-art practices in communication programs using various communication media. Participants came from the Ministry of Health and Family Welfare, ad agencies and international development/donor-sponsored NGO staff.

## 6. PLTM Campaign

“An Exploratory Study on PLTM: Knowing Customers’ Insights,” was conducted in August 2003 to identify customers’ perceptions, attitudes and practices regarding PLTM, in addition to service providers’ views on PLTM. A qualitative methodology was applied to collect 84 in-depth interviews with customers of various methods, including PLTM, and 12 focus group discussions with urban/rural service providers.

The exploratory study found that non-PLTM users did not have knowledge of PLTM. The small proportion who adopted permanent or long-term methods were afraid to discuss it because of a “culture of secrecy.” The findings also indicated that fear of side effects/complications and loosing control over method-use restrained potential users from adopting long-term methods. However, PLTM users reported benefits of permanent or long-term methods to be: hassle free, no tension,

economic solvency, and reliability of method. Findings suggested that it was essential to promote PLTM to increase awareness and knowledge, counter misconceptions, motivate PLTM use, and encourage users to advocate for PLTM.

## 7. Communities mobilize to observing various special health days

NSDP successfully used international health events to promote service delivery sites as well as services offered from Smiling Sun clinics. National guidelines were developed for NGOs to follow in observance of the special days and campaign events.

- **World Population Day:** NSDP clinic activities in conjunction with World Population Day included special programs to recognize clinics' best workers, and participation in various GOB events including rallies and round tables yearly. NGOs participated enthusiastically each year in this event throughout the network.

- **World Breastfeeding Week:** Various events were conducted throughout the week that mobilized communities, including community meetings at satellite clinics, and baby shows.



- **World AIDS Day:** World AIDS Day was observed each year by the NGOs in cooperation with the GoB. NGO program events were organized to inform communities of the risk factors for HIV transmission and how to prevent infection. NSDP provided guidelines and BCC materials for NGOs to observe this day.

- **World TB Day:** NSDP undertook a special program in the catchment areas of the clinics providing TB services. Guidelines, posters, leaflets and banners were produced and distributed in observance of World TB Day.



- **World Health Day and the International Midwives' Day:** World Health Day and the International Midwives' Day were both observed by Smiling Sun clinics through local rallies and campaigns. On World Midwives day, the White Ribbon Alliance for Safe Motherhood assisted NSDP in supporting a full-page ad in the Bangladesh Observer outlining NSDP's maternal and child health services. On that day, service providers at safe delivery clinics wore white ribbons and clinic managers presented paramedics with red roses.

## 8. NSDP's BCC support for GOB FP program

NSDP produced television commercials, two radio spots, various print materials for local distribution, and fifty billboards in support of the national Family Planning campaign. TV spots were produced on a range of FP methods. One TV commercial produced for the Director General of

Family Planning (DGFP) was broadcast 4 to 5 times per day during prime time hours in October



and November 2004. The advertisements were intended to encourage couples to choose the most appropriate method of contraception for couples. Promotion of permanent methods, a high priority for the DGFP, was the subject of another TV ad.

## 9. TV drama serial Launch



NSDP produced a 26-episode TV drama serial, *Enechhi Surjer Hashi*, for BTV, which previewed in August and was launched in September 2005 to generate demand for preventive health care and Smiling Sun services. On the 21<sup>st</sup> of September, the television series was officially launched at an event attended by high government officials, including the Minister of Information, donors, NGO representatives, other stakeholders, and the press. The launch was covered extensively by the media. A total of 18 newspapers (12 Bangla and 6 English) and 4 TV news broadcasts carried the story. The airing of the entertainment-education TV drama serial lasted 7 months and became nationally popular. There were 6 service promotion campaigns that coincided with messages from the TV drama serial. For example, the last campaign promoted family planning services, so for one week all FP services were provided free, and customers were also given a free calendar and a free dangler.

## 10. Local Service Promotion Campaign associated with TV Drama Episodes

A comprehensive plan was developed for a service promotion campaign to follow selected TV drama episodes. The promotional campaign materials complemented health care messages promoted in the TV drama series. The campaign

encompassed national, catchment area, and community levels. The national-level campaign included promotion of the drama serial itself using mass media, including TV and radio trailers, press ads, magazine ads, posters and a grand premiere. At the



local level, there were activities to promote the drama serial as well as the Smiling Sun brand. These activities included community-level premieres at all static clinics to promote both the drama and a health service campaign. The various promotional campaign materials advertised the TV drama serial and promoted health care. Over the 7 months that the TV drama aired, six separate health messages were advocated concurrently with showings of the drama episodes in both static and satellite clinics. 150 billboards promoted health messages for family planning, maternal, and child health (EPI, ARI, ANC, PNC, and general health).

## 11. Local-level BCC Campaign Plans: December 2003—April 2004

The clinic-specific, local-level BCC Campaign plan was the outcome of a 3-day planning exercise for NSDP clinics held in 18 batches for the eight regions to help NGOs develop need-based campaign plans. Each clinic was represented by two BCC focal persons, a Clinic Manager or SPO, and a service promoter. The planning meetings reviewed individual clinic's performance, NGO performance, findings of research and recommendations related to or having a bearing on community awareness and involvement, local media and campaign events, local resources, prepared campaign plans, and endorsed monitoring tools.



The campaign plan was operationalized by all 41 NGOs. The objective of the campaign plan was to increase the number of customers at low performing clinics. For the first time clinics identified BCC activities linked to services and a comprehensive monitoring tool for tracking clinic performance. With the help of these plans and monitoring tools the clinics started launching their BCC activities as per their plan.

## 12. America Week Festivities



The annual America Week events are among the most significant regional outreach activities the Mission conducts. At the “America Week” festivals in Khulna in February 2005 and in Chittagong in March 2006, free blood pressure checks and counseling were provided, and print materials were displayed at the NSDP booth. The booth itself was designed to represent a clinic where a “medical officer” provided services to visitors. Well-known Bangladeshi actress, Joya Ahsan, who starred in the role of a paramedic in the

“*Enechhi Shurjer Hashi*” drama serial, participated. She talked with the visitors and urged them to visit local Smiling Sun clinics. The NSDP booth was well attended both years and visitors included U.S. Ambassador, Mr. Harry K. Thomas, at Khulna, his successor Ms. Judith Chammas, Charge d’ Affaires at Chittagong) and Mr. Gene George, USAID/Bangladesh Mission Director.



## 13. Mystery Client Exercise



In 2005, NSDP conducted a “Mystery Client” pilot exercise, with the voluntary participation of nine clinics of four NGOs. The exercise was a sequel to a research survey on reaching the poor that revealed that the providers’ behavior was one of the major barriers preventing poor customers from receiving services from Smiling Sun clinics. The survey also showed that the providers need to improve their interpersonal and counseling skills to satisfy customers’ demands. The objective of the mystery client exercise was to improve the interpersonal and counseling skills of the counselors, particularly towards poor customers.

In the exercise, a counselor or service provider of one clinic acted as a Mystery Client and visited another clinic as a poor or least advantaged customer to seek services on RTI/STI, ANC (before 12 weeks), limited curative care (LCC) or family planning. NSDP developed different cases for role-plays on these services and provided orientation to the mystery clients, as well as the Clinic Managers on the exercise’s objectives and implementation. Each mystery client held a debriefing and discussion session with all staff of the visited clinic immediately following the exercise.

Findings from the pilot exercise were positive and it was recommended the exercise be scaled up. In 2005 and 2006 the exercise was expanded to include an additional 98 clinics.



#### 14. Jaya Ahsan, Brand Ambassador for Smiling Sun Clinics

Popular actress Jaya Ahsan, who acted in the central role of *Enechhi Shurjer Hashi* as “Ayesha,” a paramedic of a Smiling Sun Clinic, served NSDP as its Smiling Sun Brand Ambassador from June 2005 to May 2006. Her image has been portrayed on billboards throughout the country and on a number of print materials promoting Smiling Sun Clinics and services. She also visited a number of clinics to encourage community members to use services at Smiling Sun clinics.

#### 15. Cricket Star, NSDP Spokesperson on maternal health

Mohammed Rafique, a popular sports personality in Bangladesh, signed a contract to become NSDP’s spokesperson from August 2005 to June 2007 on maternal and neonatal health care. He conveyed messages directed at Bangladeshi men, recommending their involvement in their wives’ pregnancies to help ensure normal deliveries and healthy babies.

Rafique filmed a TV public service announcement which was broadcast nationally seven times (in August and September 2005) during cricket matches in which Rafique played. In the ad, Rafique urged men to prepare thoroughly for the births of their children as he does for every cricket match.



Fifty billboards featuring promotional messages directed at men on the topic of safe delivery, including Rafique’s image, were distributed nationwide. A display board containing messages on safe delivery and childbirth preparation was produced and distributed to 318 clinics, and were placed in public areas where men will see them. The displays also provided free leaflets describing men’s role in protecting maternal health.

#### 16. Enechhi Shurjer Hashi Receives National Acclaim

*Enechhi Shurjer Hashi* (ESH) received the second highest TV rating while two of the drama serial’s stars, including NSDP Brand Ambassador Joya Ahsan, were nominated for the prestigious Meril–Prothom Alo Star Performance award.

#### 17. Celebrities at Measles “Catch-up” campaign events

Both Joya Ahsan and Md. Rafique made clinic appearances in connection with a national measles “Catch-up” campaign. At least 22 daily newspapers covered the duo’s visits to clinics in Chittagong, Khulna, and Jessore managed by NGOs, Image, Nishkriti, Fair Foundation and PKS. The press coverage contributed to the national image of the Smiling Sun network and also encouraged people to have their children vaccinated.

#### 18. Rickshaws advertise Smiling Sun clinics



NGO Service Delivery Program



Rickshaw tin plates were produced and distributed, each containing the name and address of a local Smiling Sun clinic and the name and logo of the NGO managing the clinic. Each NGO produced 25-30 tin plates for each clinic, and, working with local rickshaw committees, ensured that they were affixed to local rickshaws.

**19. Best Performer award**



The “Best Performer” award was introduced to NSDP NGOs to recognize significant contributions made by Smiling Sun providers. The award ceremonies were organized on World Population Day in 2005 and 2006 at clinics, and included GOB and community stakeholders. A Best Performer was selected from each clinic among the paramedics, service promoters, counselors, clinic aids, and depot holders based on nine criteria. Best Performers were presented with a crest and a certificate.

**20. Best Clinic award**

NSDP also introduced an award for the “Best Clinic” to encourage NGOs to maintain high standards. On the basis of eleven criteria, 10 clinics were awarded. The award included a certificate and crest handed over during a NGO Coordination meeting in July 2006.

**21. Dhaka intra-city buses promote PLTM**

NSDP developed advertisements for Smiling Sun services to be displayed on Dhaka buses. Five Dhaka buses featuring promotional messages on PLTM using the image of Md. Rafique moved through Smiling Sun catchment areas (Jatra Bari-Savar-Motijheel-Mirpur-Kamlapur-Tongi-Farmgate-Gabatali) starting October 2006 for one year. The buses displayed the messages on the back panel. The services advertised were offered at nearby Smiling Sun Clinics.



**22. Technology Transfer of BCC materials for 8 new services**



To begin transferring BCC and marketing technologies to the NSDP NGOs, several promotional BCC materials such as banners, posters, leaflets, and signboards were designed for promoting eight new income-generating clinic services in communities. The designs of these BCC materials were sent to the NGOs on CD with color layouts to print locally. The clinics are using these materials to create awareness in their communities and to attract more customers to the clinics for new services, as well as for ESD.

**23. Promotion of Smiling Sun clinics by leading newspaper, "Prothom Alo"**



...ery Program

NSDP and the daily newspaper, Prothom Alo, signed a one-year contract in July 2006 to promote the Smiling Sun network of clinics. Under this contract, Prothom Alo published reports, features, interviews, editorials, and Q&A articles addressing many activities and issues important to basic health care for the poor. Prothom Alo published 16 articles through June 2007.

#### 24. Umbrellas and Saris designed for clinic staff

NSDP provided Smiling Sun-branded umbrellas and saris for services providers. The umbrellas were provided to paramedics, clinic aids, service promotion officers, service promoters, and depot holders. The saris were provided to depot holders. The Umbrellas and saris served to attract potential customers in communities and motivate providers, especially depot holders.

#### 25. Screening of cinema ad

NSDP produced TV ads on PLTM, and maternal and child health, which were not aired because sponsors were unavailable. Therefore, NSDP converted the TV ads to 35mm film to show at cinema halls in clinic catchment areas for 1 month in two phases. Each ad was 1 minute and was screened once at the beginning of each movie, 3 times per day. A total of 239 cinema halls were chosen from catchment areas based on their proximity to Smiling Sun clinics.

#### 26. Promotion through Billboards



NSDP promoted health messages through billboards at 150 strategic sites nationwide on ANC, EPI and General Health Care issues. Fifty (50) billboards were re-wrapped with new messages on NSV, PNC, IUD and home

delivery during FY 2007.



#### 27. Program Planner

A NSDP yearly program planner was printed and distributed to NGOs, clinics, government officials and other stakeholders for 2007. It provides health messages in addition to information on NSDP.

#### 28. Street Drama script developed for the NGOs



As part of local-level BCC Campaign, NSDP employed its Enter-Educate approach in developing five street drama scripts. The dramas focused on health services, such as ANC, PNC, ARI, EPI, and PLTM. Each drama featured information on a selected topic, was intended to attract a variety of people from urban and rural backgrounds and also described other health services offered at Smiling Sun clinics. A fact-pack was included at the end of every drama in which some key issues were addressed.



### 29. Implant Training Video

In conjunction with the DGFP, NSDP developed a technical training video on Implants, which was the first ever training video developed for use as a training aide by NSDP and the GOB. The video was sent to 2 NGO and 9 GOB training centers for use during implant training. The objective of the video was to assist providers to develop their skills on pre-procedural client counseling, screening, procedural steps and post-procedural counseling. The video also tackles misconceptions related to implants and how to address them.



### 30. Motivational video on PLTM



To promote PLTM services in NSDP catchment areas, NSDP developed a 20-minute video with excerpts from the *Enechhi Shurjer Hashi* drama serial, moderated by the actor, Riaz. In his role, Riaz urged the community, particularly men, to consider the benefits of a small family, be knowledgeable of PLTM, and choose one method suitable for their families. The video was distributed to Smiling Sun Clinics in early November 2006 to be shown in clinic waiting rooms and in communities.

### 31. Music video

A motivational video of songs on 8 health topics sung by four eminent singers was developed to promote health services at Smiling Sun clinics. The 8 songs addressed ANC, safe delivery, PNC, EPI, ARI treatment, permanent and long-term methods of contraception, and tuberculosis treatment. The video is shown in clinic waiting rooms, in communities, and at satellite clinic spots.



### 32. Counseling video to improve skills of service providers



NGO Service Delivery Program



It is universally recognized that effective Interpersonal Communication and Counseling skills can make a difference in client-provider relationships and impacts on a client's rights and satisfaction.



PLTM use has decreased in the past few years nationwide, so NSDP produced and distributed a 30-minute PLTM Counseling Video for paramedics, counselors and clinic aids to all 318 clinics to sharpen their counseling skills and make permanent or long-term methods of choice when appropriate.

### 33. Scaling-up dual protection program among rickshaw pullers

NSDP, in collaboration with the Population Council, piloted the intervention, “Increasing Dual Protection among Rickshaw Pullers” in FY 2006. The results were encouraging. During NSDP's last year, the collaborative effort was scaled up to 35 clinics of 5 NGOs based on several criteria. NGO management and field staff were oriented, 75 Community Educators (one per clinic) were recruited and trained at regional levels in 5 batches over 5 days. Immediately following training, implementation began to increase use of modern contraceptive methods, especially among rickshaw pullers, increase knowledge about safe sex, STIs, HIV/AIDS, and increase correct and consistent use of condoms for preventing pregnancy as well as infections.



### 34. Transfer of technology for conducting local-level BCC/Marketing



NSDP developed a BCC and Marketing Toolkit to enable NGOs and their staff engaged in promotional activities to design and implement their BCC and marketing activities at NGO and clinic levels. An orientation on the toolkit for the NGO Project Director and the Project Manager/Monitoring Officer was held on May 8 and 9, 2007 in two batches.

### 35. Impact of the Smiling Sun Communication Campaign

The NSDP communication campaign was launched in 2005-6, and consisted of two components: airing of 26 episodes of an Enter-Educate TV drama serial *Enechhi Shurjer Hashi* and local-level BCC activities. The latter were conducted in 318 Smiling Sun clinics and consisted of two elements: health services promotion and brand positioning. 6 specific health services were promoted through offers for free or 50% discounted rates in conjunction with the airing of the TV drama episodes related to those services.

An evaluation survey was conducted between December 6, 2005 and May 12, 2006, and the report was finalized in August 2006. Interviews were conducted after the airing of five selected *Enechhi Shurjer Hashi* episodes. Within Smiling Sun catchment areas, community surveys were conducted with 4,300 women and men. Outside the catchment areas, 864 people were interviewed during the fifth round of data collection. Also within catchment areas, 3,200 people were interviewed who



needed the health service depicted in the television show, but did not go to a clinic for care. Exit interviews were given to 3,200 people who did go to a Smiling Sun clinic for services.

About 40 percent of community respondents watched at least one episode of the drama and 51 percent had seen at least some form of BCC. Youth, education, socioeconomic status, and urban living were all positively associated with viewing the drama. Eighty-six percent of women and 83 percent of men reported having seen the Smiling Sun logo. Smiling Sun clinics were more widely known among women (91 percent) than men (81 percent).

The likelihood of awareness of clinics was 10.5 times higher among women who had exposure to local BCC activities compared to those who had not. The likelihood of awareness was 3.6 times higher among women who watched the drama compared to those who did not. Fifty-eight percent of female respondents reported having ever visited a clinic. Women exposed to local-level BCC activities or who watched the drama were significantly more likely to use Smiling Sun clinics, in particular, or other clinics.

The drama was rated as one of the most popular shows aired on national TV. The whole nation was exposed to the drama while only one-seventh (20 million) of the population was exposed to both the drama and local-level BCC activities. In non-catchment communities, the likelihood of seeking services from a health center was significantly higher among those who watched the drama than those who did not watch. This means that the airing of the drama had a significant impact on the use of health services in Bangladesh, in general. It also implies that information can be given to families, in both easy and hard-to-reach communities, through drama serials to enhance health awareness and improve health care. Local BCC activities, though their reach is limited, does improve the health-seeking behaviors of those who are exposed to them.

### **OBJECTIVE 3: INCREASE THE CAPACITY OF NGOS TO SUSTAIN CLINIC AND COMMUNITY SERVICE PROVISION**

#### **1. Service Expansion: Adding New Services to Improve Sustainability**

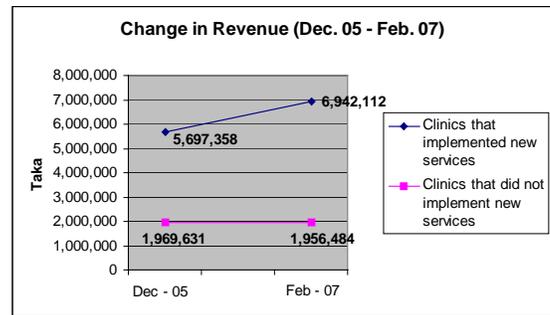
In 2005, the NGO Service Delivery Program (NSDP) began an initiative to assist NGOs to expand the range of services offered by their Smiling Sun clinics. The objective was to increase financial sustainability by increasing revenue and diversifying sources of income. The NSDP team identified a list of new services that clinics could add to their current menu of services. These services had to both generate revenue and serve the needs of the community. The services were Safe Delivery, Emergency Obstetric Care (including C-sections), Ultrasound, specialist/contract physicians, Health Care Mart, Expanded Pharmacy, Laboratory service and Ambulance services. NGOs had the autonomy to select which of these services their clinics would undertake, and, with NSDP assistance, they developed detailed Business Feasibility Plans that included in-depth market/competitor analysis and budgeting information.

Safe Delivery	28 clinics
Healthcare Mart	95 clinics
Pharmacy	26 clinics
Laboratory	135 clinics
EmOC	20 clinics
Ultrasound	33 clinics
Contract Physician	54 clinics
Ambulance	45 clinics



NSDP also worked with individual NGOs and clinics to tailor market and pricing strategies for specific catchment populations. Once these plans were approved by USAID, NSDP staff worked hand in hand with the NGOs to ensure new services were implemented within an ambitious time frame and according to required technical guidelines. In total, NSDP assisted 31 NGOs to implement 405 new services across 213 clinics in the Smiling Sun network.

The data show that over a two-year period, the clinics that implemented new services increased revenue by over 21%, while clinics that did not implement new service actually experienced a revenue decrease of 0.67%. In an increasingly fluctuating donor funding environment, it is important for NGOs to be able to diversify their sources of income and generate their own revenue. This will contribute significantly towards financial sustainability and enable the NGOs to continue to provide needed services to their catchment populations.



In addition, NSDP found that expanding services helped NGOs better meet the needs and demands of their communities. Community members clearly see Smiling Sun clinics as providers of affordable high quality services. Thus customers are pleased to access a Smiling Sun clinic for as many services as possible.

Finally, the service expansion process demonstrated that NGOs can expand their menu of services while still maintaining high quality and a commitment to their mission of serving the poor. NGOs and clinics themselves may determine which services are most compatible with the needs of their catchment population. The data show that Emergency Obstetric Care (EmOC) generates the most revenue per customer, while pharmacy, Health Care Mart and laboratory services bring in the most customers. It is recommended that NGOs look at the lessons learned from the service expansion initiative under NSDP, and consider using it as a model for providing more services to their communities.

## 2. Final MOCAT Assessment: An Analysis of NSDP NGOs' Organizational Development from FY 2003 Baseline to FY 2007 Assessment

The MOCAT (Modified Organizational Capacity Assessment Tool) is a survey instrument designed to assess the organizational capacity and sustainability of the all 33 NSDP NGOs. The MOCAT uses individual and group interviews, focus group discussions, and interviewer observations to assess each NGO across three pillars of sustainability – Institutional, Programmatic and Financial.

Findings from the MOCAT assessments show that many NGOs have made important progress between the FY 2003 baseline and the FY 2007 MOCAT assessment. All NGOs that previously ranked as Nascent have graduated to the Emerging category, and many NGOs moved from the Emerging to the Expanding category. Performance under the Programmatic Pillar maintained the highest overall scores and marked considerable improvement in the Quality of Services component. This finding is consistent with NSDP's strong focus on providing technical assistance for service



delivery and quality improvement. The second highest scores were found in the Financial Pillar. Performance under its Revenue Stability component, particularly under Core Services Fee, marked one of the highest overall score increases, in keeping with the Program's increased focus on NGO financial sustainability in the latter phase of the Program.

The Institutional Pillar remains the weakest, presenting a continued challenge for most NGOs. However, three of the subcomponents within this Pillar have marked the greatest level of improvement among all MOCAT subcomponent scores: Mission and Values, Program Planning, and Operations. Regarding the Program's designation of focus NGOs, focus NGOs registered higher overall scores than non-focus NGOs, within their cohorts. This can be explained by the fact that focus NGOs received additional targeted assistance in FY 2006 and FY 2007 and that the selection of focus NGOs was based on the existing capacity of NGOs and their demonstrated performance and commitment.

The higher level of improvement documented among the focus NGOs suggests that targeting high-performing organizations may be a useful strategy to expand upon, for the provision of technical assistance to NGOs. Focus NGOs in all cohorts showed greater progress across many critical components of the MOCAT assessment. This is likely the result of both the tailored approach to technical assistance and the targeted selection of a more dynamic set of NGOs that were better poised to receive technical assistance and test new approaches.

The tailored approach to delivering technical assistance may also be paired with a more performance-based management approach in future endeavors. NGOs are likely to make greater progress across multiple components of sustainability if they are to receive some tangible benefits and rewards for measurable success. For this type of technical assistance strategy to work, a more nimble sustainability survey and measurement system would be required. The MOCAT served as a very useful tool for NSDP NGOs and program managers wishing to document each NGO's current sustainability status on a very detailed and comprehensive level. The richness of the MOCAT data was useful in identifying areas of intervention, by both the NGOs and by NSDP as a whole. However, the comprehensiveness of the MOCAT tool and the survey methodology meant that its implementation was a time-consuming process. In order to shift towards a performance-based approach, NGOs would require a more stream-lined survey process that makes priority data readily available for decision-making on a regular basis.



## NGO Average Scores: Components and Subcomponents

Component	Subcomponent	2003 Baseline	2006 Final Score	Variance
<b>INSTITUTIONAL PILLAR</b>		1.65 – Emerging	1.69 - Emerging	0.04
Governance	Board of Directors	1.73 – Emerging	1.72 - Emerging	(0.01)
	Mission / Values	0.92 – Nascent	1.30 - Emerging	0.38
	Leadership	1.77 – Emerging	1.66 - Emerging	(0.11)
	Average score	1.48 – Emerging	1.56 - Emerging	(0.08)
Management Practices	Organizational Structure	1.87 – Emerging	1.67 - Emerging	(0.20)
	Strategic Planning	0.91 – Nascent	1.09 - Emerging	(0.18)
	Program Planning	1.27 – Emerging	1.65 - Emerging	0.38
	Operations	1.94 – Emerging	2.42 - Expanding	0.48
	Management Style	1.80 – Emerging	1.84 - Emerging	0.04
	Average score	1.56 – Emerging	1.73 - Emerging	0.17
Human Resources	HR Policy	1.66 – Emerging	1.65 - Emerging	(0.01)
	Recruitment	2.02 - Expanding	1.86 - Emerging	(0.16)
	Gender	2.05 - Expanding	1.86 - Emerging	(0.19)
	Average score	1.90 – Emerging	1.79 - Emerging	(0.11)
<b>PROGRAMMATIC PILLAR</b>		1.86 – Emerging	2.01 - Expanding	0.15
Customer Focus	Customer Needs	1.83 – Emerging	1.97 – Emerging	0.14
	Customer Reach	1.67 – Emerging	1.90 – Emerging	0.23
	Average score	1.75 – Emerging	1.93 – Emerging	0.18
Quality of Services	Culture of Quality	1.99 – Emerging	2.23 – Expanding	0.24
	Customer Service	1.98 – Emerging	2.26 – Expanding	0.28
	Average score	1.98 – Emerging	2.24 – Expanding	0.26
External Relations	Marketing / PR	1.88 – Emerging	1.87 – Emerging	(0.01)
	Community Relations	1.83 – Emerging	1.84 – Emerging	0.01
	NGO / Private Sector Relations	1.31 – Emerging	1.28 – Emerging	(0.03)
	Government Relations	2.32 – Expanding	2.22 – Expanding	(0.10)
	Funder / Donor Relations	2.01 – Expanding	2.07 – Expanding	(0.06)
	Average score	1.86 – Emerging	1.86 – Emerging	0.00
<b>FINANCIAL PILLAR</b>		1.71 – Emerging	1.82 – Emerging	0.11
Financial Management	Accounting	1.97 – Emerging	2.17 – Expanding	0.20
	Budget	1.74 – Emerging	1.64 – Emerging	(0.10)
	Inventory	1.87 – Emerging	2.16 – Expanding	0.29
	Financial Reporting	1.53 – Emerging	1.55 – Emerging	0.02
	Average score	1.78 – Emerging	1.88 – Emerging	0.10
Revenue Stability	Strategy	1.42 – Emerging	1.37 – Emerging	(0.05)
	Core Service Fee	1.83 – Emerging	2.16 – Expanding	0.33
	Local Income	1.19 – Emerging	1.40 – Emerging	0.21
	External Financing	1.53 – Emerging	1.49 – Emerging	(0.04)
	Average score	1.49 – Emerging	1.60 – Emerging	0.11

Component	Subcomponent	2003 Baseline	2006 Final Score	Variance
Cost Consciousness	Expense Management	1.75 – Emerging	1.86 – Emerging	0.11
	Procurement	1.96 – Emerging	2.10 – Expanding	0.14
	Average score	1.85 – Emerging	1.98 – Emerging	0.13

### NGO Categorization FY 2003 and FY 2007 Composite MOCAT Scores

NGO Status by Category	FY 2003 baseline (41 NGOs)	Adjusted FY 2003 baseline (33 NGOs)	FY 2007 Results
Nascent	4	2	0
Emerging	28	24	20
Expanding	9	7	13
Mature	0	0	0

### 3. Private-Sector Collaboration

In support of Objective 3, NSDP has assisted several NGOs in pursuing partnerships with multinational corporations and local Bangladeshi businesses.

#### BATB

British American Tobacco is a multinational corporation involved in the cultivation, manufacture and distribution of tobacco. The company has operations worldwide, including Bangladesh. In the interest of improving health services for its farmers, BATB formed partnerships with three NSDP NGOs, FDSR, PSKS, and Dipshikha Anirban, which operate near the tobacco fields. The partnerships have improved access to health care for 2,500 employee's and family members, increased the number of farmers working with BATB, and increased the cost recovery of the partner NGOs, one by over 50 percent.

#### Chevron

In January of 2005, Unocal (now Chevron) conducted a health care assessment to determine the needs of the community in which it was operating. The assessors found the situation to be very dire – there were three facilities in the region, all of which offered the most basic of services at very low quality. Based on this, Unocal approached USAID about partnering with a well-established NGO to develop a plan for providing health services to the community. USAID referred the company to NSDP, which worked within its Smiling Sun network to identify SSKS as the appropriate NGO to provide services under this arrangement. The partnership has resulted in two new clinics and the construction of two new clinic buildings. The clinic is providing primary health care services covering 44,000 people. For the last two years this partnership has provided services to more than 67,000 customers.



## Grameenphone

In May 2007, NSDP established a partnership with Grameenphone that focuses on maternal and child health. This national program will work within the network of Smiling Sun clinics to provide free MNC health services to the poorest of the poor. The program will focus on the coastal regions where both phone and health services are lacking.



## Garment Factories

NSDP NGOs initiated satellite clinic services to factory workers during the previous USAID project, Urban Family Health Partnership. The arrangements continued under NSDP through the workplace health initiative. Under this initiative, six NSDP NGOs formed or continued business relationships with garment factories. Currently, four NSDP NGOs work with 41 garment factories located in Dhaka, Chittagong, Narayangong, Savar, and Tongi-Gazipur. 20,557 garment factory employees have access to health services through this initiative. Further benefits include that factories are meeting the need to provide health services per international buyer pressure and NGOs have increased revenues.

The commercial sector has the resources, infrastructure and skills to contribute to initiatives that serve both health and corporate social responsibility goals. Partnerships between NGOs and private corporations can be a win-win situation: they can help communities to receive the health services they need, NGOs to increase their revenue stream, customer base, financial sustainability, connections with the private sector and improve brand recognition. At the same time, they help companies to improve worker satisfaction, community and stakeholder relationships, image, and brand recognition. These tactics fit into the goal of NSDP NGOs by advancing financial sustainability and decreasing reliance on external donor funding. However, in order to ensure that these partnerships are beneficial to all parties involved, they must be established with certain guidelines, set clear and measurable goals and be aligned with the private sector partner's mission and vision.

As NSDP is in its final months of implementation, it is important to build on what has been learned under this program, so that current private sector initiatives can be continued and new initiatives can be implemented. Areas drawn from this report to focus on in future collaborations include:

- Private sector partnerships can be successful in generating revenue for NGOs.
- 12 potential partnerships could be revitalized and expanded by the NGOs.
- NGOs need to continue to build capabilities to independently approach companies and design programs.
- NGOs must become more involved in the business community and increase networking via business coalitions such as chambers of commerce or manufacturers associations.



The experience the NGOs received through private partnerships under NSDP is a solid foundation for launching additional, larger private sector partnerships in the future – our work represents a sea change for NGOs that were previously very skeptical about working with the private sector. The NGOs have shown initiative to continue previous partnerships and commence new partnership concepts and ideas throughout NSDP implementation. With several partnership models to choose from, NGOs are well-positioned to continue increasing the number and scope of their partnerships with the private sector. Private sector partnerships offer NGOs in the health sector the opportunity to recover significant amounts of their costs and thus subsidize their less financially viable programs and better meet the needs of the poor. However, private sector partnerships and CSR initiatives need to be expanded upon significantly in the health sector through NGOs and the Smiling Sun clinics. In order to meet their dual mandate, NSDP NGOs must continue to grow and expand private sector partnerships in Bangladesh.

NSDP NGOs initiated satellite clinic services to factory workers during the previous USAID project, Urban Family Health Partnership. The arrangements continued under NSDP through the workplace health initiative. Under this initiative, six NSDP NGOs formed or continued business relationships with garment factories. Currently, four NSDP NGOs work with 41 garment factories located in Dhaka, Chittagong, Narayangong, Savar, and Tongi-Gazipur. 20,557 garment factory employees have access to health services through this initiative. Further benefits include that factories are meeting the need to provide health services per international buyer pressure and NGOs have increased revenues.

#### 4. NGO Clinic Building Construction

To help increase the long-term institutional sustainability of NGOs, NSDP took initiative to construct 25 clinics for 16 NGOs during the NSDP project period. The project-end statement of all clinic buildings constructed is given below:

Clinic Model	Clinic Sizes	Constructed in FY' 05 & 06	Constructed in FY' 05 & 06	TOTAL
A	3,900 sft	1	5	6
B	1,530 sft	2	-	2
D	1,800 sft	6	6	12
E	1,450 sft	2	3	5
TOTAL Clinics		11	14	25

#### NSDP Clinic Buildings Status at a Glance



#	NGO, Clinic Type & Location	Clinic Description
1	BMS, Type A clinic Kutobpur, Narayanganj	Two-story building with EmOC facility, lab facility, and HCM
2	CAMS, Type A clinic Chandpur	Two-story building with EmOC facility, lab facility, and HCM
3	PSKS, Type A clinic Gangni, Meherpur	Two-story building with EmOC facility, lab facility, and HCM
4	IMAGE, Type A-Spl. North Kattali, Chittagong	Three-story building with EmOC facility, lab facility, and HCM
5	PSTC, Type A – Spl. Aftabnagar, Rampura, Dhaka	Two-story building with EmOC facility, lab facility, and HCM with more space
6	UPGMS, Type B Upgr. Tajhat, Rangpur	Two-story building with EmOC facility, lab facility, and HCM
7	GKSS, Type D clinic Sadullapur, Gaibandha	One-story building with mini lab, PLTM OT facility and HCM
8	Kanchan S, Type D, Rajarhat, Dinajpur	One-story building with mini lab, PLTM OT facility and HCM
9	Swanirvar BD, Type D, Bhuapur, Tangail	One-story building with mini lab, PLTM OT facility and HCM
10	Swanirvar BD, Type D, Delduar, Tangail	One-story building with mini lab, PLTM OT facility and HCM
11	Swanirvar BD, Type D, Dhanbari, Tangail	One-story building with mini lab, PLTM OT facility and HCM
12	Swanirvar BD, Type D, Lalmohon, Bhola	One-story building with mini lab, PLTM OT facility and HCM
13	Shimantik, Type E Kanaighat, Sylhet	One-story building with mini lab, PLTM OT facility and HCM
14	SOPIRET, Type E, Nangolkot Comilla	One-story building with mini lab, PLTM OT facility and HCM
15	VPKA, Type E clinic Pangsha Rajbari	One-story building with mini lab, PLTM OT facility and HCM
16	PKS, Type A clinic Benapole Road, Jessore	Two-story building with EmOC facility, mini lab, and HCM
17	PROSHANTI, Type B clinic Noakhali	Two-story building with PLTM OT facility, mini lab, and HCM
18	PSF, Type D clinic Sreepur, Magura	One-story building with PLTM OT facility, mini lab, and HCM
19	PSF, Type D clinic Pirgacha, Rangpur	One-story building with PLTM OT facility, mini lab, and HCM

#	NGO, Clinic Type & Location	Clinic Description
20	Swanirvar BD, Type D, Dewanganj, Jamalpur	One-story building with PLTM OT facility, mini lab, and HCM
21	Swanirvar BD, Type D, Modhupu, Tangail	One-story building with PLTM OT facility, mini lab, and HCM
22	Swanirvar BD, Type D, Debiganj, Panchagarh	One-story building with PLTM OT facility, mini lab, and HCM
23	Swanirvar BD, Type D, Karimgonj, Kishoregonj	One-story building with PLTM OT facility, mini lab, and HCM
24	SOPIRET, Type E, Lakhsham, Comilla	One-story building with mini lab, PLTM OT facility and HCM
25	SGS, Type E, Muksudpur clinic, Gopalganj	One-story building with mini lab, PLTM OT facility and HCM

## 5. NGO Staff Turnover: Key Findings and Recommendations

One of the most serious problems facing NSDP NGOs is high turnover of technical staff, particularly physicians and paramedics. NGOs have now established technical staff retention strategies based on identifying the causes of staff turnover. Three HR survey tools (employee satisfaction survey, benefits survey, and exit interview) have been developed by NSDP to diagnose causes of staff turnover and to help identify solutions.

As seen in the table below, NGOs within the NSDP network are facing fierce competition for technical talent from NGOs outside the NSDP network, the Government of Bangladesh, and private clinics. Therefore, the engagement and retention of technical talent must become a mission-critical priority for NGOs to be able to continue providing essential health-care services to their clients.

NSDP NGOs are challenged because their employee benefit and pay packages are not competitive with the GOB and the other NGOs. However, implementing a comprehensive benefits package may not be feasible or practical given the NSDP NGOs' funding constraints. This may be resolved through the implementation of non-financial incentives, family-friendly leave policies, and career development opportunities, which may also address the staff turnover issue.

Benefit	NSDP Guidelines	Non-NSDP NGOs	GOB
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Benefit	NSDP Guidelines	Non-NSDP NGOs	GOB
Provident Fund	NSDP guidelines advise putting a provident fund in place as per government policy, however, most NGOs do not provide	Provident Fund is available at BRAC, Radda and NGO Forum	Provident fund is available
Maternity Leave	2 months for one child only	4 months for each child	4 months for 2 children (proposal for 6 months is in process)
Paternity leave	NSDP norms do not provide	Radda – 10 days BRAC – 3 days	No paternity leave
Pay Scale	N/A	N/A	N/A
Allowances	NSDP guidelines do not provide	BRAC provides accommodation and cook at the workplace	Furnished accommodation Several allowances
Annual leave	NSDP guidelines provide for 22 days	Radda – 40 days BRAC – 27 days, can be accumulated and encashed NGO Forum – 40 days	EL, CL and Rest & Recreation Leave EL (2 types): 1 day for every 12 days service with ½ pay and 1 day for every 11 days service with full pay CL: 20 days per year Rest & recreation Leave: 15 days per every 3 years with 1 month basic pay
Gratuity	NSDP does not provide. Swanirvar provides gratuity	BRAC and NGO Forum provide gratuity benefit; BRAC uses a sliding scale that provides higher benefit for longer service	Gratuity provided
Pension	NSDP does not provide	No info	Pension provided
Insurance	NSDP does not provide	NGO Forum provides Group medical insurance	Health insurance premium provided
Education Allowance	NSDP does not provide	BRAC provides this subject to employment bond	Study support available (leave + pay)
Non-practicing allowance	NSDP does not provide	BRAC provides this	Does not provide
Festival bonus	1.5 months basic	2 months basic	2 months basic pay in every year
Other Benefits	Not clear	Radda – Treatment allowance and subsidized pathology facilities	Income Tax paid by government status, job security

## 6. Governance

Governance refers to the system of authority and decision making within an NGO, and encompasses the role of executive committees or boards of NGOs, their missions and values, and the role of others who play leadership roles. MOCAT scoring reveals that NGO governance is the area most in need of improvement. NSDP has provided extensive TA and guidance to that end, which includes assistance with mission and values statements, and help in developing induction materials for new Executive Committee members, and work on leadership development issues.

In 2003, NSDP held a large symposium on leadership development, provided a leadership manual and other reference materials, and individual follow-up TA. Topics covered at the symposium included informing members about the roles, management responsibilities and functions of an executive committee; potential sources of conflicts of interest; diversifying member composition; the development and dissemination of a mission and values statement and also leadership development, succession planning and management styles.

NGOs have revised their vision and mission statements to emphasize the necessity of actively seeking to provide health care services to the very poor. Vision and Mission statements are important tools to reinforce institutional identity. Initially all NGOs had only project focused statements, rather than organizational ones, and those were neither widely disseminated nor well understood. All NGOs have now produced institutionally focused vision and mission statements.

## 7. Planning for Sustainability

Three “Planning for Sustainability” workshops (two in August 2003 and one in January 2004) helped NGOs with strategic plans, defining long-term goals and strategies, and action/work plans. NGOs were given templates to create their own plans.

Absence of both program planning and feasibility studies were identified by the NGOs as critical capacity gaps. NSDP now analyzes the viability of new programs, taking into account programmatic needs, community demand, and financial capacity. NSDP now requires NGOs to complete project feasibility plans to use their program income/revenue funds for expanding service options. We assist NGOs in introducing revenue-generating services based on business plans and "feasibility plans". Revenues from these services are used to cross-subsidize services for the poor, and public health services otherwise unlikely to be funded.

Poor organizational capacity assessment was also identified as a critical capacity gap for NGOs. Needs-based sustainability strategies were developed based on MOCAT scores. Annual verification of MOCAT is necessary as NGOs take up the self-assessment MOCAT methodology.

## 8. Human Resources

One of the most serious problems facing NSDP NGOs is high turnover of technical staff, particularly physicians and paramedics. NGOs have now established technical staff retention strategies based on identifying the causes of staff turnover. Three HR survey tools (an employee



satisfaction survey, a benefit survey and an exit interview) have been developed by NSDP to diagnose causes of staff turnover and to help identify solutions. Assistance in analyzing survey data and designing staff retention strategies is provided to NGOs.

In October 2003, NSDP introduced a uniform salary structure, and standard salary designations which now apply to 5,500 NGO staff –the first such time a salary system has been implemented by a USAID health project in Bangladesh. There is now a standard human resources policy and uniform job description for all NSDP NGO staff.

## 9. NSDP NGOs Leadership and Succession Planning

As NSDP NGOs develop, grow stronger they enjoy a number of successes in technical implementation, expansion and community recognition. However, as NGOs advance and mature, they are faced with a new set of challenges related to developing in the next generation of leaders. NSDP NGO leaders are the original founders and have personally carried the NGO to its current state of success. These NGOs are now struggling with issues around how to develop the leadership qualities of more junior staff and how to plan for the eventual succession of their executive directors and other senior managers.

In order to address this very challenging agenda, NSDP had organized “Succession Planning Workshop” for seven NGOs on December 17, 2006. Fifty one individuals participated from the following 7 NGOs: CWFD, Kanchan Samity, BAMANEH, PKS, SSKS, Fair Foundation and Swanirvar Bangladesh. The three best practices on leadership succession were presented by Mr. Fazle Hasan Abed, Chairman, BRAC, Mr. Kazi Fazlur Rahman, Chairman, Radda MCH-FP Centre, and Commander (Retd.) Abdur Rouf, Policy Advisor, PSTC. Additionally, a hands-on leadership succession exercise was conducted by Ms. Andrea Camoens from EMG Headquarters.



A compiled analytical report has been prepared titled “Report of the NGO Leadership and Succession Planning Workshop” highlighting best practices, present lessons learned and challenges of implementation. A template was developed and all participating NGOs received technical assistance with a specific tailor made and appropriate succession plan for the respective NGO. These plans require approvals from the General Body of the respective NGO in the next AGM before institutionalizing such plans.

## 10. Diversification of NGO Sources of Funding and Revenue

NSDP worked with the best performing NGOs to broaden and diversify their sources of revenue. A one-day workshop held in early February 2007 offered technical assistance to a group of better-performing NGOs, characterized by the resources and effort they devote to achieving revenue stability. The NGOs which participated were: BAMANEH, Swanirvar, CWFD, PKS, PSTC, Kanchan, PSF, SSKS, FDSR, BMS, Fair Foundation, Tilottama, JTS and Sopiret. The workshop focused on nine specific revenue and funding diversification strategies. Each of the NGOs



participating in the workshop developed action plans for each of the nine strategies. The strategies discussed included:

- Adding new non-core services
- Rationalizing fees for core services, products and medicines
- Fund raising in communities
- Contracting with the GOB
- Contracting with local private-sector clients
- Financing through loans and leases
- Endowments
- Corporate social responsibility and philanthropy
- Funding from donors

## 11. Restructuring User Fees

All NSDP NGOs and 318 clinics have actually changed their pricing structure at least once since April 2004, and 315 clinics have changed the pricing structure more than once. With technical assistance from NSDP, seventeen NGOs adjusted their service charges by the end of 2004 and have shown improvement in cost recovery rates. In analyzing data of all thirty-four NGOs, from July 2002 to December, 2004, we can conclude that those NGOs who adjusted service charges achieved higher cost recovery than those who did not. The average cost recovery rate of the control group (NGOs who did not adjust their user fees), at 18%, was similar to that of the intervention group (NGOs who adjusted their user fees) before price changes. The cost recovery rate of the intervention group after price changes increased to 23%. To clearly identify the impact of price changes on cost recovery, a more rigorous statistical analysis is needed.

NSDP conducted a regression analysis to estimate the impact of price changes on cost recovery. Recognizing the different initial levels of cost recovery rates of all NGOs and possible improvement over time, a linear regression was run to explain variations in quarterly cost recovery rates of all 33 NGOs for the 10 quarters. All three independent variables: initial rate, time trend, and time when price change took place, are statistically significant. On average, cost recovery rates increased by .15 percentage points each quarter. The time of price change demonstrated a much bigger impact on cost recovery rates. At a 99% significance level, the estimated coefficient for the price change is 4.5 percentage points. This means that all NGOs who conducted a rational pricing exercise and acted accordingly improved its cost recovery rate by nearly 5 percentage points.

Significant progress was made in analyzing the impact of rational pricing on clinics' revenues. NGOs were requested in December 2006 by NSDP to provide user fee information for the period from April 2004 to December 2006. User fees were reported by clinic, by service, and by month. Analyses based on regression model suggests that for each Taka increase in total user fee, the total revenue would increase by 25 Taka, representing a 250% increase. This empirical result indicates that the rational pricing strategy has been very effective in improving the total revenues of the clinics. By comparison, if total customer volume increases by one person, the total revenue would increase by only 2 Taka.



By plugging the average values of total user fees and total customers into the regression model, we estimated the average total revenue for April 2004 and December 2006. The model shows that over this period, the average total revenue increased by 8.17% (see table below). The average total user fee increased by 32.91% and therefore contributed to 76% of the 1,715 Taka increase in average total revenue. The average total customer volume increased by 3.57% and contributed to 24% of the increase in average total revenue. The above analysis once again suggests that the rational pricing intervention adopted by NSDP NGOs and clinics has been successful in raising the total revenues of the clinic.

	April 2004 Average	December 2006 Average	Changes in between	% of Changes
Average Total User Fee	158	210	52	32.91%
Average Total Customer	5600	5,800	200	3.57%
Predicted Total Revenue	20,998	22,713	1,715	8.17%

Based on the above statistical analysis, it is evident that the NSDP rational pricing intervention is a success and has contributed significantly to the improvement of cost recovery rates of many NSDP NGOs.

## 12. Designing and conducting a Cost Structure and Staff Utilization Survey of NSDP clinics

The overall objective of this study was to understand, estimate and analyze the cost structure of the ESP and explore scenarios of staff utilization in NSDP NGOs and clinics. The specific objectives of the study are as follows:

- (1) To measure the economic efficiency (cost of services and staff utilization) of NGOs and clinics in providing ESP services;
- (2) To analyze the underlying factors that determine the economic efficiency (cost structure and staff utilization) of NGOs and clinics; and
- (3) To suggest management changes that could improve economic efficiency.

The cost survey was designed by NSDP. A local firm, Human Development Research Center, was chosen by a selection committee to conduct the survey and the analysis with supervision and technical inputs from HMFT. The survey and analysis work was completed by December 2005.

The study reveals that irrespective of provider and service type, the actual time devoted to customers (as direct contact time) is less than that required as per the standard time. The volume of customers in NSDP clinics is generally low, which increases the relative share of overhead and downtime, which in turn affects the unit cost, cost of down time and average cost. Also, the highest



number of customers' visits to doctors is for LCC (both rural and urban) and for Injectables in satellite clinics. About 67-77% of downtime consists of waiting time for customers. Over 75% of urban and 80% of rural customers expressed their willingness to take service in off-peak hours.

The cost study recommended the use of a costing tool to help NGOs improve their performance and to plan their future activities. NSDP chose to use the CORE (Cost and Revenue) model along with a performance improvement approach to improve efficiency. CORE helps NGOs easily identify which areas of service provide greater cost recovery rates, and which areas are less financially successful. Armed with this information, NGOs can plan marketing campaigns to enhance revenues from more productive areas, and to increase demand, where necessary, from underperforming services. With the benefit of this information NGOs can more easily plan to cross-subsidize some less financially sustainable services with revenues generated by more profitable services.

The CORE tool has been adapted for use by Smiling Sun NGOs. Selected staff from NSDP headquarters and Smiling Sun clinics were trained in CORE and served as “master trainers”. The CORE modeling tool combined with a PI approach was introduced to 14 selected NGOs. Following data entry, NGO staff summarized and analyzed their data with the CORE tool. Using a performance improvement approach, a root cause analyses was done on findings, interventions were planned, and action plans for clinics were devised. Results of the core modeling are summarized in the table below.

**Table:** Cost and revenue information generated by CORE

A	B	C	D	E	F	G	H
	Cost recovery, FP	Cost recovery, MCH/ Obstetric care	Cost recovery, curative care	Average cost per services (Taka)	Average net revenue per services (Taka)	Average surplus/ loss per Services (Taka)	Average percentage of costs recovered
PKS_K	20%	21%	<b>65%</b>	27	6	-21	25%
Kanchan	19%	20%	32%	19	5	-14	28%
SSKS	7%	20%	16%	48	5	-43	19%
BAMANEH	28%	22%	16%	23	5	-18	22%
BMS	20%	<b>28%</b>	29%	22	6	-16	<b>31%</b>
PSTC	7%	19%	13%	32	4	-28	16%
Fair Foundation	6%	10%	11%	24	4	-20	15%
JTS	12%	14%	12%	17	2	-15	15%
MMKS	<b>30%</b>	21%	26%	21	5	-17	27%
PSKS	20%	25%	20%	21	5	-17	27%
CWFD	13%	22%	23%	33	<b>9</b>	-25	24
Swanirvar	15%	18%	15%	23	3	-20	17
VPKA	19%	12%	6%	19	2	-17	14
SOPIRET	17%	22%	13%	25	4	-21	17
PKS_J	10%	12%	13%	<b>8</b>	2	<b>-6</b>	12

Note: for columns B-D, F&H, bold figures represent “highest”; for columns E & G, bold figures represent “lowest.”

The CORE analysis has helped NGOs identify ways to improve their cost recovery rates, including readjusting fees, collecting fees, and improving clinic and staff use rates. The NGOs were surprised at some of the CORE results, such as finding that fee collection rates are too low because of clinics' propensity to accept partial payment for services. The NGOs are now better able to pinpoint problems such as under-used staff, and can reassign them to areas where there is greater need.

The CORE tool also helped NGOs highlight areas of underperformance in service provision, which NGOs can address by improving marketing plans to enhance revenues from more productive areas, and to increase demand for underused services. With the benefit of this information, NGOs can more easily plan to cross-subsidize less financially sustainable services with revenues generated by more profitable services.

Using the CORE model, NGOs are able to simulate the effects of adjustments such as:

- Reallocating staff to improve their use and reduce the average cost per service,
- Increasing patient contact time to help improve service quality and increase the staff use rate, and
- Increasing client volume to reduce the average cost per service and increase cost recovery rates.

By exploring a range of scenarios, NGOs can find the optimal use of staff and facilities.

The following are some examples of how NSDP NGOs used the CORE tool to improve performance in their clinics:

### ***JTS***

CORE results showed a big gap between the cost per services and revenue per services. To minimize this gap, JTS increased the charges for some services in their clinics. To minimize cost per service, JTS rearranged their staffing pattern and reduced the number of depot holders, thus reducing clinics' salary costs.

### ***CWFD***

CWFD found that the fee collection rate was very low in some of their clinics. Those clinics decided to decrease the service charge but increase their fee collection rate. CWFD also increased sales of health benefit cards to paying customers. CWFD's revenues have increased as a result of these efforts.

### ***BAMANEH***

One of BAMANEH's clinics took the following steps in response to the results of the CORE analysis:

- Depot holders visit each customer's house once a month to promote services.
- A list of both potential and present antenatal care satellite clinic customers was made. Depot holders visit all antenatal care customers the day before the satellite session to encourage them to attend.
- Depot holders have started selling health benefit cards.



Another of BAMANEH’s clinics has made a list of antenatal care customers who have failed to return to the clinic for follow-up visits. Paramedics visit those mothers and provide services for a fee. The NGO claims that these activities have increased both clinics’ customer volume and revenue.

### ***PKS\_Khulna***

PKS\_Khulna saw that their cost per service is too high. They took the following steps to increase customer volume in their clinics:

- Attract wealthy and middle class customers through interpersonal communication,
- Attract male customers through interpersonal communication,
- Provide special discounts for clients who must travel long distances to reach the clinic,
- Promotion of family planning for male customers, and
- Advertisement on rickshaw plates.

As a result, PKS\_Khulna has increased the number of customers in all of their clinics.

### ***SSKS***

In SSKS’s Moulvibazar clinic, the CORE analysis showed that the customer volume was low. To attract more customers, they arranged for a doctor to visit the satellite clinic two days per week. This intervention increased the number of customers attending the satellite clinic, and consequently the revenue of the clinic. The Moulvibazar clinic was previously accommodated in two rented buildings. To cut overhead cost they have condensed the clinic into one building.

Customer volume was also low in the Sunamganj clinic and the CORE analysis found a gap between the cost of services and the revenue they bring in. The clinic has increased visits to the homes of potential and existing customers and planned to increase the fee collection rate. As a result they have increased their customers and also their revenue.

With results from CORE exercise combined with PI approach, the NGOs were able to pinpoint the areas requiring further improvement so as to reduce the expenses per services. The table below shows the yearly expenditure per service (for 14 selected NGOs). Although the table below shows that the expenses per services have rather increased instead of decreasing, the reason being that during 2006 and onwards, many of NSDP clinics undertook large expenditures to expand services (such as, infrastructural developments, service expansion, etc.). It is expected that with expanded services, the cost per service will decrease because more customers will visit the clinics in order to avail the new services introduced.

<b>Year</b>	<b>Rural (in taka)</b>	<b>Urban (in taka)</b>
2004 Apr-December 2004)	13.62	23.17
2005 (Jan-December 2005)	14.28	25.65
2006 (Jan-December 2006)	16.53	36.40
2007 (Dec06-May 2007)	22.30	22.11



### 13. Health benefit cards

#### A. Health benefit cards for the poorest of poor

NSDP has actively encouraged its NGOs to increase services to the poor who cannot afford to pay, and has worked on several initiatives to reduce financial and social barriers to providing services to these least advantaged people.

##### a) Formative Research

In 2003, the Human Development Research Centre conducted formative research on reaching the poorest of the poor in NSDP's clinics. As of January 2005, NGOs used a standardized definition of "least advantaged," or "poorest of the poor", to enable a more accurate comparison and data analysis. The definition of "poorest" encompasses households' possession of, or access to, certain assets. Although data is collected on the numbers of poor served, the definitions of poor vary widely, such that paying clients that may be counted as poor clients.

**Table 1: POP Identified and Served (from Apr 04 – May07)**

Serial No.	NGO	Type	# of clinics	# of catchment ELCO	POP identified, May 07	C as % of B	E	F	G	H	I	J	K	L
<b>RURAL</b>	<b>17</b>		<b>179</b>	<b>2,441,570</b>	<b>189,375</b>	<b>8</b>	<b>171,796</b>	<b>91</b>	<b>121,455</b>	<b>1,462,341</b>	<b>8</b>	<b>1,149,444</b>	<b>89,086</b>	<b>4</b>
1	BAMANEH	Rural	18	224,887	15,215	7	14,455	95	8,497	148,589	6	49,238	7,302	3
2	BANDHAN	Rural	6	97,843	7,103	7	6,770	95	1,553	53,155	3	37,595	3,669	4
4	CRC	Rural	2	23,000	2,209	10	2,209	100	1,048	15,644	7	3,281	1,071	5
8	FDSR	Rural	12	141,864	8,115	6	7,119	88	7,748	82,850	9	57,210	41	-
10	JTS	Rural	25	302,570	19,621	6	19,352	99	17,422	239,956	7	106,237	5,669	2
14	MMKS	Rural	6	81,795	20,938	26	19,547	93	10,561	36,858	29	39,311	6,666	8
15	NISHKRITI	Rural	8	231,065	8,801	4	7,430	84	5,273	33,290	16	72,705	5,925	3
17	PROSHANTI	Rural	5	51,257	10,366	20	10,366	100	2,877	5,627	51	68,205	115	-
18	PSF	Rural	15	194,878	14,620	8	10,268	70	4,540	168,358	3	21,404	3,104	2
19	PSKS	Rural	5	62,538	4,439	7	4,242	96	3,620	24,716	15	66,953	3,366	5
21	SGS	Rural	4	48,662	2,492	5	2,492	100	2,899	30,049	10	22,521	1,902	4
22	SHIMANTIK	Rural	6	89,555	6,696	7	5,791	86	5,755	42,735	13	50,017	5,351	6
23	SOPIRET	Rural	8	94,193	6,505	7	6,322	97	7,269	48,660	15	101,384	3,684	4
25	SUPPS	Rural	1	12,333	719	6	718	100	250	2,662	9	3,857	1	-
26	SUS	Rural	6	81,393	3,781	5	2,973	79	1,921	24,515	8	19,179	2,276	3
27	SWANIRVAR	Rural	48	651,560	52,033	8	46,020	88	36,970	472,571	8	397,403	36,325	6
31	VPKA	Rural	4	52,177	5,722	11	5,722	100	3,252	32,106	10	32,943	2,619	5
<b>URBAN</b>	<b>14</b>		<b>140</b>	<b>1,603,281</b>	<b>78,856</b>	<b>5</b>	<b>69,015</b>	<b>88</b>	<b>57,130</b>	<b>412,852</b>	<b>14</b>	<b>690,742</b>	<b>58,364</b>	<b>4</b>
3	CAMS	Urban	6	63,037	914	1	843	92	486	12,430	4	8,789	195	-
5	OWFD	Urban	21	301,712	10,845	4	10,558	97	3,538	42,402	8	69,102	8,812	3
6	DIPSHIKHA ANIRBAN	Urban	1	15,522	384	2	384	100	236	2,049	12	9,375	827	5
7	FAIR FOUNDATION	Urban	11	49,425	1,074	2	1,036	96	3,573	31,702	11	69,629	3,718	8
9	IMAGE	Urban	5	101,591	7,840	8	5,212	66	4,757	21,169	22	63,099	1,108	1
11	KAJUS	Urban	2	16,259	380	2	380	100	270	5,073	5	5,716	2,263	14
12	KANCHAN	Urban	14	151,498	17,133	11	17,133	100	16,470	81,224	20	106,825	9,791	6
13	MALANCHA	Urban	2	34,459	5,190	15	2,938	57	1,367	8,555	16	6,484	68	-
16	PKS	Urban	18	186,580	8,959	5	7,293	81	8,208	49,962	16	73,646	8,281	4
20	PSTC	Urban	21	311,126	8,171	3	6,613	81	2,583	62,315	4	51,857	6,924	2
24	SSKS	Urban	14	103,005	5,102	5	3,918	77	1,745	24,259	7	53,597	5,373	5
28	TILOTTAMA	Urban	14	143,000	2,536	2	2,429	96	2,542	39,439	6	18,447	2,076	1
29	UPGMS	Urban	6	89,329	6,257	7	6,207	99	6,115	16,295	38	127,309	7,168	8
30	VFWA	Urban	5	36,738	4,071	11	4,071	100	5,240	15,978	33	26,867	1,760	5
<b>Total</b>			<b>319</b>	<b>4,044,851</b>	<b>268,231</b>	<b>7</b>	<b>240,811</b>	<b>90</b>	<b>178,585</b>	<b>1,875,193</b>	<b>10</b>	<b>1,840,186</b>	<b>147,450</b>	<b>4</b>



## b) Addressing Financial Barriers: Pro-poor Interventions

Participants in the formative research identified approximately 30 barriers faced by the very poor in seeking health care. Among the most commonly mentioned financial barriers, poor female clients commented that they simply could not afford NSDP clinics and their services. Government clinics and hospitals provide free services and medicines, whereas NSDP clinics charge for each service in addition to prices of medicines being higher than market prices. Consequently, the very poor may not choose NSDP clinics for their health care. In response to findings, NSDP designed a “safety net,” including interventions to ensure that the poor receive free or reduced prices for services, while allowing NGOs to charge other customers.

### i) Deferred payments:

NSDP’s formative research also revealed that poor clients would favor a deferred payment plan. The new pricing and exemption policy allows deferral of payments by clients in need. Because urban populations are more mobile, providers tend to discourage deferred payments because they increase their administrative burden. Instead, urban providers prefer to receive partial payments from poorer clients. NSDP’s knowledge of these alternative arrangements is anecdotal.

### ii) Funding options:

A community funding policy has been designed to support the very poor. There are two methods of financing care for the very poor. Option 1 is the use of the cumulative revolving drug fund (RDF). It is the fund that has been accumulated by each of the NGOs by selling medicines at prices lower than the market retail price (MRP). The other option uses community funds (sometimes termed as “patient welfare fund”) created from the contributions/ donations of the community. The donation is often cash or in-kind. In addition to cash contributions the clinics can collect a “fistful of rice” from the local community and deposit the sales proceeds into their poor fund.



The following table provides details for accumulated poor funds by NSDP NGOs:

<b>Table 2: Cost Sharing to Serving Very Poor (April '04-May07)</b>						
Serial No.	NGO	Type	# of clinics	Community fund, taka	Other sources, taka	Total, taka
<b>RURAL</b>	<b>17</b>		<b>179</b>	<b>25,867</b>	<b>30,089</b>	<b>55,956</b>
1	BAMANEH	Rural	18	7,395	-	7,395
2	BANDHAN	Rural	6	-	-	-
4	CRC	Rural	2	642	-	642
8	FDSR	Rural	12	5,716	3,333	9,049
10	JTS	Rural	25	1,797	8,445	10,242
14	MMKS	Rural	6	7,822	1,181	9,003
15	NISHKRITI	Rural	8	-	4,223	4,223
17	PROSHANTI	Rural	5	-	-	-
18	PSF	Rural	15	705	395	1,100
19	PSKS	Rural	5	-	750	750
21	SGS	Rural	4	950	-	950
22	SHIMANTIK	Rural	6	-	2,910	2,910
23	SOPIRET	Rural	8	-	5,057	5,057
25	SUPPS	Rural	1	-	2,530	2,530
26	SUS	Rural	6	840	135	975
27	SWANIRVAR	Rural	48	-	1,131	1,131
31	VPKA	Rural	4	-	-	-
<b>URBAN</b>	<b>14</b>		<b>140</b>	<b>89,974</b>	<b>56,100</b>	<b>146,074</b>
3	CAMS	Urban	6	-	-	-
5	CVFD	Urban	21	22,789	9,013	31,802
6	DIPSHIKHA ANIRBAN	Urban	1	-	-	-
7	FAIR FOUNDATION	Urban	11	7,331	-	7,331
9	IMAGE	Urban	5	-	-	-
11	KAJUS	Urban	2	-	-	-
12	KANCHAN	Urban	14	17,020	6,786	23,806
13	MALANCHA	Urban	2	-	510	510
20	PSTC	Urban	21	22,326	14,929	37,255
16	PKS	Urban	18	-	3,459	3,459
24	SSKS	Urban	14	9,467	15,280	24,747
28	TILOTTAMA	Urban	14	6,436	2,927	9,363
29	UPGMS	Urban	6	-	1,996	1,996
30	VFWA	Urban	5	4,605	1,200	5,805
<b>Total</b>			<b>319</b>	<b>115,841</b>	<b>86,190</b>	<b>202,031</b>

c) Providing a safety net to the disadvantaged population:

NSDP designed a safety net mechanism (also known as the pricing and exemption policy) to serve the poorest of the poor (POP) population. The policy has been revised based on field experience and places emphasis on (i) serving the POP with free medicine, lab tests, and commodities as needed and as prescribed by the providers; and (ii) using the community fund and RDF profit to dispense free medicines, lab tests, and commodities. Health benefit cards (HBC) were introduced to recruit



POP customers. With this card POPs are exempted from user fees. In addition, POP will receive free medicines, commodities, and the lab tests. All clinic managers were trained on the use of HBC and POP service. One-to-one consultations with 10 NGOs were provided. Workshops were conducted for all clinics of all NGOs and training was provided to four NGOs so that they can in turn serve as “master trainers” to other NGOs. Additional training on identifying POPs, issuing HBCs, and serving them were given in response to requests from 8 NGOs (PSTC, former BMS, BAMANEH, SOPIRET, Proshanti, NISHKRITI, Image, SUS). To track services to the POP, a monitoring and information system was designed which includes a monitoring checklist for selected NSDP regional staff to ensure the POP serving process is well established. Finally, POP service statistics were analyzed based on monthly POP serving reports.

As a result of adopting POP service delivery policies, all NGOs (319 clinics) are currently providing services to POP through HBC. More than 240,811 HBCs (90% of all POPs identified) have been distributed by NSDP NGOs as of May 2007. An estimated total of 178,585 have been served since April 04 and up to May 2007, which is 10% of total customers served. A reported amount of TK 202,031 has been raised by 319 clinics of 33 NGOs to support services to the POPs (providing medicines) since April 04 and up to May 2007.

## **B. Introducing health benefit cards for paying customers**

A Health Benefit Card (HBC) for paying customers was introduced in October 2005 in order to widen the number of paying customers for NSDP clinics. By end of February 2007, 100% of 92,728 Health Benefit Cards that were initially given by NSDP to the NGOs were sold to able-to-pay customers. A total of 18,063 HBCs were also sold to paying customers in 278 clinics of 33 NGOs.

A rapid assessment of the health benefit cards for the paying and POP customers was conducted in 2006. Households (POP with and without HBCs, and paying customers with and without HBCs) were interviewed in 6 randomly selected clinics. The purpose of this short survey was to understand the health seeking behavior of customers holding any (POP or pay) type of HBCs and also to understand whether the HBC intervention had any impact on volume of customers in the Smiling Sun clinics.

The results of the survey show that out of 290 poorest of poor interviewed, 90% have visited the smiling sun clinics prior to getting the green color health benefit cards from the clinics. Therefore, the cards probably have not been able to recruit new customers as expected. But anecdotal evidence suggest that because the clinics had to serve the poor for free, and therefore, earnings from the sale of medicines were lost, clinics did not “go out” of their clinic area to recruit new poorest of poor customers. The clinics did serve the poorest of poor customers when they visited. More than 50% of these POP customers visited the satellite clinics, and their reasons for choosing the smiling sun clinics are “less time/near from home” (33%), “availability of free medicine” (14%). Among other reasons for choosing smiling sun clinics are “better treatment and good behavior”, “require less money”, etc. Only 0.5% of the poorest of the poor respondents thought that “non availability of treatment for all diseases” and “better for female”. More than 90% of the respondents think that the green color card is good for them because with it they can obtain free medicines while no money is required for receiving services.



Out of the 420 able-to-pay respondents, about 87% bought the orange color health benefit card knowing the benefits that it offers. Others have bought it because it gives “treatment to the whole family with less costs”, “requires less money for each visit”, “somebody referred this card”, etc. About 97% of those who have bought the card have visited the smiling sun clinics prior to purchasing the card. About than 30% of card holders have utilized the clinics with the card for ANC, followed by LCC, and FP methods.

The orange color cards may not have been able to recruit new customers as expected. The anecdotal reasons suggest that this is due in part to the misconception prevailing at the provider level about the potential loss that may result due to the sale of orange color cards. However, both the green color and the orange color cards probably have been able to retain the customers and with some level of satisfaction, which was part of the purpose for initiating the intervention.

#### **14. Third-party and community financing**

NSDP/PI entered an agreement with GrameenPhone which would allow full reimbursement of services, medicines and lab tests relevant to safe motherhood and infant care services to be provided to all poorest of the poor customers at all Smiling Sun clinics. GrameenPhone will also expand services of 7 coastal belt NGOs to include a motorized van to facilitate home deliveries, EmOC centers to decrease maternal mortalities, and clinic on wheels to make ESD services more accessible to the customers.

#### **15. Design and pilot a performance-based reimbursement scheme (PBR)**

NSDP designed a comprehensive, innovative, and effective performance-based reimbursement scheme that motivates NSDP NGOs to increase cost recovery rates while serving more of the poorest of the poor clients

##### *Initial implementation of the performance-based reimbursement scheme*

In order to test the effectiveness of this performance-based reimbursement strategy, we introduced an element of operations research during initial implementation. Since total randomness in sample selection does not apply in this case, we followed the quasi-experimental design approach. The performance-based reimbursement plan was implemented initially with all clinics within four NGOs. Two urban NGOs, CWFD and PKS\_Khulna and two rural-based NGOs, Swanivar and former DCPUK were selected for the experimental group. Four NGOs chosen as the control group included Fair Foundation and BMS (urban) and JTS and former NSDP NGO JUSSS (rural). All eight NGOs were trained in POP identification and the use of HBC to recruit POPs. The Bangla dissemination manual on the incentive scheme was prepared to assist NGOs to explain the mechanism of the scheme to fellow staff.



The effectiveness of this performance-based reimbursement scheme will be measured by the impacts on the two performance indicators: the cost-recovery rate and number of POPs served.

*Impact on cost recovery:*

The data from the incentive pilot are divided into two groups: treatment and control. A clinic is considered to be an observation unit, with observations being made over two time periods: baseline (March 2004 to February 2005) and follow-up (March 2005 to August 2005). The observations are recorded monthly. There are 70 treatment observations and 39 control observations. Cost-recovery means are used from each time period for each group by dividing the total sum of the monthly revenue by the total sum of the monthly expenditure. A percent increase from baseline to follow-up is calculated for each observation. From these, a mean percent increase and standard deviation is calculated for each group (treatment and control). A one-tailed two-sample heteroscedastic t-test is performed, comparing the mean percent increase between the treatment and control groups. Letting  $\mu$  equal the mean percent increase, the hypotheses are as follows:

$$H_0: \mu_{\text{treatment}} = \mu_{\text{control}}$$

$$H_a: \mu_{\text{treatment}} > \mu_{\text{control}}$$

The mean percent increase is 26.02% for the treatment group and 20.28% for the control group. The standard deviation is 23.42 for the treatment group and 19.47 for the control group. The test yields a p-value of 0.0870. Assuming these data have the properties of the same t-distribution, it would be expected based on these data that the treatment group would perform at least this much higher than the control group by nothing other than random variation approximately 8.70% of the time. In many situations, this is considered strong enough evidence to reject  $H_0$  in favor of  $H_a$ .

*Impact on serving the POPs*

There are eight treatment observations and six control observations. The number of POP served is summed for each time period. A percent-increase of number of POP served from baseline to follow-up is calculated for each clinic. A one-tailed two-sample heteroscedastic t-test is performed, comparing the mean percent increase between the treatment and control groups. Letting  $\mu$  equal the mean percent increase, the hypotheses are as follows:

$$H_0: \mu_{\text{treatment}} = \mu_{\text{control}}$$

$$H_a: \mu_{\text{treatment}} > \mu_{\text{control}}$$

The mean percent increase is 38.28% for the treatment group and -27.04% for the control group. (Note that the control group experiences a decrease.) The standard deviation is 52.12 for the treatment group and 22.69 for the control group. The test yields a p-value of 0.0050. Assuming these data have the properties of the same t-distribution, it would be expected based on these data that the treatment group would perform at least this much higher than the control group by nothing other than random variation approximately 0.50% of the time. In many situations, this is considered strong enough evidence to reject  $H_0$  in favor of  $H_a$ .

The information on serving the poorest is more limited, since most clinics only started serving POP identified very recently. However, the result did show that *both* the paying customers and the



poorest customers **increased substantially** in the intervention group. The revenues of the intervention group increased because they serve more paying customers and more POPs.

#### *Roll out of performance-based reimbursement scheme*

Given the strong results of the pilot study, NSDP has scaled up the scheme from July 2006 in 14 selected NGOs (CWFD, PSTC, BMS, SOPIRET, PKS, Fair Foundation, PSKS, SSKS, Kanchan Samity, BAMANEH, JTS, VPKA, MMKS, Swanirvar Bangladesh).

The scaled up intervention on the performance-based reimbursement and bonus scheme ended in June 2007 with increases in customer volume (both paying and poorest of poor) and cost recovery for rural NGOs. But urban NGOs customer volume and cost recovery declined during this quarter. One possible reason could be that the number of paying customers declined and therefore the cost recovery rate have also gone down. The urban NGOs however have seen decline for poorest of poor customers as well.

In comparing the scale-up period (Jul, 06 Sept, 07) with that of baseline period (Jul, 05 – Jun 06), the overall performance for both rural and urban NGOs in terms of increasing poorest of poor customers and cost recovery rates show quite a significant positive improvement during the intervention period. However, the number of paying customers actually declined during the intervention period for the urban NGOs, bringing down the performance of the urban NGOs for total customers.

The performance of the NGOs indicates that the intervention was successful in addressing the dual challenge of the NGOs, namely, increasing services to the poorest of the poor by simultaneously increasing the cost recovery rates.



PBRS scale up: comparison between baseline and quarterly number of POP served, and rate of cost recovery											
Number of POP customer served											
NGO name	Baseline	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Jul-Jun07)	% change between baseline and intervention period
	Jul05-Jun06	Jul-Sep06	Oct-Dec06	% change	Jan-Mar07	% change	Apr-Jun07	% change			
RURAL total	79,745	41,476	66,105	59	119,911	81	130,258	9	357,750	349	
URBAN total	53,317	27,492	40,248	46	55,318	37	50,208	(9)	173,266	225	
U+R total	133,062	68,968	106,353	54	175,229	65	180,466	3	531,016	299	
Cost Recovery rate											
NGO name	Baseline	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Jul-Jun07)	% change between baseline and intervention period
	Jul05-Jun06	Jul-Sep06	Oct-Dec06	% change	Jan-Mar07	% change	Apr-Jun07	% change			
RURAL total	16	18	21	18	23	20	28	50	22	37	
URBAN total	20	25	19	(5)	28	49	25	2	24	19	
U+R total	18	21	20	7	25	35	26	26	23	27	
Number of total customers											
NGO name	Baseline	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Jul-Jun07)	% change between baseline and intervention period
	Jul05-Jun06	Jul-Sep06	Oct-Dec06	% change	Jan-Mar07	% change	Apr-Jun07	% change			
RURAL total	10,172,489	2,724,521	2,707,248	(1)	2,728,682	1	2,829,892	4	10,990,343	8	
URBAN total	3,811,130	917,256	824,895	(10)	837,728	2	774,255	(8)	3,354,134	(12)	
U+R total	13,983,619	3,641,777	3,532,143	(3)	3,566,410	1	3,604,147	1	14,344,477	3	
Number of paying (non-poor) customers											
NGO name	Baseline	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Jul-Jun07)	% change between baseline and intervention period
	Jul05-Jun06	Jul-Sep06	Oct-Dec06	% change	Jan-Mar07	% change	Apr-Jun07	% change			
RURAL total	7,449,323	1,953,347	2,297,442	18	2,203,734	(4)	2,294,533	4	8,749,056	17	
URBAN total	3,953,267	965,310	492,136	(49)	503,548	2	499,949	(1)	2,460,943	(38)	
U+R total	11,402,590	2,918,657	2,789,578	(4)	2,707,282	(3)	2,794,482	3	11,209,999	(2)	
Number of poor customers (including POP)											
NGO name	Baseline	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Jul-Jun07)	% change between baseline and intervention period
	Jul05-Jun06	Jul-Sep06	% change	Oct-Dec06	% change	Jan-Mar07	% change	Apr-Jun07	% change		
RURAL total	974,913	302,654	24	409,806	35	524,948	28	535,359	2	1,772,767	82
URBAN total	1,223,046	320,141	5	332,759	4	334,180	0	274,306	(18)	1,261,386	3
U+R total	2,197,959	622,795	13	742,565	19	859,128	16	809,665	(6)	3,034,153	38



Comparison with non-intervention group of NGOs reveal the following:

Key Indicators	Intervention clinics (focus NGOs)					% change between baseline and intervention period	Control clinics (non-focus NGOs)					% change between baseline and intervention period
	Baseline (Jul05-Jun06)	Intervention period (Jul-Sep06)	Intervention period (Oct-Dec06)	Intervention period (Jan-Mar07)	Intervention period (Apr-Jun07)		Baseline (Jul05-Jun06)	Intervention period (Jul-Sep06)	Intervention period (Oct-Dec06)	Intervention period (Jan-Mar07)	Intervention period (Apr-Jun07)	
No. of NGOs	14	14	14	14	13	-1.79	19	19	19	19	23	5.26
No. of clinics	198	198	211	205	210	4.04	119	119	106	120	121	-2.10
Average customers/month	5885	6131	5967.13	6004.06	5842.12	1.72	5305	5597	5155.61	5396	5488	-1.96
Average poor customers/month	1000	1041	1269.2	1,446.34	1,520.93	31.91	1097	1333	1757.89	1615	1784	52.46
Average poorest of the poor customers/month	36	120	167.76	293	638	931.05	77	123	199.25	295	271	168.39
Average user fee	8.12	8.62	8.5				10.24	9.7	8.62			
Expenditure/customer	23	23	39				24	24	54	23	24	
Cost recovery rate (average), %	18	21	20	25	26	27.78	17	21	15	21	23	18.09
% of poor customer served (out of total customer)	16	17	21	24	26		21	24	34	34	33	
% of poorest of poor customer served (out of total customer)	0.95	1.89	0.94	6.09	3.52		4.51	2.16	1.29	5.47	4.94	
Bonus per clinic (average) taka	NA	5,236.81	6,168.21	5,000.49			NA	NA	NA	NA	NA	
Bonus per NGO (average) taka	NA	63,867.63	68,516.19	80,500.88			NA	NA	NA	NA	NA	
Bonus per clinic provider (per clinic) taka	NA	391.10	405.57	582.26	743.32		NA	NA	NA	NA	NA	
Bonus per NGO HQ staff (per clinic) taka	NA	331.41	892.72	972.80			NA	NA	NA	NA	NA	
Net total HEF contribution (taka)	NA	10,538.03	12,013.81	38,818.96	1,818,974.94		NA	NA	NA	NA	NA	
Total amount paid out to NGO		321,516.22	751,750.37	1,127,012.33	1,074,265.52		NA	NA	NA	NA	NA	
Total amount paid out to NGO (\$)		4,593.09	10,739.29	16,100.18	15,346.65		NA	NA	NA	NA	NA	
No. of clinics qualified to get provider bonus	NA	163	55	124.00	94.00		NA	NA	NA	NA	NA	

The amount of average bonus per provider varied in each quarter, with the highest in the last quarter. The number of clinics qualifying to receive the bonus amount also varied from quarter to quarter.

**Jul-Sep06:** For all the 166 clinics that are eligible for bonus payments the range of bonus per clinic provider is 0.48 taka to 2075.15 taka and the average is 366.72 taka.

**Oct-Dec06:** For all the 55 clinics that are eligible for bonus payments the range of bonus per clinic provider is 1.94 taka to 6,036.49 taka and the average is 405.57 taka.

**Jan-Mar07:** For all the 124 clinics that are eligible for bonus payments the range of bonus per clinic provider is 2.31 taka to 3,082.31 taka and the average is 582.26 taka.

**Apr-Jun07:** For all the 94 clinics that are eligible for bonus payments the range of bonus per clinic provider is 6.09 taka to 3,232.38 taka and the average is 743.32 taka.



## **OBJECTIVE 4: INFLUENCE POLICY, IN COORDINATION WITH OTHER DONORS, TO EXPAND THE ROLE OF NGOS AS PROVIDERS OF THE ESP**

The Program Description of NSDP envisions that the NSDP Team would influence Government of Bangladesh policy to expand the role of NGOs as providers of ESP services and to facilitate the NGOs' continuing ESP delivery to its catchment population in the absence of USAID support. The following activities were prescribed for achieving this objective:

1. Collaboration with Government and other donors.
2. Mobilization of local support.
3. NGO coalition building and advocacy.

### **1. Collaboration with GOB and other Donors**

#### **Dissemination of NSDP and collaboration**

At the outset of the Program, NSDP was introduced to:

- Ministry of Health & Family Welfare (MOHFW)
- Ministry of Local Government, Rural Development & Cooperatives (LGD)
- Directorate General of Health services (DGHS)
- Directorate General of Family Planning.(DGFP)
- NGO affairs Bureau.

Both the DGHS and DGFP issued circular letters to all their field offices up to the Upazilla level advising the field staff about the inception of NGO Service Delivery Program and instructed them to provide necessary support and cooperation to the Surjer Hashi clinics run and maintained by NSDP NGOs.

Two Coordination Committees were established, one at the DGHS with the Director PHC & Line Director ESD as chair and the other at the DGFP with the Director Planning as chair, to facilitate the resolution of the NGOs' concerns affecting the ESP deliveries. Quarterly meetings were scheduled.

Following the provision of the SOAG between the USA and the People's Republic of Bangladesh, the GOB established the NSDP Working Group with the DGFP as Chair. NSDP Annual Workplans were reviewed and recommended for the Corporate Steering Group's approval. NSDP kept the DGFP posted about the progress of the implementation of the Work Plan as have been approved by GOB and USAID in the Corporate Steering Group's annual meetings.

During NSDP lifetime, there had been three DGFPs, four DGHS and five Secretaries of MOHFW, three Secretaries of LGD and three Ministers/Advisers of MOHFW. The NSDP Team maintained close contact with each of them during their tenure in the respective organizations.



Regular contact was established and maintained with the PHN sector donors in Bangladesh, such as DFID, CIDA, GTZ, SIDA, EU, World Bank and Asian Development Bank. Good channels of communication were also established and maintained with WHO, UNFPA and UNICEF. The Local Consultative Group of the PHN sector donors in Bangladesh were continuously briefed about the Program.

### **GOB pilot of Community Clinics**

With the intent of establishing a greater role for NGOs in the in the delivery of ESP, a pilot project was prepared by GOB in November 2002 for management of 12 Community Clinics (CC) for a year by NGOs. Six NSDP NGOs were selected by MOHFW to participate in the pilot. A memorandum of understanding (MOU) was concluded with GOB and the related local Government Body for tripartite collaboration to run the community clinics by a selected NGO with the support of Local Government Body: Union Parishad, and with the assistance of GOB staff at the Upazilla level. Six selected NSDP NGOs managed those six CCs in six divisions beginning from March 2003. The remaining six CCs were managed by DFID funded Bangladesh Population and Health Consortium (BPHC) NGOs. Later in October 2003, Plan was allowed to manage 18 CCs on the same basis.

At the end of the pilot period of one year, GOB opted not to expand the Community Clinic pilot project. In May 2005, the three development partners approached the Government with a report “Documenting and Sharing of Experiences from the Community Clinic Pilots.” The report observed that:

- “All the NGOs (participating in this pilot) were found to be successful in making the unused Community Clinics operational and useful to the community.”
- “The success of the Public-Private partnership ... will however depend not only on the NGO effort but unified policy decision from the Govt.”

GOB, as yet, has not come up with a policy decision about the operation of CCs, citing the need to appoint a Management Support Agency (MSA) for implementing the Diversification of Services sub-program of HNPS. NSDP NGOs, meanwhile, are continuing to manage these six CCs to the satisfaction of the catchment area communities. Incidentally, the Government of Bangladesh had constructed 10,819 CCs in rural areas during 2000-2003. These CCs were not operationalized due to the changeover in the Government in 2001. NSDP NGOs use some of these otherwise vacant premises for holding satellite clinics with permission of District Health Authorities.

### **Collaboration with Urban Primary Health Care Project (UPHCP)**

GOB allocated the task of Primary Health Care Service delivery in the urban areas of Bangladesh to LGD for providing ESP to the city/town dwellers through the respective Municipalities and City Corporations. GOB in LGD has been implementing UPHCP since 2001 with funding support mainly from ADB and DFID to augment the resources and the capacity of selected Municipalities and City Corporations to deliver ESP in their respective jurisdictions.



Since 1997, 166 Surjer Hashi clinics have been serving urban catchment population in 85 Municipalities and in all the six City Corporations. During the first phase, UPHCP served four larger City Corporations. To avoid duplication of efforts and wastage of inadequate resources available for primary health care in urban Bangladesh, an MOU was signed in February 2003 with UPHCP for these City Corporations delineating the wards to be served by NSDP NGOs and UPHCP NGOs.

The NSDP Team communicated effectively with LGD and the Preparatory Assistance Team for a Second UPHCP fielded by ADB to resolve the challenges of collaboration among NSDP NGOs and UPHCP NGOs and to achieve improved coordination between them in the second phase of UPHCP. During 2006, a Second UPHCP was launched extending the UPHCP coverage to all the six City Corporations and five selected Municipalities. NSDP has concluded a new MOU with Second UPHCP for delineating the wards that would be served by NSDP NGOs in the cities and towns where UPHCP started functioning in its second phase. Following the MOU, NSDP and UPHCP NGOs are providing ESP services in these cities and towns without encroaching each other's catchment areas.

However, a squeezing pattern adverse to NSDP NGOs emerged in the UPHCP extension scheme of GOB. A policy level resolution of this problem should be addressed to, early at the joint forum of associated Development Partners (USAID, ADB, DFID, EU & UNFPA) and GOB. A coordination mechanism has been established with the active participation of NSDP Regional Offices to ensure fair collaboration among the NGOs of both the projects. The NSDP Team continuously liaised with the Secretary of LGD, the Mayors/Chairmen and Chief health officers of City Corporations/ Municipalities to facilitate smooth collaboration with UPHCP.

### **Participation in conferences, studies, workshops and seminars organized by GOB, NGOs and other donors**

Since its inception, NSDP regularly participated in different conferences, studies, seminars and workshops organized by GOB, Development Partners and other leading NGOs, such as, BRAC, Plan International, Population Council, Engender Health, CARE, SC-USA, Concern International and others. To give a few examples:

- During the first 3 to 4 months of the Program alone, NSDP participated in a PAC workshop organized by EngenderHealth, a Community IMCI workshop organized by UNICEF & WHO, an international workshop organized by SC-USA and an Injection Safety workshop organized by GOB & WHO. NSDP continues to participate in a series of such technical and professional events. Most recently, NSDP presented papers in the seminar on "Targeting Resources for Health Care of Poor" on July 10, 2007 and organized by GOB and GTZ, and on July 18, 2007 NSDP participated in the End Project Evaluation of a Community Managed Health Care Project of GOB-CIDA in selected areas of Bangladesh.
- NSDP regularly participated as member in the technical committees of periodical 'Health and Demographic Surveys' and 'Household Income and Expenditure Surveys' of GOB conducted by the Bangladesh Bureau of Statistics.



- NSDP was a member in the DFID sponsored team for the “Scoping Study of Potential Mechanism for Strategic Financing of NGOs in Health Sector of Bangladesh”. DFID made NSDP a member of the evaluation team of their NSDP-like program, BPHC.
- At the invitation of the World Bank, NSDP presented the keynote paper on “Bangladesh Experience with Sector-wide Approach with Donor Alignments in Strengthening and Coordinating a Results-Based Evaluation system” in the Plenary of Second International Roundtable on Managing for Development Results organized by five Multilateral Development Banks (WB, ADB, AfDB, EBRD and IADB) and OECD in Marrakech in February 2004.
- By GOB invitation, NSDP participated during the first quarter of 2004 in the deliberations of World Bank Preparation Mission for the HNPSP. NSDP experiences in ESP delivery by its partner NGOs, its efforts to assist the NGOs progress towards sustainability and their pro-poor service initiatives were shared with the Mission.
- NSDP presented a paper on “Quality Monitoring & Supervision: Bangladesh Key Experiences” at the 32<sup>nd</sup> Global Health Council Conference in May 2005.
- NSDP presented two papers, one on “Quality Monitoring & Supervision: System for Promoting Sustainability” and the other on “Incentive Scheme to Serve the Poor and Enhanced Program Cost Recovery” at the American Public Health Association Annual Conference in Dec 2005.
- By GOB invitation, NSDP regularly participates at national level events (rallies, meetings, seminars and symposia) organized on important national and international days, such as:
  - International Women’s Day
  - World Health Day
  - World Population Day
  - World Breastfeeding Day
  - World Aids Day.
  - World TB Day

### **Participation in National Committees**

The MOHFW and LGD regarded NSDP as the leading and trusted NGO network delivering ESP to both urban and rural poor of Bangladesh. GOB regularly called upon NSDP to participate in national Steering Committees, Taskforces and Working Groups in the PHN Sector. To name a few, those are

- National Steering Committee for Polio and Measles Eradication
- National Steering Committee for GAVI
- National Steering Committee for IMCI
- IMCI National Working Group



- Saving Newborn Life Working Group
- Bangladesh Country Coordination Mechanism for GFATM: TB Technical Sub-committee
- National Taskforce for HIV/AIDS Control Program, Bangladesh
- Inter-ministerial Coordination Committee for urban health services delivery

### **Collaboration with GOB in the formulation of contracting mechanisms; pricing and payment mechanisms, including performance-based reimbursement**

NSDP was a member of the Government-NGO-Development Partners (GO-NGO-DP) Working Group to prepare the framework for contracting NGOs to deliver ESP at union and community levels. NSDP tried to incorporate a performance based contracting model and encourage rewards for good performance. The working group was disbanded after two meetings following the NGO Affairs Bureau's questions relating to regulatory jurisdiction in GO-NGO collaboration. It was resolved that MOHFW will pursue NGO contracting for the Program Implementation Plan of HNPSF in its Diversification of Services Sub-program through a Management Support Agency (MSA). The international competitive process of hiring the MSA is being completed now by MOHFW. NSDP is in contact with the Planning Wing of the Ministry to follow up with MSA the NSDP NGOs' concerns relating to contracting mechanism.

Previously, an ESP costing model had been developed by the Policy Project and was given to GOB in MOHFW to help them evaluate the cost-effectiveness of various ESP components and to set appropriate budget allocations. However, MOHFW did not use this model. NSDP then conducted a costing study, "Staff Utilization and Costing of ESP services" during 2004-05. Following the recommendations of the study, NSDP adopted the "Cost and Revenue (CORE)" model in selected NGOs for evaluating the costs of clinics and NGOs. This model helped the NGOs provide the ESP in their respective catchment areas in a cost effective manner. This model was disseminated to a large number of senior MOHFW staff in NSDP Conference 2007. GOB could adopt this CORE model to their needs to become cost effective in service provision.

## **2. Mobilization of Local Support**

NSDP oriented the Project Directors and the Clinic Managers to participate in local level coordination meetings. NSDP Regional Offices mentored and monitored the NGOs participation in such meetings. The following local level coordination committees are of particular importance to PHN sector NGOs:

- District Development Coordination Committee chaired by Deputy Commissioner.
- District Family Planning Coordination Committees chaired by Deputy Director Family Planning (DDFP).
- District Health Coordination Committees chaired by Civil Surgeons (CS).
- Papilla Family Planning Coordination Committees chaired by Papilla Family Planning Officers.
- Papilla Health Coordination Committees headed by Papilla Health Officers.
- City Corporations/Municipalities Health and FP Coordination Committees headed by Chief Health Officers/Health officers.



Most of these committees tend not to meet regularly. The NGO Project Directors and Clinic Managers were oriented to influence the respective chairperson of the committee to hold meetings. They were asked to play a proactive role by providing secretarial support in preparing working papers of the meeting, in facilitating the meetings' proceedings and in drafting the minutes of the meeting. NGOs were advised to raise issues of common concern, suggest a set of resolutions addressing those issues with a win-win approach for all as is possible. This approach helped in increasing the frequency of these meetings.

For improved coordination with the City Corporations and in the interest to mobilize their support for NGOs, round table discussions were organized among the GOB PHN staff, Local Government Body PHN staff and the entire PHN sector NGOs/International Organizations active in urban centers. NSDP Regional Offices played the role of catalysts in fielding this event. It was of remarkable success particularly in Chittagong City Corporation where the Mayor was unwilling to follow the MOU concluded between NSDP and UPHCP.

With the assistance of NSDP Regional Offices, NSDP NGOs planned and organized visits for Deputy Commissioners, Civil Surgeons, Dips, and Chief Health Officers of City Corporations to observe their clinics' activities, including the implementation of pro-poor strategies namely, the Performance Based Reimbursement Scheme (PBRs) and Pricing & Exemption Policy for the Poorest of the Poor. The Upazila Family Planning Officers and the Upazila Health Officers visit the clinics in their jurisdiction from time to time. These interactions are yielding the expected results. However, such visits can become costly for NGOs and clinics.

The Health Minister, the Health Secretary, and both the Director Generals of Health Services and Family Planning also visited Surjer Hashi Clinics. The latest such visit of high level GOB officials was on July 19, 2007. The Secretary, MOHFW along with DGHS and Divisional Director Health, Chittagong Division visited the Surjer Hashi Clinic at Ramu. Visits of high-level government and ministerial staff create a positive image for Surjer Hashi clinics and enhanced local level support. A few NGOs also organized visits with mixed groups of public-private sector persons of eminence to their clinics. Such visits were of good value for the NGOs and clinics, however, mobilization of resources for such visits could strain NGOs.

NGOs at the District and Upazila levels participated in national special day events, such as, International Women's Day, World Health Day, World Population Day, World Breastfeeding Day, World Aids Day, and World TB Day, etc., celebrated by GOB field offices. They regularly participate in rallies, meetings and service delivery events organized during those days.

NSDP NGOs also participate in special weeks organized by GOB in the PHN sector such as National Immunization Days, Family Planning Week, and Measles Immunization Week. During these weeks, NGOs and their clinics assist GOB field staff and organizations in implementing the action plans drawn up for these weeks.

All the above-mentioned activities help NGOs to increase the comfort level of the local officials in working with the NSDP NGOs. However, local planning activities in Bangladesh have not gained



momentum in the public sector, and thus, the expectation of increased allocation of resources for Surjer Hashi clinics by influencing local level planning was not fulfilled to any significant extent. Allocations of resources to the Surjer Hashi clinics are still influenced by central level decision making.

### **3. NGO Coalition Building and Advocacy**

A Policy Advocacy Team(PAT) with ten eminent leaders of NSDP NGOs were formed to lead the NSDP NGO network in coalition with other PHN sector NGOs to undertake policy advocacy with policy makers. This Group was rendered less effective with the passage of time due to the non-availability of representatives from a majority of the NGOs. Their substitutes were less effective.

#### **NSDP Policy Advocacy Strategy**

NSDP and PAT had developed a NSDP NGO Policy Advocacy Strategy with the objectives of:

- establishing an advocacy network of NSDP NGOs;
- strengthening existing GO-NGO collaboration in PHN sector in Bangladesh for the promotion of NGOs as the providers of ESP services in PHN sector; and
- increasing GOB-Local Government Bodies contracting to NGOs for services.

To orient the NGO leaders and the senior providers of Surjer Hashi clinics with the NSDP Policy Advocacy Strategy and to equip them for advocacy activities, an Advocacy Manual in Bangla was also developed by NSDP . NSDP organized orientation sessions for the NGO Contact Persons, Project Directors, Finance Managers and Clinic Managers to enable them in playing a leadership role in the advocacy process. In those sessions, the strategy document and the advocacy manual were disseminated. Members of the Policy Advocacy Team also participated in those orientation sessions.

#### **Policy Concerns of NSDP NGOs**

A survey was conducted by NSDP to identify the policy concerns of its NGOs with respect to their health services activities. All NSDP NGOs participated in the survey. From the survey and in the course of policy advocacy activities of NSDP, the priority policy issues that have been identified are:

- The catchment area allocation by DGFP based on their criteria of non-availability of their service providers, and hard-to-reach areas.
- Lack of coordination and communication among DGFP and DGHS in allocation of catchment areas for NGO clinics providing ESD.
- The persisting public sector/civil society perception of the gap-filling role of PHN sector NGOs.
- The NGO-clinic affiliation policy of GOB/DGFP.
- Reintroduction in 2002 of door-to-door service delivery by GOB for family planning.
- Collection of service charges for rendering immunization services and for providing GOB supplied contraceptives to customers.



- Irrational application of the 1982 Private Clinic Ordinance for NGO- run ESP clinics and laboratories.
- Lack of ESP clinics’ quality monitoring standards for the public sector inspectors.
- Contraceptive security: timely and adequate supply of contraceptives by DGFP to Clinics.
- GOB policy of providing compensation package for PLTM customers and incentives for PLTM providers.
- PHN sector urban and rural boundary divide between LGD and MOHFW in GOB ‘Allocation of Business’: UPHCP and NSDP NGO coordination problems.

### **Policy Issue Resolutions**

However, some of the policy concerns stated above were alleviated or resolved with the joint effort of PAT and NSDP staff. These are:

- NGO Clinic Affiliation/Reaffiliation Policy was revised by GOB in DGFP removing some difficulties and reducing a few steps in the processing of the affiliation/reaffiliation requests of NGOs.
- NSDP NGOs have been exempted from moving back to providing domiciliary services in family planning service delivery.
- Surjer Hashi clinics are allowed to collect service charges while providing services using GOB supplied contraceptives.
- Laboratory and clinic licenses for Surjer Hashi clinics are processed with minimized delays..
- A Memorandum of Understanding delineating the catchment areas of a particular urban center between NSDP NGOs and UPHCP NGOs was developed.

Some previously resolved issues, such as service charge collection and door-to-door services delivery issues, reemerged during the NSDP phase of the program. NGO providers continue to face uncomfortable situations with some over-enthusiastic local level family planning officials regarding the domiciliary service delivery issue and the service fee collection question.

### **Prothom Alo and NSDP Round Table: “Improving NGO Sustainability and Serving the Poor”**

During NSDP Conference 2007, a Round Table on “Improving NGO Sustainability & Serving the Poor” was organized with Prothom-Alo, the largest circulating Bangla daily newspaper. Twenty-two persons participated including they included GOB representatives, eminent civil society leaders, NGO leaders, representatives of development partners and representatives of NSDP partners. The Round Table came to the conclusion that NGOs could be sustainable while serving the poor; to achieve that

- Central Government should provide policy support and play the role of facilitator in outsourcing the ESP services to NGOs,
- NGOs should provide an appropriate range of well monitored quality services with trained staff,
- NGOs would need the support of the corporate sector, development partners and the community they serve,



- Local Government at the Union Parishad level should mentor and supervise the services, and;
- NGOs should mainstream the gender issues in the PHN sector.

## **ANALYSIS OF SERVICE STATISTICS**

### **1. Strengthening Program Management and MIS Development**

Strengthening Program Management involves capacity building of NGOs through improving data collection and analysis and NGO use of data for decision making to enhance program efficiency, cost-effectiveness, quality, and coverage of services.

The unification of the MIS was necessary as predecessor projects-UFHP and RSDP had varying reporting formats in form and substance. Initially, the MIS/M&E team prepared a unified performance, revenue generation, training, logistic and quarterly programmatic reporting forms by clinic for all NSDP NGOs. These were introduced in September 2002 after orienting all Project Directors and MIS Officers (or responsible persons for MIS) as well as NSDP Regional Coordinators.

#### **NSDP MIS**

The MIS Task Force, which includes representatives from NGOs, NSDP and USAID reviewed unified forms and formats, visited service delivery points in both rural and urban to discuss data collection with clinic managers and providers and observed MIS data collection. The team wanted to learn about difficulties and problems, if any, faced by the providers in reporting. The team also wanted to see if the reporting system could be simplified to minimize reporting time.. Four clinics of four different NGOs were visited.

Pursuant to clinic visits, a committee of the four NGOs was formed which had prepared a matrix of existing forms and formats and their contents. The matrix indicated the degree of importance of forms and individual items of information collected. The Task Force finalized the content of the NSDP MIS. Final forms and formats included only those critical items so as to reduce the data-collection burden on NGOs.

#### **NSDP MIS guidelines**

A guideline was developed, field tested, and reviewed by different NSDP teams and selected NGOs. The guideline is now used by the clinics effectively to implement the revised MIS.

#### **Training on NSDP MIS**

NGOs received new MIS forms and formats by February 2004 followed by an extensive orientation. All NGO Project Directors and MIS Officers (or responsible persons for MIS) received orientation on the NSDP MIS. They were also provided with MIS guidelines and guided through the



implementation process. Later, trained NGO staff oriented other NGO headquarter and clinic staff (Clinic Managers and Service Promoters). Finally, trained clinic staff oriented Depot Holders in rural clinics.

### **NSDP MIS database**

An ACCESS-based user friendly database was developed by NSDP with strong query builders, data consistency checking and report generation features. The data entry screen replicates the hard copy of the monthly performance report (MPR). NGOs can produce reports along with some analysis of data for their clinics. NSDP organized one-day orientations for NGO Project Directors and MIS Officers (or those responsible for MIS) on the NSDP MIS database to transfer skills to the NGOs. This database also significantly helped the NGOs in ensuring quality data as per NSDPs reporting deadlines, improve program management, and use data in decision making.

### **MIS database improvements during NSDP extension period**

In consultation with some selected NGOs and NSDP management, MIS forms have been streamlined and revised in October 2006 to include all new indicators identified in the program description of NSDP for its extension period, as well as indicators relevant to program needs.

Accordingly, NSDPs MIS database had been revised and improved to capture changes, strengthen data reliability and make it more user friendly. Adding two query builders to the database significantly reduced the burden of NGOs.

### **Revised NSDP MIS guidelines**

Revised forms were successfully implemented at all clinics on September 1, 2006 following revisions to MIS guidelines.

### **Training on revised NSDP MIS and its database**

NSDP organized two one-day orientations for MIS Officers (or responsible persons for MIS) on the revised NSDP MIS and its database to transfer skills to the NGOs on effective and efficient use of the revised system.

### **Use of data to improve program management**

To strengthen the transfer of skills NSDP regional staff had also been oriented on NSDPs MIS and provided TA to NGOs. The revised NSDP MIS database has been successfully installed at all NGOs. Currently, NGOs are using the revised database with its newer features for improved efficiency and quality of MIS data for better program management.

The MIS data verification tool had been used by NSDP regional staff at clinics to ensure quality data. All NGO PDs, MIS Officers and NSDP regional staff have been oriented on 2001, 2003 and 2005 MEASURE survey results and MIS data to understand coverage patterns.



NGOs are now able to analyze monthly stock status of contraceptives and routinely help stakeholders to minimize stock outs and plan for contingencies.

### **Use of data for decision-making**

A trend analyses of customer volume and services (by type of services) by NGO were conducted several times. The findings were presented at quarterly regional NGO meetings where NGO directors and executives interpreted the trends of services and customer volume in an attempt to identify the causes of decline, if any. TA was provided to NGOs on how they can examine their data trends and identify any weaknesses within their programs. NGO directors and executives then developed strategies designed to lead to program improvements and increases in the number of customers and associated revenue generation. Work plans were developed accordingly during each quarterly meeting.

### **Use of data for setting goals during NGO renewal process**

As a process, NSDP NGOs set annual performance goals during the grant renewal process. Guidelines were developed and technical assistance provided to NGOs on goal setting. All NGO leaders and NSDP Regional Officers were oriented on goal-setting methods and procedures. The variables used for setting performance goals were: NGO catchment population size, prevalence rate of ESP service use, NGO market share, and past performance. Goals were set for all clinics and NGOs. The NGO goals were consistent with those of NSDP.

### **NGO and local-level data analysis, including data validation**

NGOs had been given technical assistance on how to develop strategies to improve performance through regional NGO coordination meetings. NGOs had been shown how clinics can rationalize the service delivery network by using MIS data. For example, NGOs learned how to identify a low performing clinic from MIS data. A Clinic Manager can decide to relocate or reshuffle satellite clinics that have poor performance. Such a relocation or reshuffle can increase customer size substantially. Regional Coordinators provided technical assistance to Clinic Managers on the use of MIS data to identify performance improvement strategies at the local level. Regional Coordinators routinely validate data on site using a data validation tool developed by NSDP.

### **Training on ACCESS (basic), Excel (advance) and SPSS (basic)**

NSDP organized four-day training on ACCESS (basic), advanced features of Excel and SPSS (basic) for MIS Officers of selected NGOs. Twenty MIS Officers of 18 NGOs were trained and are now able to build queries, capture data from different sources and export data/outputs to other applications to conduct analyses based on their program needs.



## Community mapping

The exact locations of all NSDP static clinics and referral points have been collected with GPS coordinates affixed onto exact locations on GIS maps. NSDP clinics received the A4 size maps along with detailed information sheets of the corresponding referral clinics/hospitals/centers of GOB, other NGOs and private enterprises. NSDP digitized the rural satellite-clinic catchment areas from the hand-drawn maps. One GIS map is displayed here as an example.

A NSDP GIS users' manual with all basics on using the software has been published for the NGO users. An orientation on NSDP GIS was organized for 86 persons (project directors and MIS officers).

NSDP GIS has been used for rationalization of clinic spots. Other uses of the GIS include mapping clinics by utilization rates including coverage of the allotted catchment area, cost recovery, quality scores and statistics by specific services. NSDP merged the MIS with the GIS making it possible to provide one map for all of the statistics now presented in tabular form.

## Catchment area analysis

The catchment area analysis helped NGO's in two ways. First, by using their service statistics, NGOs were able to tell to what extent they reached customers within their catchment populations. This information indicated the need for designing or redesigning their service delivery and BCC/M activities. Second, NGOs strengthened their catchment sampling frame, which was used by MEASURE to conduct its community survey.

A written data-collection guideline was given to each clinic manager through their respective NGO. The clinic managers used their service statistics for the period of January through March 2003 to identify the locations of customers relative to their service delivery points. Each mahalla/para (the smallest unit of a town/city) of a town/city was listed. Based on the number of customers, the clinic managers identified the following for each town:

- Officially allocated mahalla/paras to the NGO
- Number of customers from each mahalla/para
- Mahalla/paras that NGOs recommend as their catchment area



- Population size in each mahalla/para

There were 10.6 million people in the towns that have been officially allocated to NGOs, of which NGOs cover 8.4 million. Of 3,629 mahallas/paras in the towns, about 65% are covered by NSDP NGOs. The coverage varies by NGO and by city type.

Although NGOs cannot officially cover 20% of the populations within the mahalla/paras, they receive customers from outside of their catchment areas. Service statistics show that about 20% of customers come from areas that are not officially allocated to NSDP NGOs.

### **NSDP's Family Registration**

NSDP NGOs registered all families within their catchments areas during 2003 and 2007. About four million families were visited each time to collect basic information related to ESD service utilization. Additionally, information on economic indicators were collected to help identify the poor.

The DGFP requires updated information on catchment area populations and ELCOs. The registration was completed by Depot Holders (DH) in the rural areas and by volunteers in urban areas while the service promoters closely supervised the registration activities. NGOs used this as their database of customers. This helped NGOs to identify potential customers and to follow-up past and/or current customers.

The Family Registration Form was developed, pre-tested, and finalized in consultation with GoB and NSDP NGOs. All NGO Project Directors, MIS Officers and NSDP Regional Coordinators were oriented and furnished with guidelines on the data collection and implementation process. In turn, trained NGO staff oriented other NGO headquarter and clinic staff (Clinic Managers and Service Promoters). Finally, trained clinic staff oriented Depot Holders in rural clinics and volunteers in urban clinics.

### **Coordination of family registration activities with the GOB**

Couple registration is an MIS activity of the doorstep ESD service delivery of the GoB. The registration is done by the Family Welfare Assistant (FWA) and is updated every year. It includes basic demographic information on family members along with ESP services received by each. This register affords the FWA to plan her service delivery activities in her catchment area.

NSDP staff met with DGFP to discuss the issue of collection of updated information on population and ELCOs with the Director (Planning) present during the discussions. Director (MIS) and PM (MIS) have also been updated on NSDP NGO family registration. This was required because the NGO family registration form is slightly different from the GoB form.

### **The use of family registration data for identification of the poor**

NSDP organized a workshop with Project Directors on "Reaching the Poor". The family registration data included simple socio-economic indicators at the family level which were used to



classify a family as poor versus non-poor. These indicators were selected through a process, including a field test. Indicators were validated at the community level through participatory rural appraisal (PRA) methods. PRA was applied in eight small communities in urban and rural areas covering six divisions and six different NGOs.

Family Registration data were used by clinics to identify and validate the poorest of the poor (PoP) customers in the catchment areas. NSDP community response and health management and financing teams oriented NGO Project Directors and concerned staff on how to utilize the family registration data system to increase the utilization of services by PoP customers.

### **TA through quarterly meetings**

NSDP provided technical assistance to NGOs through simple analyses of their data. Based on performance data analysis, program priority areas were identified. NSDP teams prepared technical assistance materials for NGOs, which were disseminated to NGO managers in regional coordination meetings. Such areas of technical assistance were child health and PLTM.

### **Use of MEASURE survey data to identify potential customers**

Data collected through the MEASURE survey indicate rates of ESD service use in NSDP areas. There are sharp differences between urban and rural areas; for many indicators urban rates seem to be at a saturation level but for rural areas there is room for increases in utilization. However, use of ESD services is low among poor in both urban and rural areas. NSDP has to further strengthen its activities targeted towards serving the poor for increased ESD service use by the poor. A large number of poor are potential customers of NSDP.

In both areas, continuation of services should be increased, although the rates have improved between 2001 and 2005. Full immunization rates are below 70% and 85%, in rural and urban areas, respectively. ANC3 and iron supplementation coverage are very low in rural areas. Pill and injectable discontinuation is high both in urban and rural areas. PLTM use is low. NSDP has made efforts to both increase continuation of pills and injectables and to help users who want to space their children or do not want more children, to switch from short to long-term and permanent methods. There are a large number of such customers in NSDP areas.

ARI treatment by trained providers has increased in recent years but the level of treatment is still low in both areas.

There are at least four sources of potential customers from which NSDP clinics can draw customers. They are: current non-users of ESP services, the disadvantaged, current users who are likely to discontinue services, and current users from non-NSDP sources. Strong BCC/M activities, including training, are being undertaken to increase NSDP customers.

### **Pilot activities with Depot Holders (DH) at urban sites**

NSDP MIS data related to the role of Depot Holders were analyzed and it was found in the rural areas that DH contribution to the supply of pills and ORS to the community and to customer referral



to clinics is substantial. Data on sources of ESD services from MEASURE surveys in urban and rural areas were also reviewed in the context of the role of DHs. A decision was made to conduct a pilot with DH activities in selected urban areas.

Accordingly, NSDP designed a pilot scheme, and prepared guidelines on Depot Holder activities in urban sites. Three sites were selected: one each from Type A (city corporations); Type B (district towns); and Type C (thana municipalities). The clinics, Rayer Bazar in Dhaka (Type A), Brahmanbaria (Type B), and Sherpur (Type C) were selected for the pilot activities. Half of each site was treated as an experimental area and the other half served as a control given that no Depot Holder activities existed there. A total of 60 DHs were recruited. DH's activities were followed by the training of the Service Promoters who supervise Depot Holders.

In 2003, ICDDR,B conducted a quantitative and qualitative survey in the three Depot Holder pilot sites to establish baseline information regarding DH activities. ICDDR,B colleagues made an informal presentation at NSDP on their qualitative findings. Respondents of the in-depth interviews indicated that they are likely to benefit from Depot Holder services because they provide information on ESD services, pills, condoms, and ORS, and make referrals to NSDP NGO clinics.

### **Rationalization of service delivery network**

Rationalization of the NGO service delivery network was one of NSDP's priorities. An analysis of data was conducted and shared with shared with NGO Project Directors so that they can use performance data to improve the efficiency of their static and satellite clinics. Data for each clinic were analyzed to determine the scope to which a static or satellite clinic can increase its daily customer flow. Project Directors responded positively to the notion of rationalization.

### **Community Clinic Assessment**

A half-day workshop was conducted with project directors , MIS Officers, and clinic managers of four NGOs on the midterm assessment of community clinics. The data indicated that two CCs serve 40-50 customers per day, other three serves 20-27 customers, and one clinic serves only 14 customers per day. The clinics provided quite a range of services, and it varied by clinic. About 20-50 percent of services were for family planning, 10-30% services for child health, 5-30% for maternal health, and 15-50% for limited curative care.

### **Community-Based ARI Program**

NSDP and DHS had an MOU on the community-based ARI Program. NSDP had an ARI pilot in three upazilas where Depot Holders deliver ARI services. NSDP developed an assessment tool, conducted a survey in three upazilas, and wrote a report on the survey. The ARI baseline data was collected and analyzed by MIS colleague and survey findings presented in the launching ceremony of the Community-based ARI program.

## **2. Project Accomplishments**



Throughout the life of the program, NSDP monitored programmatic progress by carefully tracking service delivery outputs. This effort allowed NSDP to assess the strengths and weaknesses of the program for informed decision-making. In addition, the final measurement of these outputs highlights NSDP's success at increasing both the number of service contacts and the range of services provided. Smiling Sun providers made XXX million service contacts in the last year which is XX% higher than that of the starting year FY03. However, the project could not achieve more in the last year because of the critical shortages and stock outs of contraceptives.

### Project Performance by Indicator

Ind. #	Objectives	Data source	Achievement					
			FY03	FY04	FY05	FY06	FY07	
							9 months	Estimated 12 mos

#### Objective 1: Expand range & quality of ESP (Total clinics=317)

1.1	% of clinics providing a new range of services	HRIS						
	- Safe delivery		4 (11)	3 (11)	5 (16)	5(17)	9(280)	9 (28)
	- EmOC		0.4 (1)	1 (3)	2 (6)	3(9)	6(20)	6 (20)
	- Health Care Mart		NA	NA	5 (16)	5(16)	30(95)	30 (95)
	- Extended Lab		NA	NA	13 (41)	13(41)	43(135)	43 (135)
1.2	# of paramedics trained to provide home-based delivery	HRIS	NA	NA	27	87	92	
1.3	% of clinics with facility-based IMCI	HRIS	26	44	64	100	99 (317)	
1.4	Average composite quality compliance score (%)	QMS	NA	86	83	85	87	

#### Objective 2: Increase utilization of services

2.1	Total service contacts (million)	MPR	22.900	24.200	26.600	28.224	20.452	27.269
2.2	CYP (million)	MPR	1.046	1.139	1.205	1.305	0.738	0.984
2.3	CYP for non-clinical contraception (million)	MPR	0.933	1.049	1.128	1.256	0.709	0.945
2.4	# of children who received DPT 1 (million)	MPR	0.349	0.351	0.336	0.332	0.243	0.324
2.5	# of children immunized against measles (million)	MPR	0.328	0.324	0.328	0.32	0.221	0.295
2.6	# of children treated for pneumonia (million)	MPR	0.137	0.149	0.167	0.157	0.121	0.161
2.7	# TT 2+ doses given to pregnant women (million)	MPR	0.451	0.472	0.482	0.586	0.319	0.425
2.8	# of ANC 3+ (million)	MPR	0.514	0.467	0.472	0.453	0.321	0.428
2.9	# of confirmed TB cases managed	MPR	1,416	3,285	4,475	3930	3,699	4,932
2.10	% of clients who are poor	MPR	7	14	19	18	26	

#### Objective 3 : Increase NGO capacity (Total NGOs=33)

3.1	% of cost recovery	GFR						
	Urban		21	21	22	22	22	
	Rural		12	15	17	18	20	
3.2	Cost per service-contact (Taka):	MPR &						
	Urban		27.46	26.31	20.59	27.45	35.95	

Ind. #	Objectives	Data source	Achievement					
			FY03	FY04	FY05	FY06	FY07	
							9 months	Estimated 12 mos
	Rural	GFR	15.83	14.68	13.16	15.06	17.06	
3.3	Composite MOCAT score	MOCAT	1.75	2.05	2.21	2.53	1.88	

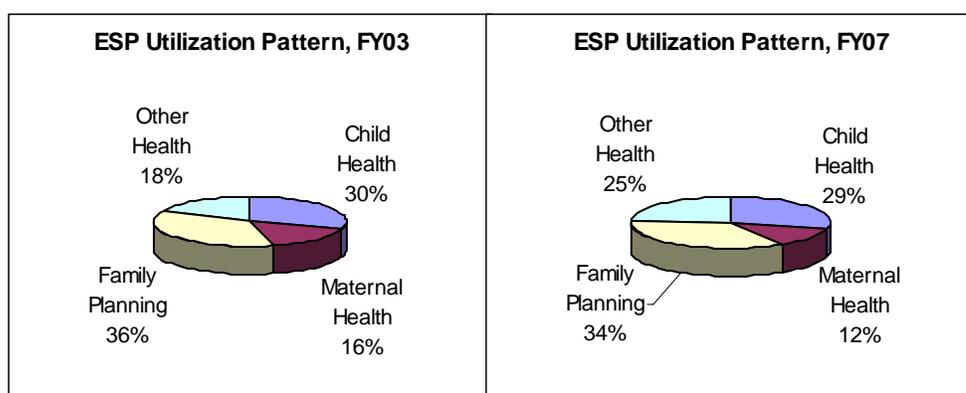
**Objective 4 : Policy and GoB coordination (Total clinics=317)**

4.1	% of clinics having stocks of FP commodities:	MPR						
	- Pill		99	98	98	98	96	
	- Condom		98	98	98	93	89	
	- Injectable		94	92	95	92	52	
	- IUD		98	94	93	89	74	
	- Norplant	58	69	80	63	29		
4.2	Restriction on service charges for immunization revoked for NGOs	GoB circular	Ministry of Health and Family Welfare Circular, March 2, 2005					
4.3	Required domiciliary visits waived by GoB for NGOs	GoB circular	Directorate of Family Planning Circular, June 14, 2005					
4.4	Pricing principles for the able-to-pay customer populations adopted for GoB contracting of NGOs	GoB circular	Study completed, April 2005					
4.5	Performance-based reimbursement practices implemented and adopted for GoB contracting of NGOs	GoB circular	Pilot completed, October 2005					
4.6	# of NSDP NGOs receiving contracts from the GoB	GoB circular	UPHCP II and MSA, for example					

NSDP made a consistent effort over time to expand and increase the use of essential services, particularly among the poor. During FY07 26% of all service contacts were for the poor which has increased by 271% since FY03. TB service provision continues to perform well.

A clear picture of the critical stockouts may be found in the summary reports on contraceptive logistics position sent to CTO in each month. Shortages and stockouts of contraceptives, especially injectables and Norplant, have led to fewer customers than expected during the last year.

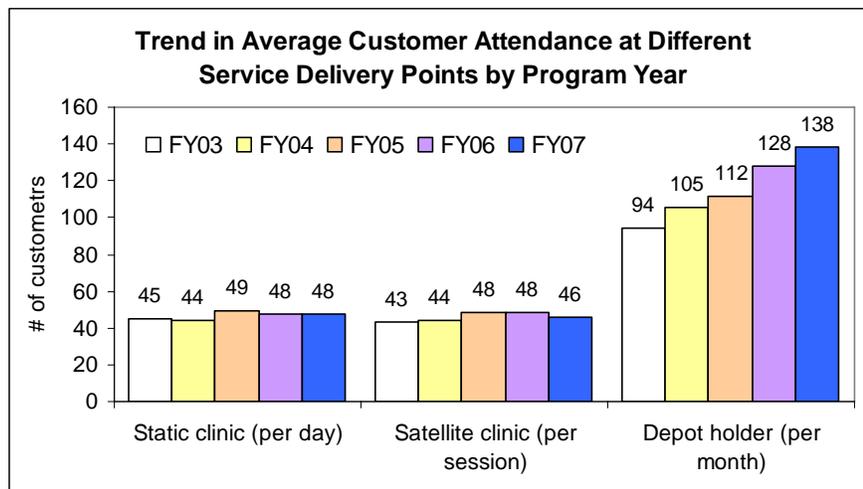
NSDP efforts have resulted in marked improvements in the reach of service delivery points and of specific essential services. The mix of services also increased. NSDP customers had access to multiple



types of services. The graph above provides a picture of the overall ESP utilization pattern in NSDP by service category. Child health accounted for 29 % of services provided while family planning accounted for 34%. Some highlights are provided below.



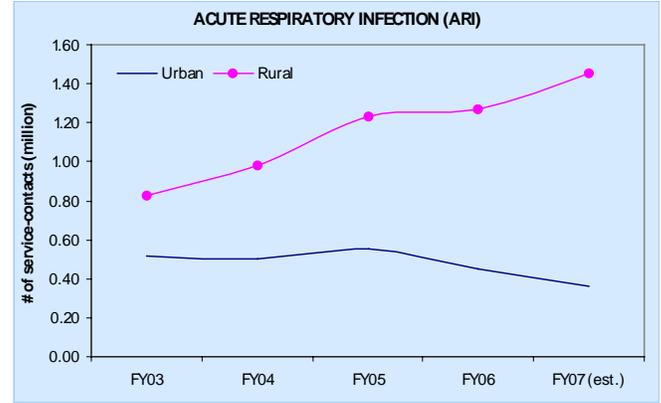
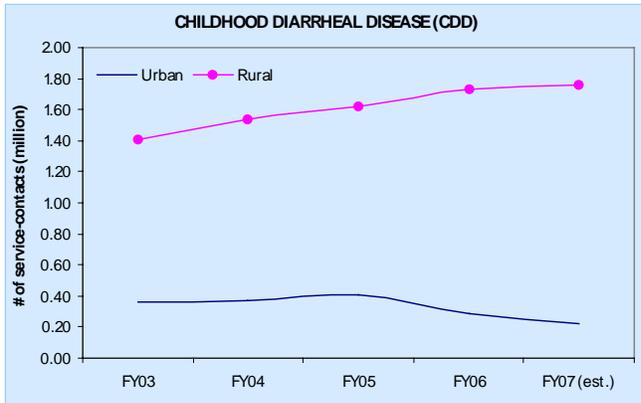
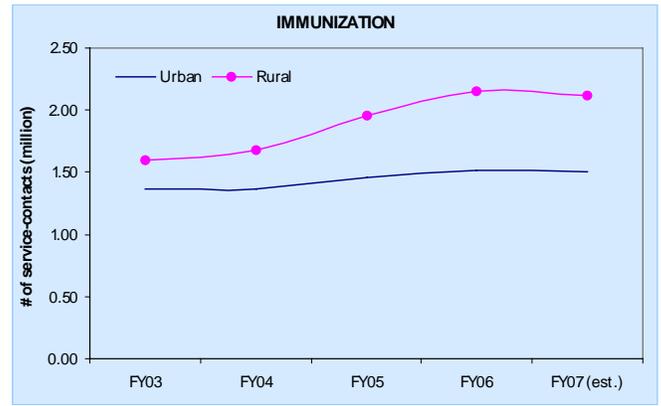
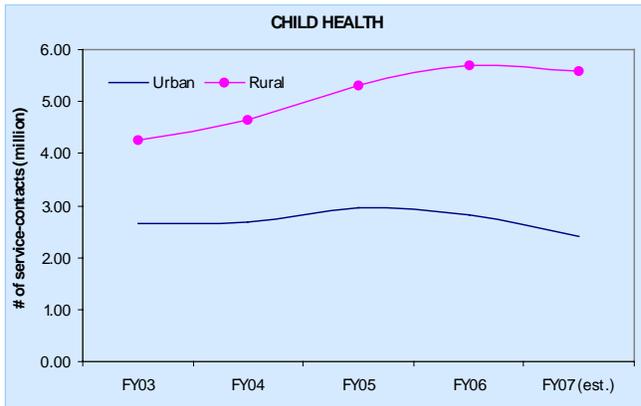
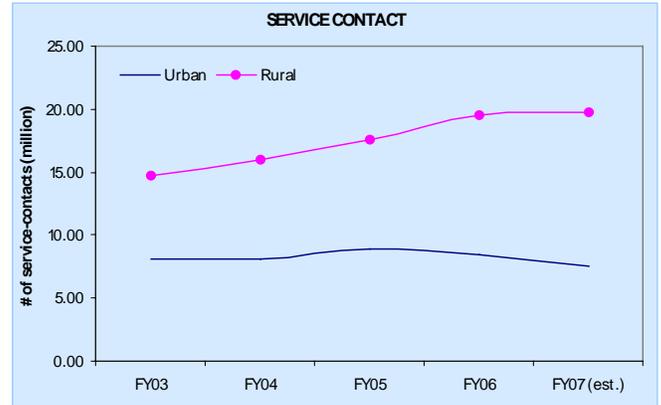
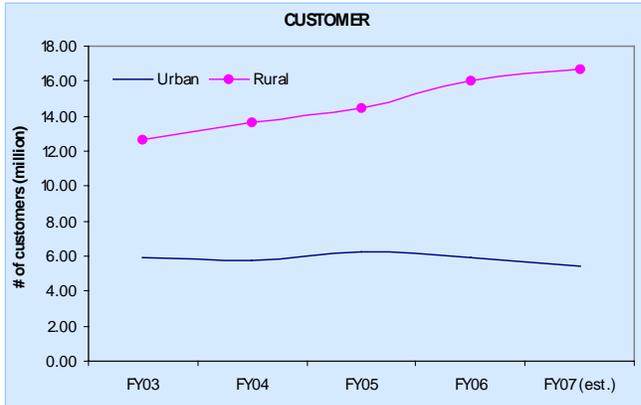
- Average monthly customer flow per clinic increased from 45 to 48 customer at static clinics (7% increase), from 43 to 48 per satellite session (7% increase) and from 94 to 138 (47% increase) per month for Depot holders.



- Overall family planning service delivery has increased by 13% since the beginning of the project. Among non-clinical methods, the pill has increased by 43% since FY03.
- Clinical services expanded significantly since FY03. As of June 2007 all clinics offer IUD, 203 clinics offer Norplant, 111 clinics offer NSV, and 51 clinics offer tubectomy services.
- NSDP made improvements in the area of child health with a 16% in child health services since the program's inception.
- Since the start of NSDP, safe delivery services have increased by 257%.
- Tuberculosis services increased by 300% during NSDP.
- Other health service contacts have increased by 66% since program inception.
- New services expanded significantly since FY03. As of June 2007, twenty eight clinics offer safe delivery, 20 clinics offer EmOC, 135 clinics offer laboratory, 95 clinics offer health care mart, 26 clinics offer pharmacy, 33 clinics offer ultrasound, 54 clinics use contracted physicians and 47 clinics offer ambulance services.

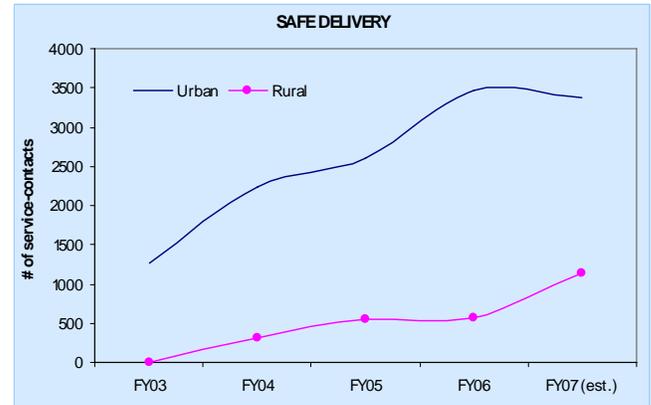
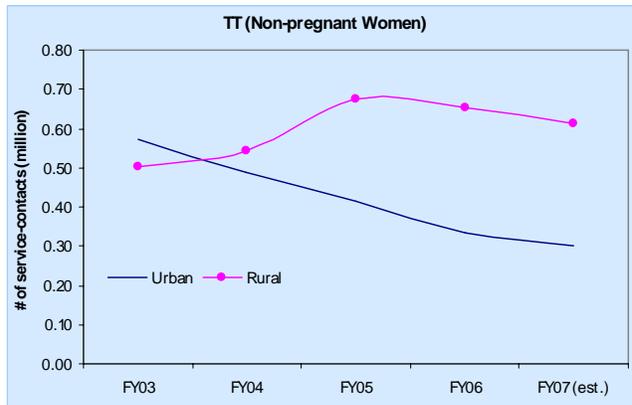
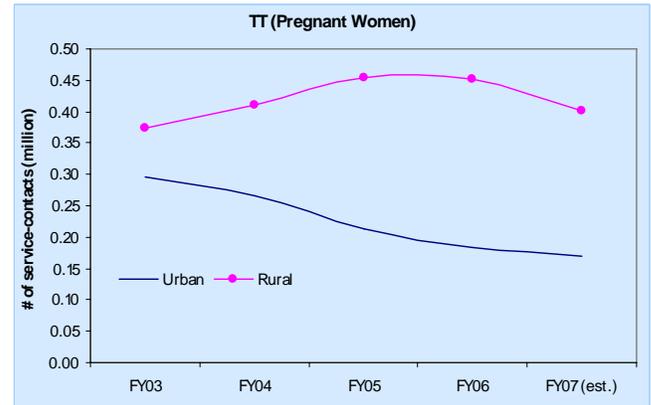
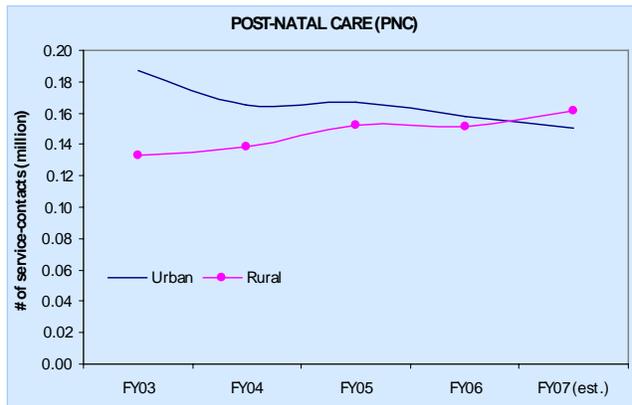
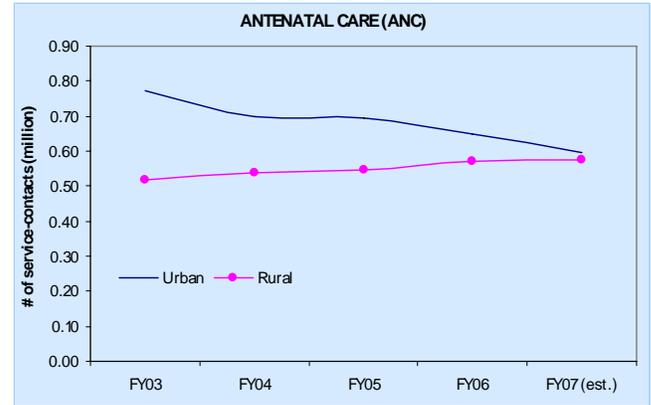
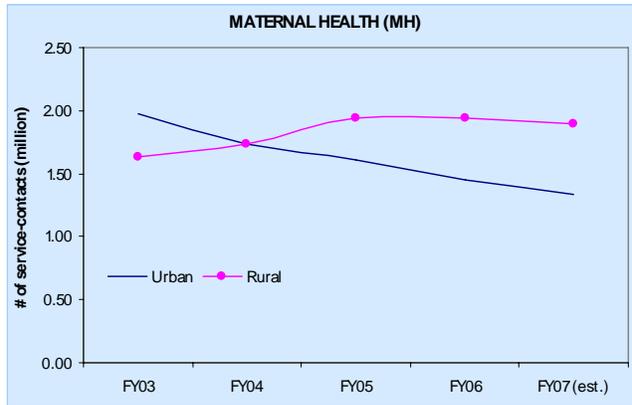
The following graphs show yearly service contacts at rural and urban NSDP clinics by type of service from FY 2003 through FY 2007. The performance of urban clinics has declined due to increased competition in the urban sector.





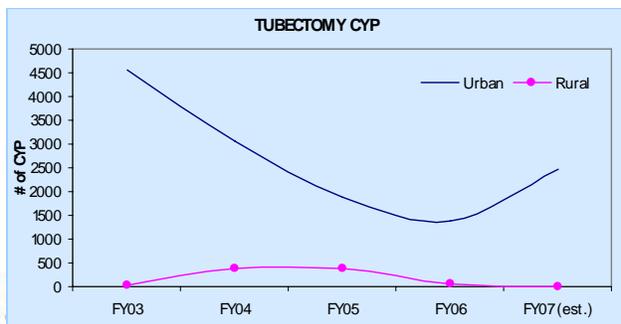
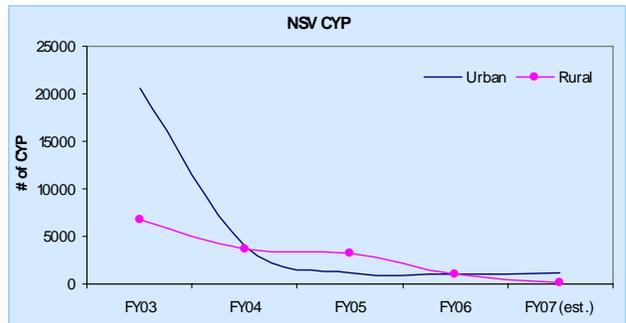
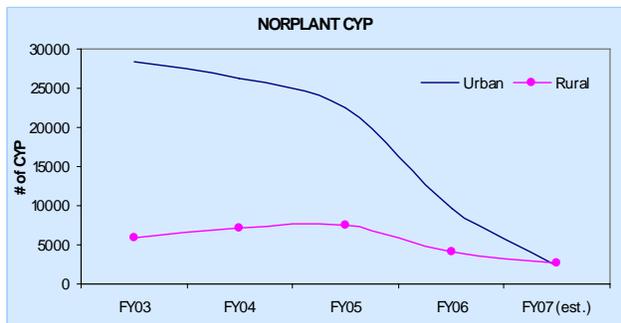
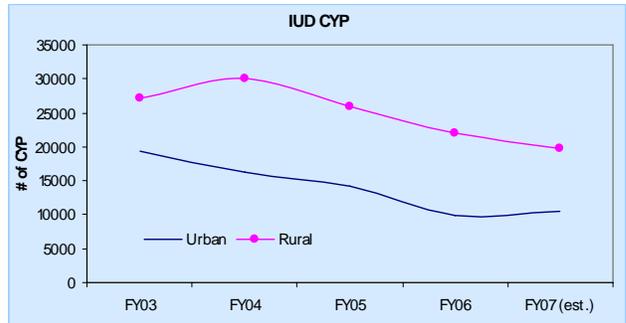
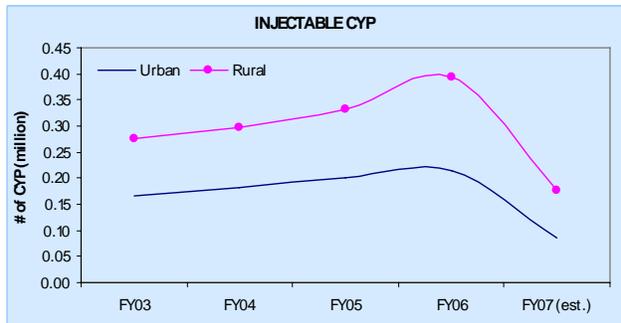
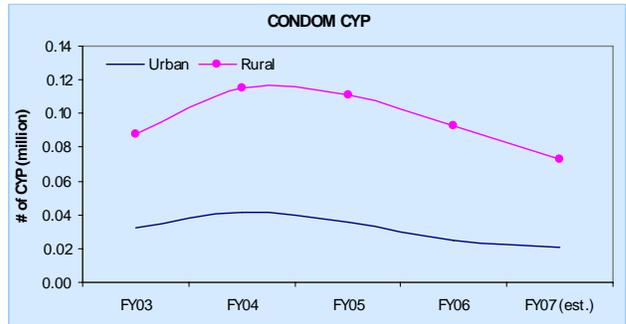
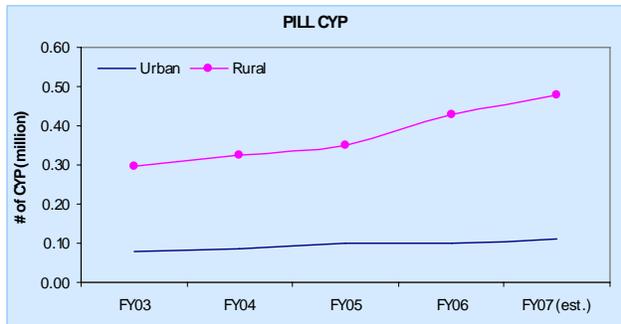
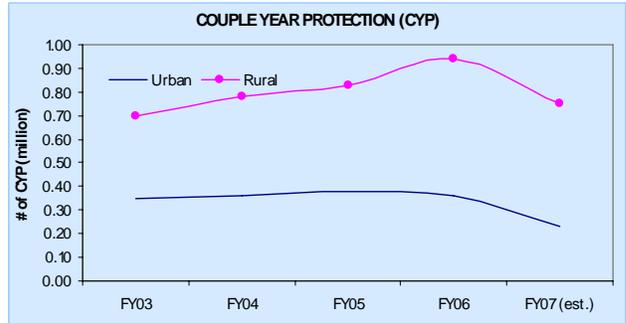
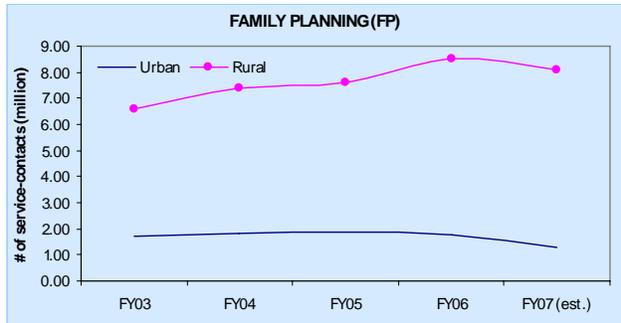
Child health service contacts were steadily increasing up to FY06, but has since decreased since GoB reduced the number of routine sessions organized by NSDP's clinics. EPI sessions held during FY07 decreased to 1, 9827 from 2, 9497 sessions during FY06, a 37% decline.



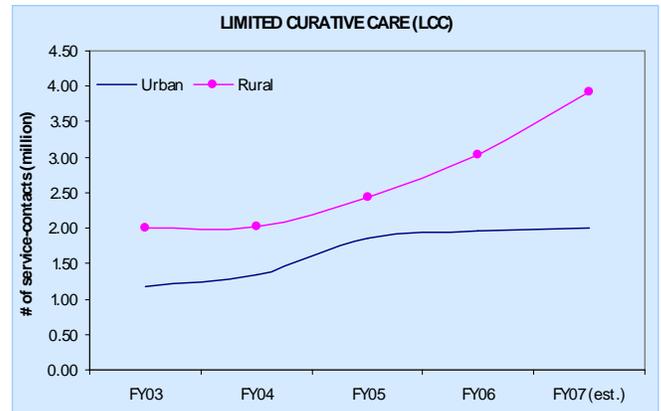
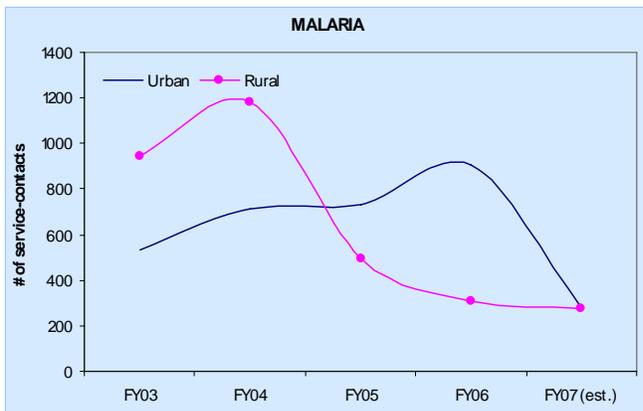
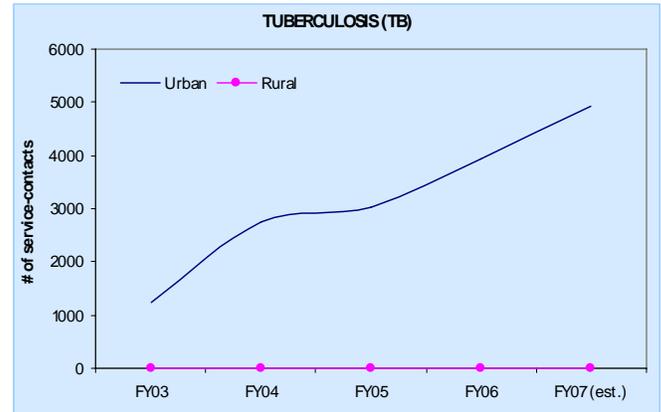
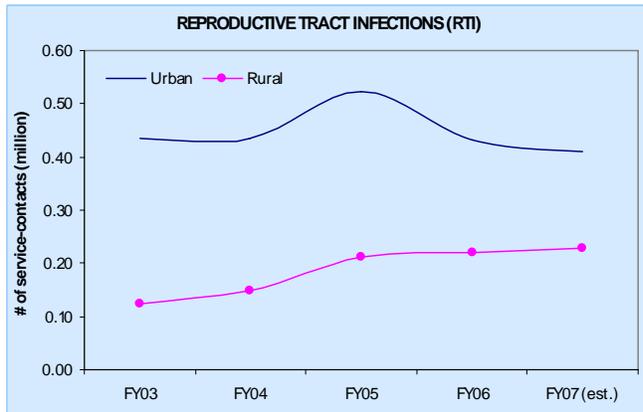
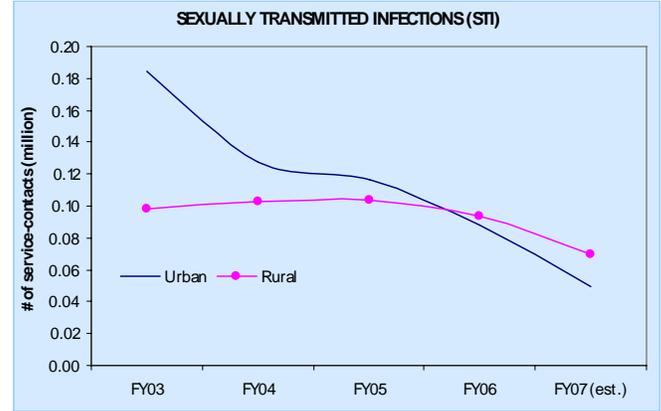
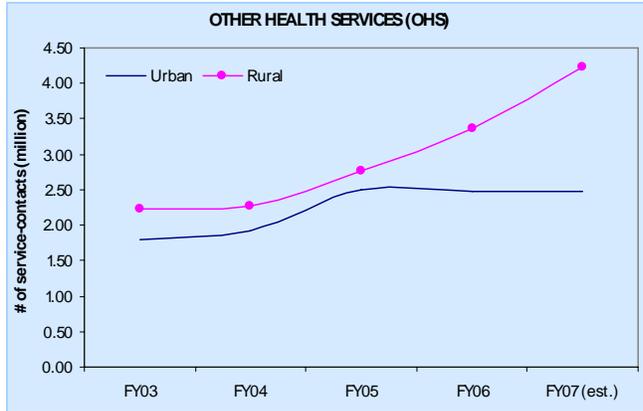


Safe Delivery service provision in the urban clinics continue to perform well. GoB policy reducing the number of sessions at static and satellite clinics also had a negative impact on TT for pregnant and non-pregnant women.





Couple years of protection (CYP) has increased up to FY 2006, but due to critical stock outs, CYP has decreased significantly during FY07, especially CYP through Norplant, injectables and condoms. To improve PLTM use, NSDP has organized training of counselors, paramedics, and other clinic staff on PLTM, and improved follow-up of PLTM customers at the household level during FY07.



Limited curative care and TB service contacts performed well during NSDP. In addition to increasing awareness on STI in all clinics, NSDP in collaboration with Population Council implemented “Increasing Dual Protection among Rickshaw Pullers in Bangladesh” program in 35 clinics to reduce the STI problems. Concerned clinic staffs are organizing sessions at the community level to prevent and increasing awareness on STI.



## **MCP, TIAHRT and HELMS MONITORING**

Like all USAID-funded programs, NSDP's foreign NGO partners are prohibited from performing or actively promoting abortion as a method of family planning pursuant to the "Mexico City Policy" (MCP). Pathfinder International conducted orientation workshops in June 2002 that presented the new Cooperative Agreement and sub-grant process, including the Voluntary Population Planning Standard Provision, which includes the Mexico City Policy, Tiahrt Amendment and Helms Amendment. All NGOs funded by NSDP signed agreements with Pathfinder stating that they would not perform or actively promote abortion or MR as a method of family planning.

In July 2004, Pathfinder's NSDP staff were told that one of the NGOs funded by NSDP had been providing menstrual regulation (MR) services to clients "after hours." MR is early-gestation pregnancy termination. In Bangladesh, MR is legal when it is performed within 10 weeks after last menses and before pregnancy is clinically confirmed. The government of Bangladesh distinguishes between MR as a legal procedure and abortion, which is illegal. The US Government considers MR to be the equivalent of abortion and by agreement, NSDP NGOs only offer USAID-approved services. The alleged noncompliance is the first in the experience of Pathfinder in Bangladesh or any other country.

Since its discovery of violations, NSDP undertook immediate action, including conducting assessments, suspending and managing NGO clinics, and terminating agreements with four NGOs. In addition, it strengthened its own monitoring process and introduced more rigorous monitoring requirements for NGOs to undertake as part of its agreement with Pathfinder/NSDP.

### **1. Assessments**

To learn whether NGOs were honoring their commitments to comply with MCP, Pathfinder and NSDP developed two assessment methods: rapid assessment and detailed verification. These methods reflect both the need to efficiently survey a large number of clinics and the need to be scrupulously fair and detailed when noncompliance is suspected.

NSDP produced the following assessment and verification reports which were submitted to USAID.

**NSDP Depot Holders' Compliance to the Mexico City Policy: A Rapid Assessment**, September 23, 2004

**NSDP Compliance to the Mexico City Policy: Summary Report of the Second-phase Rapid Assessment of Clinics and Providers**, September 23, 2004

**NSDP Compliance with The Mexico City Policy: Summary Report of the Assessment Findings-to-Date**, October 19, 2004

Results of Detailed Investigation with Three NSDP Depot holders, **October 31, 2004**

**NSDP Compliance with the Mexico City Policy: Phase-Three Assessment Summary Report on Clinics**, December 23, 2004

**NSDP Depot Holders' Compliance with Mexico City Policy (MCP): Further Verification of Three Depot Holders**, January 19, 2005

**NSDP Compliance with the Mexico City Policy: Assessment of Shimantik Clinics**, April 7, 2005



**NSDP Compliance with the Mexico City Policy: Community Survey on Sources of Abortion/Menstrual Regulation Services, April 17, 2005**

**NSDP Compliance with the Mexico City Policy (MCP): Summary Report on NGO Facilities Funded by Sources Other than NSDP and ADB, April 24, 2005**

**NSDP Compliance with the Mexico City Policy (MCP): Assessment of NSDP NGO Clinic Referral Centers in Relation to Referral for Abortion/Menstrual Regulation Services, May 11, 2005**

**NSDP Compliance with the Mexico City Policy (MCP): Assessment of NGO Promotion Activities That May Actively Promote Abortion or Menstrual Regulation, May 15, 2005**

## **2. MCP Orientation and Training**

Orientation and training was provided not just for key sub recipient NGO managers, but for *all* NGO staff, including depot-holders and the staff of clinics not funded by USAID. As part of this effort, NSDP carried out the following:

Conducted a comprehensive Training for NGO staff: NSDP felt a comprehensive re-orientation and training on MCP should be provided to all existing and new NGO staff, including management staff, service providers, and volunteers. Also targeted were those who worked with ADB-funded clinics, as these staff were, according to NSDP's investigations, less likely than staff at USAID-funded clinics to be fully informed about MCP. NSDP therefore initiated a cascade orientation and training whereby senior staff of sub recipient NGOs (three from each NGO) were oriented and trained between August 26 2004 to August 31 2004 and November 29 to December 22, 2004, respectively, using Pathfinder's One-Day Curriculum. The cascade one day training was completed by February 2005. In February 2006 and March 2007, Project Directors, NGO Executive Committee contact persons and Project Directors of non-USAID funded projects of NSDP NGO's participated in this annual One Day training.

Created a new training curriculum. NSDP felt that the comprehensive training program described above warranted a *One-Day Training Curriculum*. This training curriculum was initially developed with content covering MCP and Tiahrt Amendment, with Helms Amendment restrictions included in 2006. To Pathfinder's knowledge, this is the first curriculum of its kind, dedicated to providing on-the-job training on MCP to staff at all levels.

Produced MCP reference materials. To support training and ensure transparency, NSDP has developed a flyer answering "Frequently Asked Questions" and job aide about MCP, Tiahrt and Helms, distributed to NGOs and used in training. NSDP also developed and distributed a MCP booklet to all partner NGOs. In 2006, NSDP provided a compendium of materials related to FP policy restrictions for NGO reference and use. In addition to the above-mentioned reference materials, NGOs could refer to critical correspondence between USAID and GoB, family planning policy directives from GoB, and protocols for maintaining family planning related documentation, such as for permanent methods.

Required signed acknowledgements from all retrained NGO staff. NSDP obtained signed acknowledgements from all staff trained using this new curriculum. The acknowledgements state that they have received training, understand the MCP provisions, and will not perform or actively



promote abortion or MR as a method of family planning. Copies of signed acknowledgements are now kept by clinics, NGO headquarters, and NSDP.

### **3. On-site Monitoring for MCP Compliance**

As the recipient of USAID family planning funds, Pathfinder International/NSDP is obligated to require sub-recipient monitoring, as well as, monitor sub-recipients in its effort to verify NGO validity of certifications of compliance with the Voluntary Population Planning Standard Provision Statement.

Although monitoring for MCP compliance was initially integrated within its comprehensive programmatic monitoring effort<sup>1</sup>, Pathfinder International/NSDP intensified its onsite monitoring, not just of USAID-funded clinics, but of all clinics managed by NSDP NGOs. To improve routine MCP monitoring, NSDP developed a monitoring tool specific to USAID family planning policies, intensified guidelines for NGO monitoring and record keeping, tracked NGO agreements with other donors and engaged NSDP staff, both at headquarters and regional levels to monitor NGOs and ensure compliance with USAID family planning policies.

Developed a MCP and Tiahrt Monitoring Tool. NSDP developed and distributed a MCP and Tiahrt-specific Monitoring Tool to NSDP Regional Coordinators, NGO staff, and NGO Executive Committee members. NGO Project Directors are responsible for orienting staff on the use of this tool. NGO's have employed the use of this tool since its introduction in early 2005 to assist in conducting on site monitoring visits and spot checks at their clinics, satellite spots and depot holder sites.

In November 2005, NSDP introduced a revised version of the MCP and Tiahrt Monitoring Tool. This tool also incorporates questions to assess knowledge of the Helms amendment and where applicable, requires a record review of voluntary sterilizations (tubectomy and vasectomy). NSDP also introduced a monitoring tool for use at non-USAID funded clinics and programs. Both NSDP and NGO staff employed use of these modified tools when conducting monitoring visits at NSDP clinics, satellite spots, and depot holder sites and at non-USAID funded clinics and programs.

In order to obtain specific information for monitoring service provider knowledge and clinic record review performance, monitoring tools were developed for entry into an access database. This allows NSDP to report on knowledge on indicators such as the % of interviewees who stated that they have been monitored, the % or number of staff who have full or partial knowledge of all of the clauses within the Mexico City Policy, and the % of staff with full knowledge of the exceptions to the MCP.

Intensified guidelines for NGO clinic monitoring. NSDP finalized its Comprehensive Monitoring Plan together with USAID on September 21, 2004. Monitoring plans were updated yearly in conjunction with sub-recipient project renewals and documentation of Pathfinder NSDP's efforts at verifying the validity of sub recipient certificates of compliance with the Mexico City Policy. These

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<sup>1</sup> Technical Assistance Providing Tool for Regional Officers, December 8, 2003.



expanded MCP monitoring guidelines build on NSDP's existing monitoring procedures and initially included the following provisions:

- MCP compliance must be discussed during *all* clinic visits.
- NGO monitoring staff must use the MCP Monitoring Tool quarterly in all NSDP clinics.
- NGO Executive Committee members must use the MCP Monitoring tool at least twice a year in both NSDP and non-USAID-funded clinics managed by the NGO.
- Monitoring must take place both during and after clinic hours.
- All "passive responses" by service providers, including depot-holders, must be recorded. Initially, NGOs were encouraged to record passive responses within their clinic records. However, in the interest of ensuring client privacy, a passive response form was developed for clinic staff.
- Routine clinic monitoring were reinforced by periodic random assessments of both USAID- and non-USAID-funded clinics, particularly in cases with a suspected .

For FY 2006, NGO requirements for monitoring were modified based on the increased knowledge among staff of the USAID family planning policy restrictions. Prior to renewal of grant agreements, NSDP required that NGO's provide:

NGO Certification of the Voluntary Population Planning Provision Statement.

A Certified Copy of NGO EC resolution which reflects organization's acceptance on MCP.

A copy of NGO EC and project staff's (HQ level) specific visit plan for monitoring MCP, Tiahr and Helms amendment at each NSDP clinic and MCP monitoring at non-USAID funded clinics and programs was required for October 2005 to September 2006 and subsequent grant years.

Certification, orientation, training and monitoring of VPPP was specified in each sub-agreement work plan.

Documentation within the sub-recipient proposals of their efforts to verify their validity of their certifications of compliance. Sub-recipients documented their efforts during FY 2005 and in subsequent years, within the categories of : 1) certifications and acknowledgements, 2) orientation and training, 3) monitoring and 4) reporting.

NGO staff were required to conduct monitoring visits quarterly to USAID funded clinics, satellite sessions and depot holder sites, and to non non-USAID funded programs twice yearly. In order to have depth of coverage in monitoring sites, NSDP required that clinic managers, monitoring officers, all paramedics, counselors, one service promoter or service promotion officer be subject to monitoring. A lesson from terminated or suspended NGOs was that their cases of non-compliance were possibly due to rogue providers or providers who were not aware of the policy restrictions. This depth of coverage during the monitoring process assured NGOs that individual staff were cognizant of USAID family planning policy restrictions, as well as, the outcomes for the organization if such policies are violated by any individual service provider.

NGO monitoring requirements were again modified for the FY 2007 grant period to reflect increased knowledge of policy restrictions. This determination was based on NSDP monitoring results, as well as findings from the Annual Survey on the Knowledge and Practice of the Mexico City Policy (MCP)<sup>2</sup>. Monitoring requirements within sub recipient grant agreements for this last grant year included the following:

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<sup>2</sup> November 2005 and December 2006



NGO Executive Committee members conducted monitoring visits of its NSDP and non-USAID funded clinics once yearly.

NGO Management staff were required to conduct monitoring visits of its NSDP and non-USAID funded clinics twice yearly.

Centralized/streamlined NGO record-keeping system. To facilitate document review, NSDP guided all sub recipient NGOs to maintain a *separate file on MCP compliance* at their headquarters offices and also at each clinic level. This file must contain copies of all agreements with sub-sub recipients, MCP training agendas, participant lists, signed staff acknowledgements; MCP related any policy memo, correspondence with NSDP and completed monitoring forms.

Tracking NSDP partners NGOs MOU with other Donors: NSDP has also developed a tracking system to track all NSDP partnership MOU for other donors since FY05 to ensure compliance with USAID policies. As part of NSDP's strategies for sustainability of its sub-grantees, securing alternative sources of funding is encouraged by NSDP.

MCP Indicators:

As of November 2005, NGO's were required to report on five indicators related to adherence with the Mexico City Policy.

Number of clinics that provided at least one passive response

Number of clinics that provided at least one referral for MR under very special circumstance

Number of clinics that received at least one monitoring visit from NGO or NSDP officials

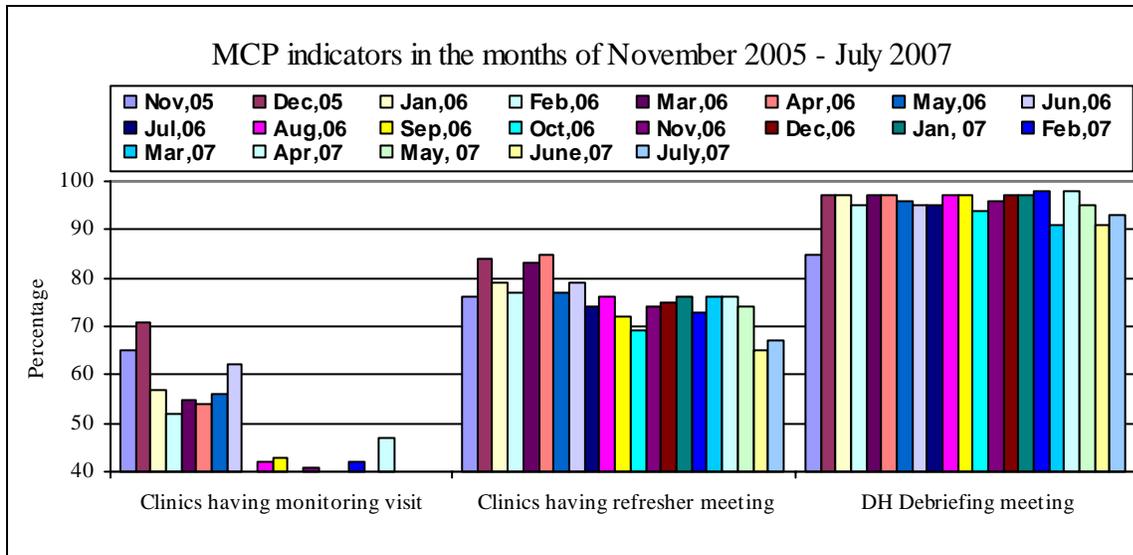
Number of clinics that organized at least one refresher meeting

Number of clinics that organized monthly Depot Holder (DH) debriefing meeting

To date, only one passive response was recorded by an NGO at the Aftab Nagar clinic of PSTC in May 2007. No NGO staff provided referrals in the case of exceptions during the life of the project.

During the last year of NSDP's implementation, monitoring efforts decreased in response to the increased knowledge as determined through NSDP's annual assessments and routine monitoring. Exceptional efforts at service expansion during the last year of the project did result in sporadic monitoring efforts. However, Depot Holder debriefings remained constant with an overall average of 95% being conducted at clinics monthly, while refresher information on family planning policies were conducted in 75% of clinics monthly.





Staff monitoring of NGOs to verify the validity of their certifications of compliance with VPPP: In addition to orienting and training NGOs on USAID Family Planning policy restrictions and conducting rapid assessments and detailed verifications of NSDP NGOs, Pathfinder International/NSDP monitored its sub-recipient NGOs in its effort to verify NGO validity of certifications of compliance with the Voluntary Population Planning Standard Provision Statement.

Initially, monitoring for compliance with USAID Family Planning policies was an effort integrated with comprehensive monitoring visits conducted at individual NGO clinics, satellite spots and depot holder homes. NSDP’s *Technical Assistance Providing Tool for Regional Officers* formalized the programmatic monitoring process. This tool includes a section for determining sub-recipient compliance with family planning policies, including questions regarding . Service providers were asked to explain the Mexico City Policy and Regional Officers were charged with ensuring that information regarding Mexico City Policy was made available at each service delivery site. Staff were oriented on the use of the Tiahrt Poster or Banner and sites inspected to ensure that the poster or banner were available and visible to clients.

During the period of October 2004 to September 2005, NSDP sub recipient monitoring efforts were supplemented with rapid assessments, detailed verifications and when necessary, investigations. In addition to these special initiatives, NSDP Regional Staff continued to use MCP and Tiahrt<sup>3</sup> monitoring tool on a quarterly basis to assess knowledge, verify monitoring of the site by NGO headquarters staff and review documentation using the MCP and Tiahrt monitoring tool. Regional staff also visited non-NSDP clinics twice a year to verify the validity of NGO certifications of compliance. NSDP regional staff report on their visits and findings, if any, through monthly trip reports to NSDP. As a result, NSDP conducted 1031 clinic visits to 314 clinics, 428 satellite spot visits and 329 Depot Holder visits in its effort to verify NGO validity of certification of compliance with USAID Family Planning policies.

<sup>3</sup> Table 1: NGO Clinics monitored for MCP, Tiahrt and Helms monitoring, FY 2006.



As of October 2005, NSDP engaged both Headquarters and Regional Staff to conduct monitoring visits to NGO headquarters, clinics, satellite spots and depot holders. Clinic monitoring visits were assigned to Headquarters and Regional Staff by a ratio of one to three respectively. All Clinic Managers, Monitoring Officers, Paramedics, at least one Service Promoter or Service Promotion Officer, Counselor and one AYA were subject to monitoring during each clinic visit. At least four Depot Holders were subject to monitoring, either through visits to Depot Holder homes or if Depot Holders were reporting to the clinic, such as during monthly depot holder meetings. Paramedics who comprised satellite teams were either monitored before reporting to the satellite spots or upon return to the clinic following the satellite session. In addition to the depth of monitoring at clinics during the FY 2006 grant year, NSDP aimed to conduct monitoring visits to “vulnerable sites”- safe delivery centers, hard-to-reach clinics and non-NSDP clinics twice yearly.

As a result of its modified monitoring plans during the FY 2006 period, NSDP Headquarters and Regional Staff conducted 58 visits to 35 NGO Headquarters offices, 33 visits to 17 safe delivery clinics, 22 visits to hard-to-reach clinics and 54 visits to 33 non-NSDP clinics. 617 Depot Holders, 2,951 clinic and satellite staff, and 200 non-NSDP service delivery staff were interviewed.

For the final year of the NSDP project, compliance monitoring efforts were further prioritized to “vulnerable sites,” NGO headquarters, and a sample of static and satellite clinics and Depot Holders. This strategy assumed strengthened knowledge of the restrictions of Mexico City Policy, Tiahrt and Helms Amendments among NGO staff by the fifth year of NDSP, with NGO monitoring systems in place for training, orienting and monitoring for compliance with the Voluntary Population Planning Statement.

At the clinic and field levels, NSDP prioritized its efforts to “vulnerable sites” twice-yearly. The vulnerable sites were: 12 ADB clinics, 12 NGO clinics funded by donors other than USAID or ADB, 28 Safe Delivery Centers, 17 NDSP hard-to-reach clinics. Newly approved UPHCP clinics of NSDP’s NGOs, PSTC, SGS and VWFA, were added to the list of “vulnerable sites” as the FY 2007 year progressed and once these clinics were functional. Each quarter a sample of static clinics will be selected for MCP monitoring such that 25% (approximately 70 clinics) of clinics were monitored once for MCP compliance in FY 2007 by NSDP regional and headquarters staff. Service delivery staff including clinic managers, all paramedics, one service promoter or SPO, counselors, and four depot holders were subject to monitoring. NSDP Headquarters and Regional Staff conducted 62 visits to 33 NGO Headquarters offices, 54 visits to 28 safe delivery clinics, 32 visits to 17 hard-to-reach clinics and 86 visits to 53 non-NSDP clinics. 278 Depot Holders, 1447 clinic and satellite staff, and 390 non-NSDP service delivery staff were interviewed during FY 2007.<sup>4</sup>

USAID extended the NSDP program until December 2007, including grant agreements of sub-recipient NGOs. At the clinic and field levels, NSDP will prioritize its monitoring efforts to cover

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<sup>4</sup> Number varied in case of HQ, Safe delivery, hard to reach and non NSDP clinic visits (required 2 visits per site). For NGO HQ and safe delivery, it is due to termination of NGOs, for hard to reach clinics, because of bad weather, and inclusion of newly awarded clinic incase of non NSDP funded clinic of NGOs.



12 ADB clinics managed by PSTC and Shimantik in Dhaka City Corporation, 6 ADB clinics managed by PSTC in Rajshahi City Corporation, 8 newly opened ADB clinics within the Sylhet City Corporation as managed by Shimantik, and 8 recently opened clinics in Khulna City Corporation as managed by SGS/VWFA. In addition to its monitoring obligations as the recipient of USAID funds, NSDP has required MCP monitoring at these sites by the above-mentioned sub-recipient NGOs.

During this extension period, MCP monitoring also includes PSTC's 3 brothel-based clinics. This project is a collaborative effort between Bangladesh Women's Health Coalition (BWHC), with other partners being Community Health Care Project (CHCP), PSTC and ICDDR,B. This project provides STI/RTI prevention and treatment services, distributes condoms and conducts prevention education through "peers" at a nearby brothel. PSTC is also required to monitor these 3 clinics.

At the close of the NSDP project, Pathfinder International/NSDP has met its due diligence with USAID's Family Planning Policy restrictions. NGO knowledge of USAID's Family Planning Policy restrictions are high in Bangladesh among NSDP participating NGOs and service delivery staff within the NSDP NGO network.



Attachment A:  
**NSDP Enhanced Financial Sustainability Initiative Summary Sheet  
Up to May 2007**



*NGO Service Delivery Program*



NGO	R/U	Process					Intermediary results					Strategic objective results				
		Workshop			One-to-one consultation  HBC for paying customer:  Non-NSDP + NSDP experience  Process of price set up	Costing study:  Questionnaire Pre-test  Training  CORE Training & PI approach	Restructured user fees	Safety net to POPs			Cost recovery		Safety net to POPs		# of HBCs sold to paying customers	
		Restructuring user fees	Safety net to POPs	Performance-based reimbursement scheme:				POP ELCOs identification	HBC printed	Amount of Poor fund generated	Baseline (Jan-Mar 2003)	Current (Mar-May07)	# of POP served	# HBC distributed		
				Pilot												Scale up
BAMANEH	R U R A L	√	√		√	√	+	15,215	√	7,395	12	21	8,497	14,455	7,302	
BANDHAN		√	√					7,103	√	-	9	16	1,553	6,770	3,669	
CRC		√	√					2,209	√	642	7	11	1,048	2,209	1,071	
FDSR		√	√				+	8,115	√	9,049	13	28	7,748	7,119	41	
JTS		√	√		√	√		19,621	√	10,242	11	32	17,422	9,352	5,805	
MMKS		√	√		√	√		20,938	√	9,003	11	14	10,561	19,547	6,666	
NISHKRITi		√	√					8,801	√	4,223	22	31	5,273	7,430	5,925	
Proshanti		√	√			√		10,366	√	-	16	20	2,877	10,366	115	
PSF		√	√			√	M	14,620		1,100	11	28	4,540	10,268	3,104	
PSKS		√	√		√	√		4,439	√	750	15	27	3,620	4,242	3,366	
SGS		√	√					2,492	√	950	7	22	2,899	2,492	1,902	
SHIMANTIK		√	√					6,696	√	2,910	10	18	5,755	5,791	5,351	
SOPIRET		√	√		√	√		6,505	√	5,057	10	21	7,269	6,322	3,703	
SUPPS		√	√					719	√	2,530	8	15	250	718	1	
SUS		√	√					3,781	√	975	11	13	1,921	2,973	2,276	



NGO Service Delivery Program



Swanirvar		√	√	√	√	√	√	M	52,033	√	1,131	15	26	36,970	46,020	36,365
VPKA		√	√		√		√		5,722	√	-	12	23	3,252	5,722	2,619
Total		17	17	1	7	5	7	5	189,375	16	189,450	12	22	121,455	161,796	89,281

NGO	R/U	Process						Intermediary results			Strategic objective results						
		Workshop			One-to-one consultation		Restructured user fees	Safety net to POPs			Cost recovery		Safety net to POPs		# of HBCs sold to paying customers		
		Restructuring user fees	Safety net to POPs	Performance-based reimbursement scheme:	HBC for paying customer:  Non-NSDP + NSDP experience  Process of price set up	Costing study:  Questionnaire Pre-test  Training  CORE Training & PI approach		POP ELCOs identification	HBC printed	Amount of Poor fund generated	Baseline (Jan-Mar 2003)	Current (Mar-may07)	# of POP served	# HBC distributed			
CWFD	U R B A N						√								√	√	√
Dipshikha		√	√						384	√	-	21	77	236	384	827	
Fair Foundation		√	√		√			√	+	1,074	√	7,331	14	22	3573	1036	3,718
Image		√	√							7,840	√	-	25	29	4757	5212	1,108
KAJUS		√	√							380	√	-	12	34	270	380	2,263
Kanchan		√	√		√	√	√	√	+	17,133	√	23,806	12	27	16470	17133	9,791
MALANCHA		√	√							5,190	√	510	14	16	1367	2938	68
PKS_j		√	√		√			√		8,959	√	37,255	24	21	8208	7293	8,281
PSTC		√	√		√	√	√	√	+	8,171	√	3,459	20	25	2583	6613	6,924
SSKS		√	√		√			√	+	5,102	√	24,747	20	36	1745	3918	5,373
Tilottoma		√	√							2,536	√	9,363	12	16	2542	2429	2,076
Upgms/r		√	√			√			M	6,257	√	1,996	15	18	6115	6207	7,168



NSDP  
NGO Service Delivery Program



VFWA		√	√					-	4,071	√	5,805	13	21	5240	4071	1,760
Total		13	13	1	6	4	6	6	77,942	14	106,941	18	28	56,644	68,172	309,808
<b>GRAND TOTAL (R+U)</b>		<b>30</b>	<b>30</b>	<b>2</b>	<b>13</b>	<b>9</b>	<b>13</b>	<b>11</b>	<b>267,317</b>	<b>30</b>	<b>296,391</b>	<b>30</b>	<b>50</b>	<b>178,099</b>	<b>229,968</b>	<b>399,089</b>



NSDP  
NGO Service Delivery Program



## Attachment B: Achievement Matrix

Achievements up to June 2006	Achievements during June 2006 to September 2007
<b>OBJECTIVE 1: EXPAND THE RANGE AND IMPROVE THE QUALITY OF THE ESSENTIAL SERVICES PACKAGE (ESP) PROVIDED BY NGOS AT THE CLINIC AND COMMUNITY LEVELS</b>	
<p><b><u>Family Planning Services:</u></b></p> <ul style="list-style-type: none"> <li>• IUD service expanded to all 318 clinics</li> <li>• Norplant expanded to 203 clinics</li> <li>• NSV to 110 clinics</li> <li>• Tubectomy in 51 clinics</li> <li>• Counseling contacts per month increased from 25,337 visits in 2004 to 28,170 visits in 2005, (11%).</li> <li>• Depotholder referral system, (which compliments clinic referrals) to GoB facilities for minilap and vasectomy services.</li> <li>• Strengthened the process of managing FP referrals. PLTM referrals increased by 13% from FY03 to FY04, and by 28% from FY04 to FY05.</li> <li>• Emergency contraception available at all clinics.</li> </ul>	<p><b><u>Family Planning Services:</u></b></p> <ul style="list-style-type: none"> <li>• Continued all Family Planning Services as per service provisions</li> <li>• 33 NGO managers were oriented on policy boundaries related to FP and they conducted step-down training in all 317 clinics</li> <li>• Skills were transferred to service providers to provide PLTM services at the clinic level               <ul style="list-style-type: none"> <li>○ 494 on FPCSC,</li> <li>○ 231 doctors and 233 paramedics on Norplant:</li> <li>○ 85 doctors and 73 paramedic on NSV</li> <li>○ 29 doctors and 43 paramedic on tubectomy</li> </ul> </li> <li>• 22 NGOs implemented community level follow-up mechanism for PLTM customers at 169 clinic catchment areas.</li> <li>• Satisfied customers used as volunteers to counsel potential PLTM customers</li> <li>• Developed capacity of training institute on OJT (AITAM and Radda)</li> <li>• 18 Paramedics received training as 'Preceptors' and acted as clinical trainer for 10 NGOs</li> <li>• 9 NGO managers were trained as OJT supervisor</li> <li>• 10 Zoe Model were distributed to NGOs and training institute</li> <li>• 149 paramedics were trained through decentralized training approach in 5 NGOs</li> <li>• OJT were introduced for IP, Counseling and IUD</li> <li>• Post training follow-up tools were developed and NGO managers were trained on it</li> <li>• A new Implant training center was established at PKS (NSDP NGO) Jessore clinic which is a second implant training center</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
<p><b><u>Maternal Health: SD and EmOC:</u></b></p> <ul style="list-style-type: none"> <li>• 16 facilities upgraded for facility delivery, including PAC;</li> <li>• An average of 300 women deliver at NSDP facilities monthly.</li> <li>• 6 of these 16 clinics are comprehensive, offering EmOC services.</li> <li>• On average 60 women per month receive c-sections at these clinics.</li> <li>• 500 women with obstetric complications per month are referred to comprehensive EmOC facilities.</li> <li>• 29 NGO clinic staff given on-site coaching for EmOC</li> </ul>	<p><b><u>Maternal Health: SD and EmOC:</u></b></p> <ul style="list-style-type: none"> <li>• Safe Delivery services expanded at 28 clinics</li> <li>• EmOC services expanded at 20 clinics</li> <li>• Staff training on SD – 48 doctors and 101 paramedics</li> <li>• Service delivery guideline developed on EmOC</li> <li>• Service delivery guideline developed on USG</li> <li>• 31 clinics were equipped with mini ambulances</li> <li>• 14 clinics were equipped with ambulances</li> <li>• 28 clinics were equipped with rickshaw vans</li> <li>• MH workshop organized for to mentor 32 NGO managers</li> <li>• 505 paramedic were trained on ORH</li> </ul>
<p><b><u>Maternal Health: Community EmOC:</u></b></p> <ul style="list-style-type: none"> <li>• 76 NGO managers and service providers trained on birth preparedness, community support systems, and strengthening referral linkages.</li> <li>• 4,740 NGO staff have been trained on promotion of birth preparedness, community support systems, and referral linkages;</li> <li>• 83% to 89% of families in the NSDP catchment population report some preparedness for obstetric emergency that include monetary savings, transport to an EOC facility, and others.</li> </ul>	<p><b><u>Maternal Health: Community EmOC:</u></b></p> <p>Community EOC was implemented at all clinic catchment areas including community PAC.</p>



Achievements up to June 2006	Achievements during June 2006 to September 2007
<p><b><u>Maternal Health: Home Delivery:</u></b></p> <ul style="list-style-type: none"> <li>Interested NGOs were identified along with clinics and the Paramedics to implement the pilot initiative.</li> <li>Community expectations and willingness to pay for SBA service were assessed</li> <li>Training needs were assessed for all paramedics who were eventually trained</li> <li>Paramedics were trained according to the findings of TNA with a special emphasis on AMTSL, Newborn Resuscitation and use of partograph.</li> <li>27 SBAs at 10 clinics (pilot) are providing the service in 10 clinic catchment areas.</li> <li>During last one year, they have conducted 421 deliveries and referred 99 cases</li> <li>Quality assurance and monitoring system was developed.</li> <li>Paramedics were provided with required logistic.</li> <li>From the experience of the pilot selection criteria were revised</li> </ul>	<p><b><u>Maternal Health: Home Delivery:</u></b></p> <ul style="list-style-type: none"> <li>81 paramedics trained to provide the service in 61 clinics</li> <li>Their skills were enhanced on use of partograph, AMTSL and newborn resuscitation</li> <li>Refresher training organized for 23 paramedic in HD intervention</li> <li>Extensive marketing was done for this new component in the clinic</li> <li>Regional HD workshops were organized for 47 Clinic Managers and 41 Paramedics</li> <li>Referral mechanism was strengthened in case of complication</li> <li>Paramedics were provided with required logistic (delivery kit)</li> <li>A supervisory mechanism was established along with the development of checklist</li> </ul>
<p><b><u>Other Reproductive Health:</u></b></p> <ul style="list-style-type: none"> <li>186 paramedics were trained on ORH (Other Reproductive Health) that includes ANC, PNC and Newborn Care.</li> <li>600,000 printed pictorial cards on the promotion of birth preparedness were developed and distributed throughout all the clinics.</li> </ul>	<p><b><u>Other Reproductive Health:</u></b></p> <ul style="list-style-type: none"> <li>Skills enhanced on ANC, PNC</li> <li>Total paramedics trained – 505</li> <li>25 staff were trained on PAC</li> </ul>
<p><b><u>Child Health: Immunization:</u></b></p> <ul style="list-style-type: none"> <li>NSDP provided over 3 million childhood immunizations in 2004 and 3.4 million in FY 05</li> <li>69% children fully immunized (rural)</li> <li>84% children fully immunized (urban)</li> <li>AFP &amp; AEFI Job Aide developed &amp; distributed to the service provider.</li> <li>National Immunization Days Observation (NID).</li> <li>Measles Catch-up Campaign 2005-2006</li> <li>Phase – 1 (2005) 0.2 M</li> <li>Phase -2 – (2006) 3.8 M</li> </ul>	<p><b><u>Child Health: Immunization:</u></b></p> <ul style="list-style-type: none"> <li>Fully Vaccination Coverage improved to 76 % (Rural Area)</li> <li>Fully Vaccination Coverage improved to 81 % (Urban Area)</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
<p><u>Child Health: F-IMCI:</u></p> <ul style="list-style-type: none"> <li>• Upgraded 315 Smiling Sun clinics to provide IMCI Services.</li> <li>• 802 Paramedic &amp; 217 Doctors have received an 11 day Clinical Management course on IMCI</li> <li>• Paramedics are able to manage 1 day to 2 month old children.</li> <li>• Service providers now correctly identify and treat childhood illness and refer severe cases when required.</li> <li>• NSDP uses the WHO adapted F-IMCI checklist for supervision and monitoring.</li> <li>• 25 NGO Managers received 5 days Training on Follow- up After training on IMCI.</li> <li>• Decentralization of IMCI training to regional level Medical College Hospital.</li> <li>• 286 NGO Managers and Supervisors (Technical &amp; Non technical) oriented and updated on IMCI.</li> <li>• IMCI Guideline developed and Updated for NSDP NGOs.</li> <li>• IMCI Mothers Card adapted, printed Supplied for all Smiling Sun Clinics.</li> </ul>	<p><u>Child Health: F-IMCI:</u></p> <ul style="list-style-type: none"> <li>• Assessment of F-IMCI services were done in 15 pilot clinics</li> <li>• IMCI guideline was developed for NSDP</li> <li>• F-IMCI expanded to all 317 clinics</li> <li>• Training provided on 11-day IMCI course to 1003 paramedic and 366 doctors</li> <li>• Training provided on 5-day follow-up after training to 45 NGO mangers</li> <li>• 1 day IMCI orientation was conducted for 317 Clinic Managers and 83 NGO Managers</li> <li>• 80% clinics received IMCI follow-up visits by NGO managers</li> <li>• A formal follow-up visit was conducted through cross-visit in randomly selected 106 clinics</li> <li>• IMCI mothers card was adopted, printed and supplied to all SS clinics</li> <li>• IMCI indicator was incorporated in QMS</li> <li>• Weight for age campaign was carried out in all clinics</li> <li>• NSDP clinics participated in all special vaccination campaign (NID, Measles, Vit-A and MNT campaign)</li> <li>• Developed job aid on AEFI and AFP surveillance and staff were trained on it</li> <li>• Effective referral linkages established between facility and community</li> <li>• IMCI training was decentralized in 3 Medical Colleges outside Dhaka</li> <li>• Capacity built up for IMCI training in Addin, LAMB and Shishu Hospital</li> <li>• 100 ILR were purchased and distributed to 100 clinics</li> <li>• All Clinic Managers, Paramedic, SPO, SPs were trained on EPI at local level with the support of GOB</li> <li>• 33 clinics in DCC received ILR from GOB</li> <li>• Expanded immunization services in DCC peri-urban areas</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
<p><b><u>Child Health: C-IMCI:</u></b></p> <ul style="list-style-type: none"> <li>• 33 of the 58 C-IMCI clinics began activities in 2004</li> <li>• 67 C-IMCI clinics</li> <li>• Training curriculum developed</li> <li>• 142 NGO trainers have received TOT training using this curricula.</li> <li>• Trainers have trained 173 service promoters, 139 paramedics and 2825 DHs on C-IMCI.</li> <li>• More than 95% of DHs have been trained on C-IMCI.</li> <li>• Refresher training on C-IMCI was given to 166 DHs in 7 Clinics of 3 NGOs.</li> <li>• 3100 ARI timers, flip-charts, posters and Bangla CDs on IMCI distributed to NGOs and are being used in the field.</li> </ul>	<p><b><u>Child Health: C-IMCI:</u></b></p> <ul style="list-style-type: none"> <li>• C-IMCI was expanded to 156 SS clinics</li> <li>• 6-day TOT was provided to 156 Paramedic and 156 SP</li> <li>• 9-day C-IMCI training was provided to 6471 depholders and equipped with Pediatric Cotrimoxazole and timer/watch</li> <li>• 2500 ARI timer and 4360 watches were distributed</li> <li>• Demonstrative comprehensive model of C-IMCI was implemented in Shazadpur</li> <li>• 135 Village Doctors were trained on C-IMCI</li> <li>• Linkages were developed with village doctors associations</li> <li>• Checklist developed on C-IMCI</li> <li>• A formal assessment was done by external reviewer on C-IMCI</li> <li>• Local level public information campaign was carried out on C-IMCI</li> </ul>
<p><b><u>PAC:</u></b></p> <ul style="list-style-type: none"> <li>• 8 static clinics offer PAC services.</li> <li>• PAC manual developed.</li> <li>• 13 doctors received TOT on clinical PAC.</li> <li>• 9 physicians and 17 paramedics trained in clinical PAC.</li> <li>• 3000 community health workers were trained on community PAC.</li> <li>• 150 clinics have integrated community PAC with community EOC.</li> </ul>	<p><b><u>PAC:</u></b></p> <ul style="list-style-type: none"> <li>• Existing clinics continued to provide clinical PAC services and the community work-force used for identification and timely referral of any bleeding case</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
<p><b>TB:</b></p> <ul style="list-style-type: none"> <li>• DOTS service at 55 urban clinics</li> <li>• 37 clinics provide DOTS</li> <li>• 18 clinics provide microscopy services.</li> <li>• 1 NTP-approved EQA.</li> <li>• 70 Doctors have received training on 'Modular Course on Management of Tuberculosis'</li> <li>• 29 Doctors have received refresher DOTS Orientation</li> <li>• 15 Doctors have received training on Monitoring and Supervision of DOTS</li> <li>• 50 Paramedics have been trained on DOTS Orientation</li> <li>• 26 laboratory technicians have received Sputum microscopy training</li> <li>• 93 Counselors/service promoters have been Oriented on 'DOTS</li> <li>• 9,030 clients have been served to date.</li> <li>• TB referrals increased 323 % between FY03 and FY04 and 63% between FY04 and FY05.</li> <li>• Case detection rate increased 34% to 43% (2004-5)</li> <li>• Case treatment rate 84.8%</li> <li>• A partnership has been established with FHI partner NGOs to provide TB services in Dhaka City.</li> </ul>	<p><b>TB:</b></p> <ul style="list-style-type: none"> <li>• NSDP signed agreement with the Directorate General of Health Services and Involved with National Tuberculosis Control Program in June 2003 for Tuberculosis Diagnosis and Treatment program with DOTS strategy in urban areas of Dhaka, Chiattagong, Rajshahi and Khulna divisions. 9 NGOs namely PSTC, CWFD, Swanirvar, Bamaneh, Image, Nishkriti, Fair Foundation, PKS-Khulna, Tilottama are involved. Total Catchment Population: 3.8 Million, total number of Smiling Sun Clinics providing TB Services is 56.</li> <li>• At the beginning in 2003 total number of TB microscopy centers were 18 (12 in Dhaka, 1 in Chittagong, 1 in Rajshahi and 4 in Khulna). Number of Microscopy centers has been increased to 32 (21 in Dhaka, 5 in Chittagong, 4 in Khulna and 2 in Rajshahi) i.e. 14 new Microscopy centers have been added during the year 2005 and 2006.</li> <li>• First External quality Assurance center of NSDP established in July 2005 in Dhaka to ensure the quality of TB microscopy at smiling sun clinics in Dhaka. It was among 22 National EAQ centers of the Country. Microscopy center of Chittagong brought under quality assurance in 2004, those of Rajshahi and Khulna in 2005 and at beginning of the year 2006. Now all microscopy centers are under quality cross checking.</li> <li>• Case detection rate of new smear positive TB cases is a principal indicator of progress of TB control program. In 2003 it was 23.0%. Detection rate gradually increased to 33%, 39.78% and 48.16 % in the year 2004, 2005, and 2006 respectively. In 2007 up to quarter January-March, the detection rate is 62%.</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
	<ul style="list-style-type: none"> <li>• Treat success rate is another important indicator of the Program. Treatment success at the beginning was 80.2% only, this also gradually increases over the years and current treatment success rate is 88%</li> <li>• Total Number of TB Contacts since inception in 2003 till March 2007: 13,218 TB patients</li> <li>• Staff Trained: 444 health staff (129 graduate doctors, 92 paramedics, 38 lab technologists, 185 SP/SPOs/Counselors). Routine trainings were conducted by NTP and need based training by BRAC free of cost. Training information are incorporated in the NSDP TMIS.</li> <li>• In May 2006 community volunteers have been introduced and 110 volunteered recruited (2 volunteers per one smiling sun clinic that provides TB services) to extend services out to community and home level. Volunteers were oriented by the NGOs following National guidelines of NTP and orientation guidelines of BRAC.</li> <li>• Monitoring and Supervision of the program strengthened by developing mechanism of involving NGOs, NTP and BRAC. Routine quarterly review meeting on performance introduced at the beginning of the year 2006. Feed back on improving performances is regularly given.</li> <li>• On job orientation provided to staff as a continuous process throughout the project period for quality record keeping and reporting.</li> <li>• Operational guide line for the operation of Tuberculosis Control Program by the NSDP NGOs developed in 2005. NGOs introduced the guideline in practices in 2006.</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
	<ul style="list-style-type: none"> <li>• An un-interrupted supply of drugs and logistics, publications from NTP and BCC materials from both NTP and BRAC/GFATM ensured by maintaining close liaison with NTP, WHO, BRAC and other NTP stakeholders.</li> <li>• NSDP and partner NGOs contributed in developing country proposal for GFATM Round 5 for Bangladesh. Bangladesh awarded the grant for TB and NSDP partners involved with GFATM TB control program in May 2006. Partners received \$ 216,000 USD for 14 months to work in four Service delivery areas: 1. Strengthening current DOTS activities; 2. Involving private sectors in delivering TB/DOTS services; 3. Creating demand for services by introducing comprehensive Advocacy, Communication and Social mobilization; and 4. Strengthening supervision, monitoring and evaluation.</li> <li>• NSDP and Partner NGOs contributed during the project time in developing 3 important National Documents: 1. The Strategic Plan for TB Control: 2006-2010</li> <li>• 2. National Guidelines on Advocacy, Communication and Social mobilization (ACS) and 3. National Guidelines on Public Private mixed Partnership (PPM).</li> </ul>
	<ul style="list-style-type: none"> <li>• Partnership between NSDP partner CWFD and FHI partners, CREA and DAM developed under signed agreement in February 19, 2006 to provide TB services to Injecting Drug Users (IDUs). A total of 533 Clients served, 14 of them diagnosed as TB patients, 10 patients completed treatment, 4 patients dropped out (as of June 30, 2007).</li> <li>• NSDP partner Nishkriti and FHI partner YPSA signed agreement in September 15, 2006 to provide ESP services from selected Smiling sun clinics to the street based sex workers and their family members served by YPSA. A total of 409 clients of which 373 Female and 36 Children received services from 2 smiling sun clinics at Chittagong. Total 247 LA distributed to poor clients with supply of free medicines (as of June 30, 2007).</li> <li>• NSDP partner PSTC and FHI signed agreement in May, 2007 to provide HIV/AIDS screening Voluntary Counseling and Testing (VCT) service to TB positive patients and potential high risk groups from 2 selected Smiling Sun Clinics in Dhaka. So far (as of June 30, 2007) total 39 Clients tested for HIV of which 20 were male and 19 were female. No body found positive for HIV.</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
<p><b><u>STI/RTI:</u></b></p> <ul style="list-style-type: none"> <li>• 68 clinics provide specialized RTI/STI management and HIV/AIDS public education.</li> <li>• 'Clinical Governance System' has been introduced at the 68 clinics.</li> <li>• Curriculum, guidelines and check list revised to address the needs of at risk populations. 5 trainings have been organized with the revised curriculum involving 70 participants, 40 doctors and 30 paramedics.</li> <li>• NGOs are "partner of choice" for other organizations. Presently 9 NGOs are working in partnership with CARE-Bangladesh, UNICEF and the Population Council.</li> <li>• 812,621 STI/RTI cases in FY 2004,</li> <li>• 955,395 in FY 2005</li> <li>• Population Council study in 4 sites to promote condoms as a dual protection method</li> <li>• National AIDS and STI Program selected NSDP as core member to update and develop the National Technical Guideline on STI/RTI</li> </ul>	<p><b><u>STI/RTI:</u></b></p> <ul style="list-style-type: none"> <li>• A total of 149 Health staff trained on STI/RTI case managements of which 62 were Graduate doctors and 87 paramedics.</li> <li>• A total of 3.95 million clients received STI/RTI services since 2003 till May 2007 form 317 Smiling Sun clinics.</li> <li>• Monitoring and supervision ensured in 68 smiling sun clinics serving high risk population. Quality of STI/RTI services improved in all 317 Smiling Sun clinics.</li> <li>• Successful piloting with PoP council completed on promoting dual protection among customers of high risk population in 4 smiling sun clinics of 2 NGO partners. Scaling up started in 2007 in 35 new clinics of 10 partner NGOs.</li> <li>• Updated information, National guidelines, publications are disseminated to Partner NGOs regularly.</li> <li>• NSDP and Partner NGOs contributed during the project time in developing important National documents: 1. The National guidelines on HIV/AIDS 2. National guideline on STI/RTI managements 3. National Guidelines on BCC of HIV/AIDS</li> <li>• STI orientation guideline prepared</li> <li>• Clinical Governance guideline developed</li> </ul>
<p><b><u>LCC:</u></b></p> <ul style="list-style-type: none"> <li>• Customer contacts increased 6% between FY 03 and FY 04 and are expected to increase by 25% between FY 04 and FY 05:</li> <li>• Essential drug list developed, serves as a job-aid to procure drugs following the approved list.</li> </ul>	<p><b><u>LCC:</u></b></p> <p>LCC activities/services continued</p>
	<p><b><u>HRIS:</u></b></p> <ul style="list-style-type: none"> <li>• Management of Training and Service Information:</li> <li>• Collected and compiled the training data of 3719 trainees for different training programs through 364 batches conducted by Clinical Services Team</li> <li>• Collected data for the training follow – up visits and recorded the finding in the system</li> <li>• Track and recorded the entire work plan update into MS Project with the inputs from different teams of NSDP</li> <li>• Collected and recorded the data of workshop arranged by CST for Continuous Technology Update</li> <li>• Collected data from 320 clinics on special services</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
	<p>providing by all the clinics</p> <p><b>New Intervention:</b></p> <ul style="list-style-type: none"> <li>• Collected data for base line survey prior to initiate Home Delivery intervention in 10 NGOs of NSDP network</li> <li>• Collected data for expanding the Home Delivery services in the year 2006 in 46 Smiling Sun clinics of 16 NGOs</li> </ul>
	<p><b>Event Management and Communication with other stakeholders:</b></p> <ul style="list-style-type: none"> <li>• Communicated with NGOs and with Training institute for different correspondence needed by CST</li> <li>• Supported in organizing training courses and ensuring payment of tuition and other related fees.</li> </ul> <p><b>Documentation:</b></p> <ul style="list-style-type: none"> <li>• Compiled the entire Clinical Training Expansion plan in 2005, 2006, and 2007</li> <li>• Compiled and supplied information in reporting to USAID for each quarter</li> <li>• Assisted Clinical Services Team members in developing tools for data collection, Checklists etc.</li> </ul> <p><b>Development of HRIS:</b></p> <ul style="list-style-type: none"> <li>• Assisted IntraHealth Information System Manager to perform the 1st round user acceptance test of the HRIS System</li> <li>• Coordinated the worked closely with the HRIS developers and NSDP MIS in determination and development of the query tool.</li> <li>• Perform 2nd round user acceptance test of the HRIS system.</li> <li>• Collected personnel details of 3900 staffs from 33 NGOs</li> <li>• Worked closely with the data entry operators to clean and entry of all the data into the HRIS System for 3900 staff</li> <li>• Took the delivery of the HRIS system and its source code.</li> </ul>
<p><b><u>Drug Management:</u></b></p> <ul style="list-style-type: none"> <li>• Revised Essential Drug List</li> <li>• MOU signed with 13 pharmaceutical companies to allow NGOs to buy drugs at institutional rate</li> <li>• Provided pediatric cotrimoxazole to the C-IMCI clinics</li> <li>• Developed, revised &amp; integrated RDU &amp; RDF indicators into QMS system</li> </ul>	<p><b><u>Drug Management:</u></b></p> <ul style="list-style-type: none"> <li>• Revised EDL booklet for NGO service providers' use and decentralized the periodic updating of the EDL booklet</li> <li>• Developed on-the-job Clinical Skill Standardization RDU curriculum</li> <li>• Conducted TOT on RDU for 14 NGO HQ managers</li> <li>• Developed monitoring system for drug management</li> <li>• Negotiated with drug companies to change the payment system for 14 focus NGOs</li> </ul>



Achievements up to June 2006	Achievements during June 2006 to September 2007
	<ul style="list-style-type: none"> <li>• Provided TA to focus NGOs on managing consolidated procurement system</li> </ul>
<p><b><u>Quality Improvement:</u></b></p> <ul style="list-style-type: none"> <li>• 20 two-day QMS training workshops, covering the concepts of quality of care and supportive supervision, have been conducted to date, and skills have been transferred to 573 NGO staff, to date.</li> <li>• Conducted Community Perception of Quality study</li> <li>• A QMS implementation guideline and Monitoring and Supervision checklists produced in 2003 and updated in 2006, prepared.</li> <li>• NGOs completed 5 Rounds of QMS using QMS checklists and the PI approach.</li> <li>• Two rounds of QMS data validation conducted by NSDP.</li> <li>• Reviewed GoB protocols to ensure that NSDP training is in compliance.</li> <li>• Managers from 2 NGOs mentored to jointly conduct QMS Training Workshops for their peers.</li> <li>• Expanded the number of trained NGO managers, doctors and paramedics who routinely mentor and coach their counterparts at the clinic levels</li> </ul>	<p><b><u>Quality Improvement:</u></b></p> <ul style="list-style-type: none"> <li>• Increase the number of NGO level mentors for QMS training and TA at the local level</li> <li>• Continue to provide TA for integrating quality improvement efforts at all levels</li> <li>• Strengthen local level inter-NGO collaboration to ensure continued quality improvement</li> <li>• Continue standardizing staff at the NGO and clinic levels</li> <li>• Standardize clinical personnel on RDU and MCH.</li> <li>• Provide support to relevant NSDP areas to incorporate element of quality.</li> <li>• Incorporate quality of care into training systems.</li> <li>• Rationalize clinic management and service delivery to improve compliance to standards and protocols, especially for the focus NGOs.</li> <li>• Rapid assessment and documentation of NSDP's quality of care efforts.</li> <li>• Work with focus NGOs to integrate the major information systems</li> </ul>



**OBJECTIVE 2: INCREASE THE USE OF THE ESSENTIAL SERVICES PACKAGE, ESPECIALLY BY THE POOR**

- 26 part TV drama produced and aired
- M and E of TV drama
- TV drama-related local service promotion campaigns on 6 health topics
- 150 billboards promote specific health messages for EPI, ARI, ANC, GH,
- Three main categories of health service messages promoted nationwide –child health, maternal health and family planning.
- Brand Ambassador Joya Ahsan, has made several clinic visits to promote clinics, their services, and to encourage better health seeking behavior
- Cricketer Rafique, spokesperson for maternal and neonatal health, makes clinic visits
- Media survey conducted to identify brand recognition of SS logo is 60.8% (rural) and 87.3% (urban)
- Range of BCC materials:  
8 TV spots, 7 radio spots,  
3 videos (including the 26-episode TV drama serial),  
4,429,721 leaflets,  
1,496,378 health and promotional cards, 8,000 flip charts, and  
1,256 signboards.
- Mystery client exercise piloted at 9 clinics of 4 NGOs
- NSDP TV spot to promote SS clinics piloted airing in 12 cinema hall
- Rickshaw Tin plate for condom use protection piloted at 4 NGOs
- Rickshaw Tin plate to promote SS clinics piloted and now for all clinics
- 10,000 sets of Imam materials produced
- Used Imams to mobilize clients on World TB Day and HIV

- Re-airing of ESH in national satellite channels; local cable;
- DVD/VCD copies of ESH provided to NGO clinics to show to customers at the clinic and arrange show at satellite spots
- Prothom Alo media partnership produced 22 newspaper articles
- New messages with Md. Rafique put-up on the existing 50 billboards
- Community level BCC/M
- Technology transferred of BCC/M skills to NGOs
- 12 NGOs replicated Mystery client exercise to improve access of poor customer including 4 pilot NGOs
- Expanded work with Imams in the community
- Local level BCC monitoring tool developed and transferred to NGOs for monitoring BC



### Serving the Very Poor

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| <ul style="list-style-type: none"> <li>• Conducted a Formative Research to identify perceptions of and barriers of serving the poor from Smiling Sun clinics</li> <li>• Identify ways in which the poorest can be encouraged to seek health care more often;</li> <li>• Assist NGOs in their efforts to reduce barriers to serving the poor;</li> <li>• Strengthen NGO-community interaction</li> <li>• 35 NGOs have been trained on community response and serving the poor.</li> <li>• 4 NSDP NGOs have co-facilitated these workshops based on their experience and expertise developed throughout the project.</li> <li>• 284 clinics (static &amp; satellite) completed identification of poorest of the poor using participatory approaches in their catchment areas.</li> <li>• Developed a “pricing and exemption policy” for the NGOs to better serve the poorest of the poor</li> <li>• A Health Benefit Card scheme was designed and implemented which ensures free services and medications for the poorest of the poor.</li> <li>• 51,682 (33%) of the identified poorest of the poor families received Health Benefit Cards for free from 32 NGOs</li> <li>• 225,255 poorest of the poor card holders have utilized Health Benefit Cards</li> </ul> | <ul style="list-style-type: none"> <li>• complete identification/update of poorest of the poor using participatory approaches in their catchment areas (static &amp; satellite) of 318 clinics</li> <li>• 124,684 (80%) of the identified poorest of the poor families will have received Health Benefit Cards</li> </ul> |
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**OBJECTIVE 3: INCREASE THE CAPACITY OF NGOS TO SUSTAIN CLINIC AND COMMUNITY SERVICE PROVISION, INSITUATIONALLY AND FINANCIALLY**

**MIS:**

- Established MIS Task Force which reviewed and finalized the MIS format, streamlined the data collection process, and revised indicators.
- Implemented a unified system of reporting for all NSDP NGOs.
- Developed comprehensive MIS guideline
- Provided TA to NGOs on analyzing performance
- Established an NSDP-specific GIS to strengthen referral system and program management
- Developed a Family Registration database to identify the poor and to increase their ESP utilization.
- Provided TA to three rural clinics/NGOs in learning rapid assessment and completing ARI Baseline Survey (Assessment tools, survey and data collection and analysis and report writing)

**MIS:**

- Revised MIS format and database for FY 07
- Assisted NGOs in using MEASURE results
- Analyzed performance indicators to minimize performance gaps between goals and achievements.
- Trained focus-group NGOs to modify MIS and to streamline data collection or collect additional data if needed cost effectively.
- trained 14 MIS Officers of focus-group NGOs on Excel (advance), ACCESS(basic) and SPSS



<p><b><u>New service expansion:</u></b></p> <p>Service expansions up to June 2006:</p> <ul style="list-style-type: none"> <li>• 40 health care marts</li> <li>• 0 expanded pharmacies</li> <li>• 76 extended labs</li> <li>• 14 ultrasonogram machines</li> <li>• 0 specialist physicians</li> </ul>	<p><b><u>New service expansion:</u></b></p> <p>Service expansions up to October 2007:</p> <ul style="list-style-type: none"> <li>• 95 new health care marts</li> <li>• 23 expanded pharmacies</li> <li>• 136 extended labs</li> <li>• 33 ultra-sonogram machines</li> <li>• 54 specialist physicians</li> <li>• 209 Norplant clinics</li> <li>• 97 NSV clinics</li> <li>• 55 Tubectomy clinics</li> <li>• 28 Safe Delivery clinics</li> <li>• 61 Home Delivery clinics</li> <li>• 28 EmOC clinics</li> <li>• 317 IMCI clinics</li> <li>• 155 community IMCI clinics</li> <li>• 14 Ambulances for safe delivery/EmOC clinics</li> <li>• 40 Refrigerators for rural lab implemented clinics</li> <li>• 50 SBA kits re-supply</li> <li>• 19 rickshaws for SBA services</li> <li>• 31 auto-rickshaws for SBA services</li> <li>• 162 nebulizers</li> <li>• 14 NGOs implemented performance reimbursement scheme</li> <li>• 634 Imams/Religious Leaders worked as volunteers in all clinics</li> <li>• 12 clinics purchased OT equipment</li> </ul>
<ul style="list-style-type: none"> <li>• To date, 41 NGOs have undergone the baseline MOCAT assessment resulting in 41 individual NGO performance improvement reports</li> <li>• 38 NGOs' rapid self assessments took place in FY 2004, and 35 assessments in FY 2005.</li> <li>• NGOs used sustainability indicators derived from the MOCAT to develop the FY 2006 Grants Proposals.</li> <li>• 304 NGO leaders, 85 NSDP NGO staff and 10 other NGO leaders and staff trained in different sustainability issues.</li> <li>• Overall MOCAT scores increased 19 % between FY03 and FY04</li> <li>• 10 NGOs EC induction trainings</li> <li>• 11 new clinics built</li> <li>• CSR (4 partnerships)</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthened revenue stability through public-private partnerships (e.g. CSR) and funding diversification from other donors</li> <li>• Constructed 25 long-term physical infrastructure (clinic building)</li> <li>• Strengthened governance and administration at 12 focus NGOs</li> <li>• Build staff retention strategies at 14 focus NGOs</li> <li>• End of project MOCAT assessment of 33 NGOs by NSDP to measure improvements in NGO sustainability</li> <li>• Overall MOCAT scores between 2003 baseline and 2007 Final score shows a positive variance by pillars: Institutional – 0.04, Programmatic – 0.15 and Financial – 0.11</li> </ul>



<p><b><u>Costing:</u></b></p> <ul style="list-style-type: none"> <li>• Study on cost structure and staff utilization of NSDP NGOs have been completed revealing areas of improvement for NGOs and its clinics</li> <li>• CORE (cost and revenue) tool has been adapted for use by NSDP NGOs.</li> <li>• TOT (training of trainers) on CORE has been conducted with 3 trainers from 3 NGOs.</li> <li>• CORE training is being rolled out in 6 focus NGOs</li> </ul>	<p><b><u>Costing:</u></b></p> <ul style="list-style-type: none"> <li>• Improved NGO cost consciousness through the use of the CORE (cost and revenue) model</li> <li>• 8 more focus NGOs trained on CORE tool to analyze their cost of service provision, provider utilization rates</li> <li>• Service provision costs reduced by 5% per service to 13.58tk (from 14.3tk) for 7 focus rural and 21.67tk (from 22.8tk) for 7 focus urban NGOs</li> </ul>
<p><b><u>Rational Pricing:</u></b></p> <ul style="list-style-type: none"> <li>• A price adjustment process was devised which allows NGOs to consider several factors and to set NGO or even clinic specific service charges.</li> <li>• 35 NGOs were trained on the process of price revision.</li> <li>• 4 NSDP NGOs have co-facilitated Pricing Workshops based on their experience and expertise developed throughout the project.</li> <li>• 31 NGOs have conducted price adjustments and/or set prices in consultation with the community, improving their rate of increase in cost recovery to 5% point.</li> </ul>	<p><b><u>Rational Pricing:</u></b></p> <p>14 focus NGOs reviewed their existing pricing structure for the paying customers (with new information generated from costing study and application of CORE model)</p>
<p><b><u>Performance Reimbursement:</u></b></p> <ul style="list-style-type: none"> <li>• The scheme was piloted in 4 NGOs (CWFD, PKS_K, SWV &amp; ex-DCPUK) during Mar-Aug06. The scheme makes effective use of program income funds, removal of disincentive to serve non-paying customers.</li> <li>• Piloted scheme showed that both numbers of the poorest of the poor and cost recovery rates increased significantly compared to the control group (Fair Foundation, BMS, JTS, &amp; ex-JUSSS).</li> <li>• The scheme has been scaled up to 14 focus NGOs during July 06-Jun07.</li> <li>• The results of scale-up show that <ul style="list-style-type: none"> <li>○ Cost recovery rates for 7 focus urban NGO is 24 and 22% for 7 focus rural NGOs</li> <li>○ 14 focus NGOs will provide services for free to 3,034,153 poorest of the poor customers as of March 2007</li> </ul> </li> </ul>	<p><b><u>Performance Reimbursement:</u></b></p> <ul style="list-style-type: none"> <li>• 14 focus NGOs will have been trained and implemented the scheme.</li> <li>• Cost recovery rates to increase to 25% (from 23%) for 7 focus urban and 20% (from 18%) for 7 focus rural NGOs</li> <li>• 14 focus NGOs will provide services for free to 244,605 poorest of the poor customers (from 174,718)</li> </ul>
<p><b><u>HBCs:</u></b></p>	<p><b><u>HBCs:</u></b></p>



<ul style="list-style-type: none"> <li>• This attempts to secure at least some revenue from able-to-pay customers. 35 NGOs have been trained in implementation of HBCs for paying customers.</li> <li>• Promotional strategies and materials to sell HBCs were developed.</li> <li>• From Oct05-Apr06, 32 NGOs have sold 18,385 HBCs (4% of total printed cards) to the paying customers from its 220 clinics.</li> </ul>	<ul style="list-style-type: none"> <li>• 9% of able-to-pay customers have purchased Health Benefit Cards</li> </ul>
<p><b><u>Community Mobilization and Cost Sharing:</u></b></p> <ul style="list-style-type: none"> <li>• Funding options to serve the poor were devised for the NGOs</li> <li>• 35 NGOs have been trained.</li> <li>• Since April 04-May07 , 202,031 taka amount of fund generated from communities of 33 NGOs to serve the poorest of the poor.</li> <li>• 6 NGOs have implemented the Health Care Mart (HCM)/pharmacy expansion plan. 43 static clinics sell drugs and other commodities directly</li> <li>• 23 NGOs have been given focused TA to introduce revenue-generating services</li> </ul> <ul style="list-style-type: none"> <li>• 6 NGOs have implemented the Health Care Mart (HCM)/pharmacy expansion plan. 43 static clinics sell drugs and other commodities directly</li> <li>• 23 NGOs have been given focused TA to introduce revenue-generating services</li> </ul>	<p><b><u>Community Mobilization and Cost Sharing:</u></b></p> <ul style="list-style-type: none"> <li>• 14 focus NGOs linked with the performance based reimbursement scheme and 2 NGOs through CSR activities on fund generation and/or cost sharing.</li> <li>• Local stakeholders (including SCSG/SCAT) strengthened for generating local funds</li> </ul>



**OBJECTIVE 4: INFLUENCE POLICY, IN COORDINATION WITH OTHER DONORS, TO EXPAND THE ROLE OF NGOS AS PROVIDERS OF THE ESP**

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| <ul style="list-style-type: none"> <li>• Standardized monitoring checklists for service providers were developed in collaboration with GoB</li> <li>• NSDP clinics have copies of all GoB guidelines,</li> <li>• Established criteria for NGOs to use in this selection of ESP components</li> <li>• Harmonized curricula and service delivery protocols:</li> <li>• Facilitated clinical staff to receive GoB training/certification.</li> <li>• Internal Policy Working Group established to identify and prioritize policy issues,</li> <li>• Actively participated in DGFP and DGHS committees</li> <li>• Assistance to the Department of Family Planning (DFP) in updating the GoB family planning manual.</li> <li>• NSDP collaborated with other donors and the GoB on a number of initiatives,</li> <li>• NSDP has taken a number of steps to strengthen NSDP NGO- Local Government Bodies</li> <li>• NSDP has been engaged in wide-ranging and active collaboration with the GoB to help facilitate GO-NGO cooperation,</li> <li>• The Policy Advocacy Team of 10 NSDP NGO leaders prepared the NSDP NGO Policy Advocacy Strategy paper</li> <li>• The NGO “champions” team has prepared an advocacy orientation manual;</li> <li>• NSDP, with assistance from USAID, succeeded in convincing the GoB that the NSDP can continue to collect service charges for services which involved supplies provided free by GoB</li> <li>• NSDP succeeded in having the DGFP exempt its NGOs from undertaking door-to-door services in family planning services delivery.</li> </ul> | <ul style="list-style-type: none"> <li>• Continued clinic-based ESP delivery by NSDP’s NGOs despite the GoB returning to domiciliary services for family planning.</li> <li>• Revoked GoB ban against collection of user fees by NGO clinics for the services rendered with GoB supplies (contraceptives and vaccines).</li> <li>• Perused to amend GoB policy on NGO clinic affiliation and re-affiliation.</li> <li>• Pricing and payment mechanisms adopted performance-based reimbursement</li> <li>• Perused to design the systems for MOHFW and MOLGRD&amp;C oversight, and evaluation, including uniform quality standards for essential services delivery.</li> </ul> |
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*NGO Service Delivery Program*

