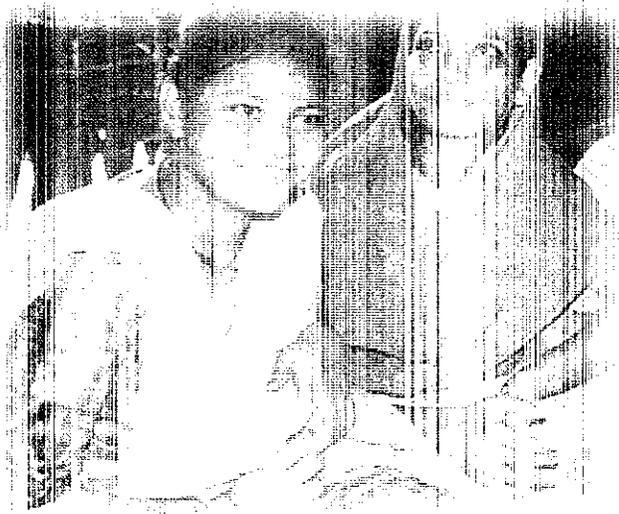


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FINAL REPORT 1997-2002



JSI Research & Training Institute, Inc.

SUMMARY OVERVIEW

With USAID Financial Support under CA No. 388-A00-96-90025-00

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List of Abbreviations and Acronyms

ACPR	Association for Community and Population Research
ADB	Asian Development Bank
ADCC	Assistant Directors of Clinical Contraception
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
BARD	Bangladesh Academy for Rural Development
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BCCP	Bangladesh Center for Communication Programs
BCG	Bacillus of Calmette and Guerin
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CA	Cooperating Agreement
CARE	Cooperative for Assistance and Relief Everywhere
CDC	Communicable Diseases Contact
CCC	Chittagong City Corporation
CDD	Control of Diarrheal Disease
CH	Child Health
CM	Clinic Manager / Community Mobilizer
COPE	Client-Oriented, Provider-Efficient Services
CPR	Contraceptive Prevalence Rate
CSI	Child Survival Intervention
CYP	Couple Year Protection
DCC	Dhaka City Corporation
DDFP	Deputy Directors of Family Planning
DGFP	Director General, Family Planning
DH	Depotholder
DPT	Diphtheria Pertussis and Typhoid
DTC	District Technical Committee
ECP	Emergency Contraceptive Pill
ELCO	Eligible Couple
EMER	Ei Megh Ei Roddra (Drama serial)
EOP	End of Project
EPI	Expanded Program on Immunizations
ESP	Essential Services Package
FHI	Family Health International
FP	Family Planning
FWV	Family Welfare Visitors
GOB	Government of Bangladesh
GP	General Practitioner
GPN	General Procurement Notice
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
ICB	Institutional Capacity Building
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
ICN	International Conference on Nutrition
IDA	International Development Association

List of Abbreviations and Acronyms

IDB	Inter-American Development Bank
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IMCI	Integrated Management of Childhood Illness
IOCH	Immunization and Other Child Health Project
IPC/C	Interpersonal Communication and Counseling
IR	Intermediate Results
IUD	Intra Uterine Device
JSI	John Snow, Incorporated
KCC	Khluna City Corporation
LCC	Limited Curative Care
LTFP	Long Term Family Planning
MCH/FP	Maternal and Child Health and Family Planning
MH	Maternal Health
MIS	Management Information System
MNT	Measles and Neonatal Tetanus
MO	Monitoring Officer/ Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOS	Month of Supply
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
NID	National Immunization Day
NIPHP	National Integrated Population and Health Program
NPAN	National Plan of Action for Nutrition
NSDP	NGO Service Delivery Program
NSV	Non-Scalpel Vasectomy
OPV	Oral Polio Vaccine
OR	Operations Research
ORP	Operations Research Program
ORS	Oral Rehydration Saline
ORT	Oral Rehydration Therapy
PAC	Post Abortion Care
PHN	Population, Health & Nutrition
PNC	Post-natal Care
PO	Program Officer
QA	Quality Assurance
QCC	Quality Compliance Coefficient
QIP	Quality Improvement Partnership
QMS	Quality, Monitoring and Supervision
QOC	Quality of Care
RCC	Rajshahi City Corporation
RDF	Revolving Drug Fund

List of Abbreviations and Acronyms

RDU	Rational Drug Use
RH	Reproductive Health
RSDP	Rural Service Delivery Program/Partnership
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
SCSG	Satellite Clinic Support Group
SDP	Safe Delivery Program
SDP	Service Delivery Point
SP	Service Promoters/Service Providers
SSP	Senior Service Promoters
SMC	Social Marketing Company
STD	Sexually Transmitted Diseases
STFP	Short Term Family Planning
STI	Sexually transmitted Infection
TA	Technical Assistance
TAF	The Asia Foundation
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
TO	Technical Officer
ToT	Training of Trainers
TT	Tetanus Toxoid Injection
UFHP	Urban Family Health Partnership
UHC	Upazila Health Complex
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Acknowledgements

In partnership with cooperating agencies and the Government of Bangladesh (GOB), United States Agency for International Development (USAID) launched the National Integrated Population and Health Program (NIPHP) in 1997, in support of the GOB's new philosophy of service delivery. This innovative approach featured a transition away from door-to-door service delivery with emphasis on family planning to integrated, clinic based, one-stop shopping for the whole family with emphasis on increased use of good quality clinical services, adequate technical training of service providers to high standards and protocols, improved organizational management and sustainability.

Urban Family Health Partnership (UFHP), the urban service delivery partner of NIPHP, implemented by JSI, provided health care services in 4 city corporations and 80 municipalities. The services were provided through a network of 146 static clinics, 70 upgraded satellite clinics and more than 350-satellite teams conducting over 8,000 sessions per month through-out the country serving on estimated population of over 14 million in the urban areas. These clinics were run by 24 NGOs with financial and *management* support from UFHP.

The success and achievements of UFHP in delivering high quality essential services package (ESP) to the urban residents have been enormous as documented in the present report. It has been possible for UFHP to reach the high water mark because of the support and cooperation received from partner organizations, agencies and individuals.

We are grateful to the Government of Bangladesh in the Ministry of Health and Family Welfare, Directorate of Health Services and Directorate of Family planning for their unstinted support and cooperation during the implementation of the project.

The technical and financial support provided by USAID enabled us to implement the project successfully. We are thankful to the past and present PHN and Contract Office teams members as well as USAID supported TA agencies for their valuable guidance and assistance.

JSI's partners in the implementation of UFHP program BCCP, PSTC and CWFD as well as other NIPHP partners, especially QIP, ICDDR,B, IOCH, RSDP, SMC and DELIVER made significant contributions towards the implementation of the project. JSI also appreciates the collaborative support it has received from FHI, HK, Population Council, PRIME, CARE, CONCERN and UPHCP. We are grateful to them all.

The success of UFHP is the success of the 24 partner NGOs, the dedication, commitment and untiring efforts of whom made it possible for us to achieve the desired result. We thank the NGO executive committee members and their project personnel for their efforts to adopt and implement the new service delivery approach. We also owe our

gratitude to the community leaders and members for their support and understanding.

JSI, Boston has always given invaluable advice and guidance in course of the implementation of the project. We are thankful to Joel Lamstein, Ken Olivola, Dr Richard Moore and many other back stopping team members at the headquarters for their continuous support, inspiration and assistance.

The UFHP team has worked with sincerity and dedication to make the program a success. We acknowledge with gratitude the valuable contribution of Peter Connell at the initial years of the project. Sharmake Osman and Amy Deschaine have assisted us from time to time. The contributions of these professionals are gratefully acknowledged. Our thanks are also due to Amy Cullum and Syed Anwarul Islam for their assistance in the compilation of the report. We sincerely thank all our partners and cooperating agencies for their role in accomplishment of this successful program.

Ahmed Al-Kabir Ph.D.
Chief of Party
Urban Family Health Partnership

EXECUTIVE SUMMARY

A. Introduction:

In partnership with NIPHP cooperating agencies and the Government of Bangladesh, the United States Agency for International Development (USAID) launched the National Integrated Population and Health Program (NIPHP) in 1997. The NIPHP's strategic objectives were improving family health and reducing fertility. In keeping with the objectives, the Urban Family Health Partnership (UFHP), the urban service delivery partnership of NIPHP, had the mission to provide high quality, high impact, family health services to the urban populations in Bangladesh, particularly in low performing, underserved areas, as well as in the low performing pockets in the high performing urban areas. The Urban Family Health Partnership was led by John Snow Research and Training Institute, Inc. (JSI) and included the Bangladesh Center for Communication Program (BCCP), Concerned Women for Family Development (CWFD) and Population Services Training Center (PSTC) as its management partners. Besides, it also comprised the network of local level sub-grantee NGOs in Bangladesh. UFHP delivered high quality essential services package (ESP) to the urban residents in 4 city corporations and 80 municipalities through a network of 146 static clinics, 70 upgraded satellite clinics and more than 350 satellite teams conducting over 8,000 sessions per month. These clinics were run by 24 NGOs with financial and management support from UFHP.

To maximize the use of the ESP, specially the high priority services, among those in need, UFHP followed the six program management objectives as given below:

- Comply 100% with quality standards
- Ensure optimum customer flow every day
- Achieve an average of 15% cost recovery
- Achieve leadership in community health
- Develop new management skills
- Adhere to UFHP policy guidelines

Thus, UFHP identified the following project objectives to achieve its overall goal:

- Establish a network of service provides and service delivery points (SDPs), including satellite, upgraded satellite, and static sites providing high impact and high quality family health information, services and products;
- Strengthen ESP service delivery activities and organizational sustainability of NGO and private sector partners, and achieve a cost-recovery of at least 20% of operating costs;
- Utilize existing policy and planning mechanisms of the NIPHP steering committee and standing and functional committees to ensure coordination and collaboration of all urban-oriented health stakeholders, including donors; and
- Achieve coverage rate for high impact family health services of at least 40-50% of the population in the selected urban areas in collaboration with other sustainable ESP service providers.

Five Intermediate Result (IRs) were defined to achieve the NIPHP strategic objective of 'improving family health and reducing fertility, and these were all relevant to achieving the UFHP goal and for implementation of the UFHP program. These IRs were:

- > **IR 1** Increased use of high-impact elements of an 'Essential Services Packages' among target populations, especially in low-performing areas.
- > **IR 2** Increased knowledge and changed behaviors related to high-priority health problem, especially in low-performing areas.
- > **IR 3** Improved quality of services at NIPHP facilities.
- > **IR 4** Improved management of NIPHP service delivery organizations
- > **IR 5** Increased sustainability of NIPHP service delivery organizations.

B. Program highlights:

1. JSI strove to achieve the intermediate results through UFHP, providing the GOB approved ESP services. All the static and a large number of upgraded satellite clinics in the UFHP network were offering clinical contraceptive services including at least two long-term family planning methods. All the clinics were providing at least four high impact services, i.e., immunization and other child health, maternal health and family planning services. UFHP also collaborated with 2 private hospitals in the delivery of ESP services. The sub-grantee NGOs collaborated with 96 garments factories to provide primary health care including TT immunization to the workers.
2. UFHP undertook special initiatives like the safe delivery program, post-abortion care program, nutrition promotion program, HIV/AIDS/STI prevention program, adolescent reproductive health program, integrated management of childhood illness (IMCI) program and the tuberculosis prevention and control program. In March 2000, six UFHP clinics began implementing the safe delivery program to complement the ANC and PAC services offered under the ESP and combat maternal mortality. This program included upgrading physical facilities, technical skills, post-training follow-up, quality of care, and creation of community awareness. UFHP with technical assistance from EngenderHealth implemented the PAC program for specifically the treatment of incomplete abortion. UFHP's nutrition program aimed to prevent malnutrition in children under two and improve the nutrition of pregnant and lactating women, adolescent girls and women of reproductive age by integrating nutrition counselling with other maternal and child health programs. The HIV/AIDS prevention special initiative was designed to respond to the threat of HIV/AIDS. The program worked with at-risk populations to increase awareness of HIV/AIDS and prevention strategies, distribute condoms and to treat RTIs/STIs. The Adolescent Reproductive Health program provided information and training to adolescents on personal hygiene, nutrition, environment and safe water, changes during and after puberty, gender relations, understanding of sexual relationships and abuse, safe sex and prevention of STI, RTI and HIV/AIDS. UFHP collaborated with GOB to achieve the

national goal of tuberculosis treatments and control program . The collaboration was for urban populations only, using the WHO treatment strategy DOTS.

3. UFHP implemented its long-term family planning program with training to broaden service offerings and ensure quality. As many as 41 clinics were upgraded to comprehensive clinics to offer a full range of choice of family planning methods including four long-term methods. A number of BCC materials were developed to support LTFP initiatives.
4. UFHP focused on its BCC/M efforts on the NGO program to create awareness and demand for services within and from the community. The main thrust of the activities was to empower the NGOs to plan and undertake BCC/M activities according to their local needs and socio-cultural norms. A new symbol, 'the smiling sun' was developed to popularize UFHP clinics so that people would associate with, visualize and recall the 'smiling sun'-marked Paribarik Shasthya Clinic in times of their need. A variety of communication materials and job aids were developed on all ESP components. In 2000, health cards were introduced in the UFHP network to generate a captive customer group for a one-year period that in turn helped to explore options for more services, including LTFP.
5. UFHP initiated a quality assurance (QA) visit planning and implementation process in collaboration with the Quality Improvement Partnership (QIP). The overall goal of the initiative was to ensure the highest level of service quality within the UFHP network to improve the quality of information, services and products as well as customer satisfaction. A two-member QA team conducted the QA visits per UFHP static clinic once a year. Four rounds of QA visits were completed between 1998 and 2002, corresponding with the phased roll out of ESP components. The quality scores, as measured by the Quality Compliance Coefficient (QCC) derived from the QA reports improved from 39 per cent to 86 per cent.
6. UFHP trained the service providers to ensure the delivery of quality counseling services at all SDPs in the network. Missed opportunities were addressed in all practitioner training programs and a simple, one-page 'missed opportunity checklist' was developed. The counselling services ensured audio-visual privacy, informed choice, and effective communication and addressed missed opportunities.
7. UFHP set up an MIS in 1997. Initial components of the MIS included ESP Family Health Card (clinic level patient record), as well as daily and monthly tally sheets, satellite clinic registers etc. Beginning in 2000, UFHP rolled out an 'encounter form', a data collection tool for providing information on the number of customers per day and the average revenue per customer. The NGOs performance analysis report was introduced to transform data already collected by the UFHP MIS into indicators of program success that would be useful to the managers for decision-making. Each report ranked clinic and NGO status and progress against each indicator, giving UFHP a way to identify and recognize those NGOs and clinics showing the most overall performance. Concurrent to the introduction of the NGO Performance

Analysis Report, UFHP launched the Institutional Development Workshops, a training series for NGO managers. This series helped develop manager's skills in interpreting data to identify problem areas, strategize solutions and develop concrete action steps for program improvement. UFHP also developed financial management manual and budget development software for use by service delivery NGOs. Five rounds of financial audits for the NGOs were commissioned to review compliance with UFHP's financial management manual and USAID guidelines. Other major activities included central procurement of Norplant from the Directorate of Family Planning and logistics management training for all UFHP Clinics management, Senior Service Promoters and Documentation Officers. For improvement of NGO planning and management capacity, UFHP introduced a Bangla strategic planning tool and held strategic planning workshop for NGO managers and Executive Committee members. The Executive Committees of the partner NGOs were invited to a retreat. The purpose of the retreat was to clarify the roles and responsibilities of the NGO leadership in program planning, monitoring and development and to build support for the UFHP program to promote long-term sustainability of ESP services.

8. UFHP established pricing guidelines for its SDPs. A discounting tool was developed which was designed to help UFHP SDPs to rationalize discounting while ensuring that the eligible customers received a discount on service fees. The revolving drug fund (RDF) was introduced to ensure that the customers have access to, buy, and take the correct medication. The RDF also had the capacity to contribute to clinic cost recovery. To help the poor customers who could not afford to purchase needed medications, UFHP clinics took collections from the community to establish Zakat funds to finance the cost of the drugs. Efforts were made to contain the total operating costs of the NGOs. The activities included regular budget and expenditure reviews, regular audits, Cost Efficiency Institutional Development workshops and joint cost reduction exercises.

C. Program achievements:

The service delivery points in the UFHP network provided services to over 15 million customers over the last 5 years. It is expected that the overall population coverage in the target area may well have exceeded the targeted 50 per cent by the end of the project

1. UFHP successfully increased the number of customers served from each of the service delivery points. The customer flow to the SDPs of UFHP NGOs increased from 143,701 in June 1998 to 602,022 in June 2002 (an increase of 419%). The service contact during the same period increased by 600 per cent from 143,701 to 864,030.
2. The overall CYP distributed by the UFHP service delivery network was 148,222 for the April - June 2002 quarter. This was more than double the expected CYP of 55,000 per quarter. The overall CPR including traditional methods stood at 60.7 per cent of currently married women. The UFHP network achieved an average of 13,264 measles contacts per month while contacts for BCG were 15,502 per month. The contacts per month for DPT 1 and Polio 1 were 31,945, those of DPT 2 and Polio 2 were 30,690; DPT 3 and Polio 3 were 29,779 and Polio 4 was 13,251. The UFHP

network managed on an average 56,323 children ARI cases monthly. The average monthly ANC visits in the UFHP service delivery network during January - June 2002 were 72,348.

3. As many as 52 per cent of the women who were identified as pregnant at the UFHP clinics, between March 2001 and March 2002, returned to seek assistance in childbirth. This bears special significance for a country where a very small proportion of the births takes place outside the home. About 95 per cent of those who delivered at the safe delivery clinics of UFHP network returned for PNC. This may be seen against only 2 per cent nation-wide post-natal coverage. A total of 126 women received post-abortion care from the six UFHP clinics providing the service. Another 45 women were referred to facilities for higher-level care and management complications of incomplete / unsafe abortion.
4. Monthly RTI/STI contacts totalled at 64,150, which was roughly 9 per cent of the total ESP contacts. Appropriate counseling and communication activities for behaviour change with regard to HIV/AIDS were provided through 1,744 organised institutions or fora of at-risk populations. So far, approximately 94,800 customers from target groups have participated in the group meeting and an average 1500 men and 1800 women have received IPC monthly on HIV/AIDS from UFHP service providers. On an average 93,882 condoms were distributed monthly among these at-risk populations.
5. UFHP successfully imparted ToT to 108 schoolteachers in Dinajpur, Thakurgaon, Hilli, Khulna and Dhaka, from 36 schools on reproductive health education to adolescents. A total of 7,500 adolescents, both male and female, are expected to benefit directly from this initiative every year as these teachers are conducting special classes in ARH issues. Between January 1999 and June 2002, adolescents comprised almost 15 per cent of the total customer volume in the clinics where the intervention was piloted.
6. The IMCI strategy was implemented in 15 location in the UFHP network on a pilot basis. In most of the pilot clinics the flow of under-5 children increased at the rate of 20 per cent.
7. The number of TB patients seeking DOTS at UFHP clinics increased from 18 in 2000 to 453 in 2002. The cure rate was 90 per cent.
8. Family planning performance increased significantly in the UFHP SDPs. A total of 161,239 customers received family planning services in the month of June 2002 compared to only 31,907 in June 1998. Of them, the member of short-term family planning acceptors was 158,202 and that of long-term family planning acceptors was 3,037.
9. Almost all married women in UFHP catchment populations (98.6 per cent) could describe three modern family planning methods. As many as 93.6 per cent of the pregnant women knew the complications threatening the life of a mother during pregnancy, delivery or post delivery. While 71 per cent knew about the appropriate

complications, 22.6 per cent mentioned other complications as well. It was also encouraging to find that almost all women (99.7 per cent) knew that they should seek medical care in case of pregnancy complication.

10. It was altogether very difficult to change customers' mind-set, particularly regarding the paradigm shift from home-based to clinic-based service delivery, especially paying for the services. With the introduction of the elements of quality and range of services from a single SDP, along with the extensive effort in informing the community about the benefits of clinic-based services made UFHP successful in drawing over 850 thousand customers in a single month (March 2002).
11. By March 2000, the technical standards and service delivery guidelines on child health, maternal health, RTI/STD, Rational Drug Use (RDU), as well as Infection Prevention Pictorial Job Aid were disseminated to all SDPs. The standard on Family Planning was also distributed to all SDPs. Technical standards on Limited Curative Care (LCC) and Common Ailments were introduced. The technical standards on Essential Obstetric Care (EOC) and Post Abortion Care were developed and distributed to relevant SDPs.
12. The UFHP Network was able to achieve cost recovery rate of over 19% at the project end, up from 3% at the beginning of the program. At EOP, all UFHP Clinics had a functioning revolving drug fund. Initial seed capital for the fund totalled Tk. 5,904,955. As of June 2002, the total value of the RDF was nearly double the amount, at Tk. 12,343,839. Over the course of the program, UFHP was able to achieve 145% its cost-sharing goals. The NGOs contribution amounted to \$ 2,037,072 of which \$ 1,043,104 was cash contribution and \$ 655,168 was imputed contribution.

INTRODUCTION

This document is a summary of the life of the Urban Family Health Partnership (UFHP), which is the urban service delivery partnership of the National Integrated Population and Health Program (NIPHP) of USAID, a collaborative program with the Government of Bangladesh. The partnership is led by John Snow Research and Training Institute, Inc. (JSI), and includes the Bangladesh Center for Communication Programs (BCCP), Concerned Women for Family Development (CWFD), and Population Services Training Center (PSTC) as its management partners. Besides, it also comprises the network of local level sub-grantee NGOs in Bangladesh. The project results of UFHP compared to the NIPHP strategic objective and cooperative agreement (CA) indicators, as well as resources used, and lessons learned are presented here.

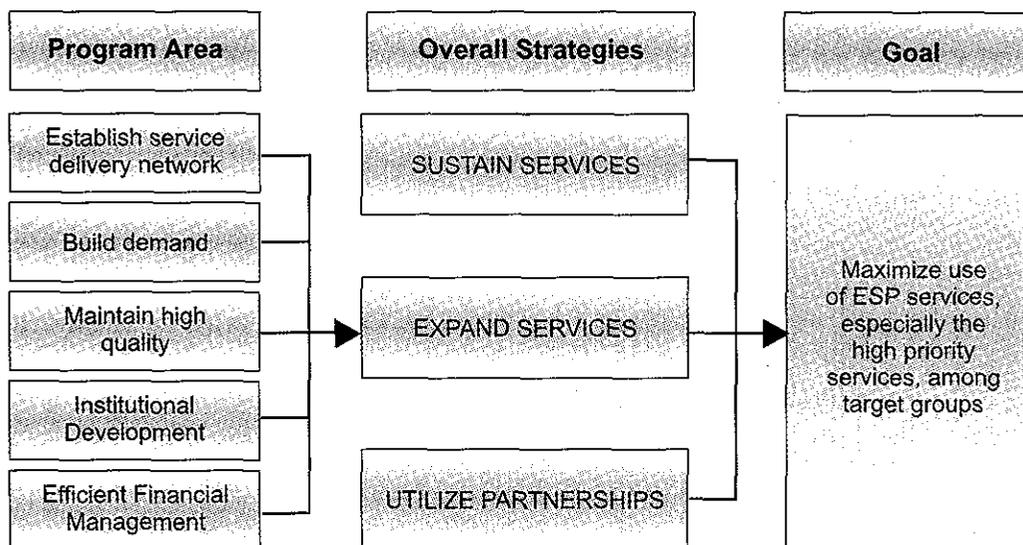
PROJECT CONTEXT

PROJECT OBJECTIVES, RESULTS AND INDICATORS

UFHP's mission was to provide high quality, high impact family health services to the urban populations in Bangladesh, particularly in low performing, under-served areas, as well as in the low performing pockets in the high performing urban areas. The project aimed to develop a sustainable service delivery network capable of providing quality, high impact family health information, services, and products. UFHP also stressed on strengthening NGO and private sector capabilities through intensive institutional development activities so that they may continue to sustain themselves with little or minimum external assistance.

Maximizing the use of the Essential Services Package (ESP), especially the high priority services, among those in need has been the driving force behind UFHP's operations since inception. During this period, the overall strategies and specific program areas that UFHP focused on in order to attain this goal are defined in Figure 1

Figure 1: UFHP Strategic Framework



To operationalize this framework, UFHP followed the six program management objectives given below:

- Comply 100% with quality standards
- Ensure optimum customer flow every day
- Achieve an average 15% cost recovery
- Achieve leadership in community health
- Develop new management skills
- Adhere to UFHP policy guidelines

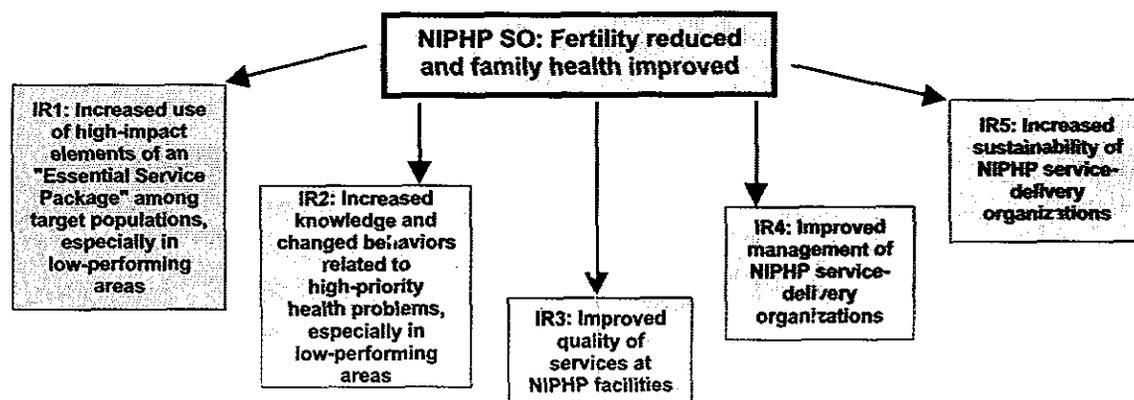
Thus, UFHP identified the following project objectives to achieve its overall goal:

- Establish a network of service providers and service delivery points (SDP), including satellite, upgraded satellite, and static sites providing high impact and high quality family health information, services and products
- Strengthen ESP service delivery activities and organizational sustainability of NGO and private sector partners, and achieve a cost-recovery rate of at least 20% of operating costs
- Utilize existing policy and planning mechanisms of the NIPHP steering committee and standing and functional committees to ensure coordination and collaboration of all urban-oriented health stakeholders, including donors
- Achieve coverage rate for high impact family health services of at least 45-50% of the population in the selected urban areas in collaboration with other sustainable ESP service providers

Five Intermediate Results (IR) were defined to achieve the NIPHP strategic objective of 'improving family health and reducing fertility', and these were all relevant to achieving the UFHP goal and for implementation of the UFHP program. These IRs were:

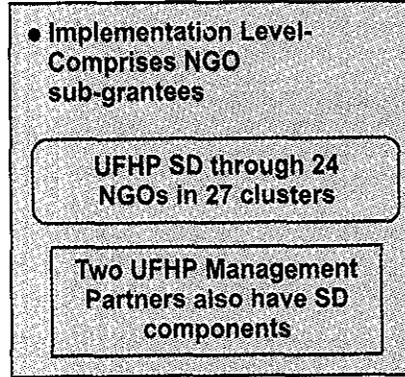
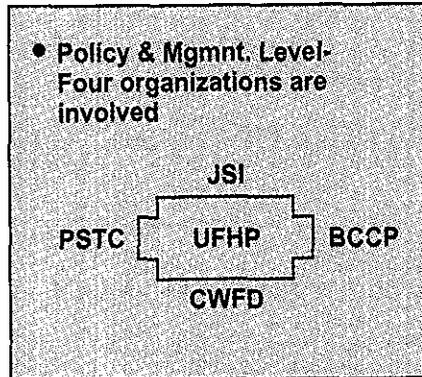
- IR 1: Increased use of high-impact elements of an "Essential Services Package" among target populations, especially in low-performing areas
- IR 2: Increased knowledge and changed behaviors related to high-priority health problems, especially in low-performing areas
- IR 3: Improved quality of services at NIPHP facilities
- IR 4: Improved management of NIPHP service-delivery organizations
- IR 5: Increased sustainability of NIPHP service-delivery organizations

Figure 2: The NIPHP Strategic Objectives framework



IMPLEMENTING PARTNERS

In partnership with several cooperating agencies and the Government of Bangladesh (GOB), USAID launched the National Integrated Population and Health Program (NIPHP) in 1997 in support of the GOB's



new philosophy of service delivery. This innovative approach featured a transition from the community-based door-to-door service delivery model to an integrated, clinic-based, one stop shopping for the whole family, with emphasis on increased use of high-quality clinical services, adequate technical training of service providers to high standards and protocols and improved organizational management and sustainability.

JSI supported the new philosophy of service delivery through Urban Family Health Partnership (UFHP), a partnership of the aforementioned four management partners. This partnership along with its 24 sub-awardees, who operated through 27 NGO clusters nationwide, made up the largest urban service delivery network in the country, second only to the government, providing the GOB approved Essential Services Package (ESP) in 4 city corporations and over 80 municipalities.



Group Counseling session

URBAN FAMILY HEALTH PARTNERSHIP PROJECT RESULTS

INTERMEDIATE RESULT 1: INCREASED USE OF HIGH-IMPACT ELEMENTS OF AN "ESSENTIAL SERVICES PACKAGE" AMONG TARGET POPULATIONS ESPECIALLY IN LOW-PERFORMING AREAS.

Intermediate Result 1 had two sub results (SR) to attain its objective of increasing the range and use of high quality ESP services. These were:

- Sub Result (SR) 1 - Priority ESP services offered in an integrated manner to meet customer expectation of 'one-stop shopping' in approximately 90 municipalities /City Corporations
- Sub Result (SR) 2 - Service delivery infrastructure for more clinical and long-acting methods expanded

Major achievements under IR 1 as per the ca performance indicators:

During the 1997-2002 period, the UFHP supported NGOs focused intensively on enhancing their geographical coverage along with increasing the range and quality of ESP services offered at their clinics and customer flow.

Number of Municipalities having ESP services that meet standards

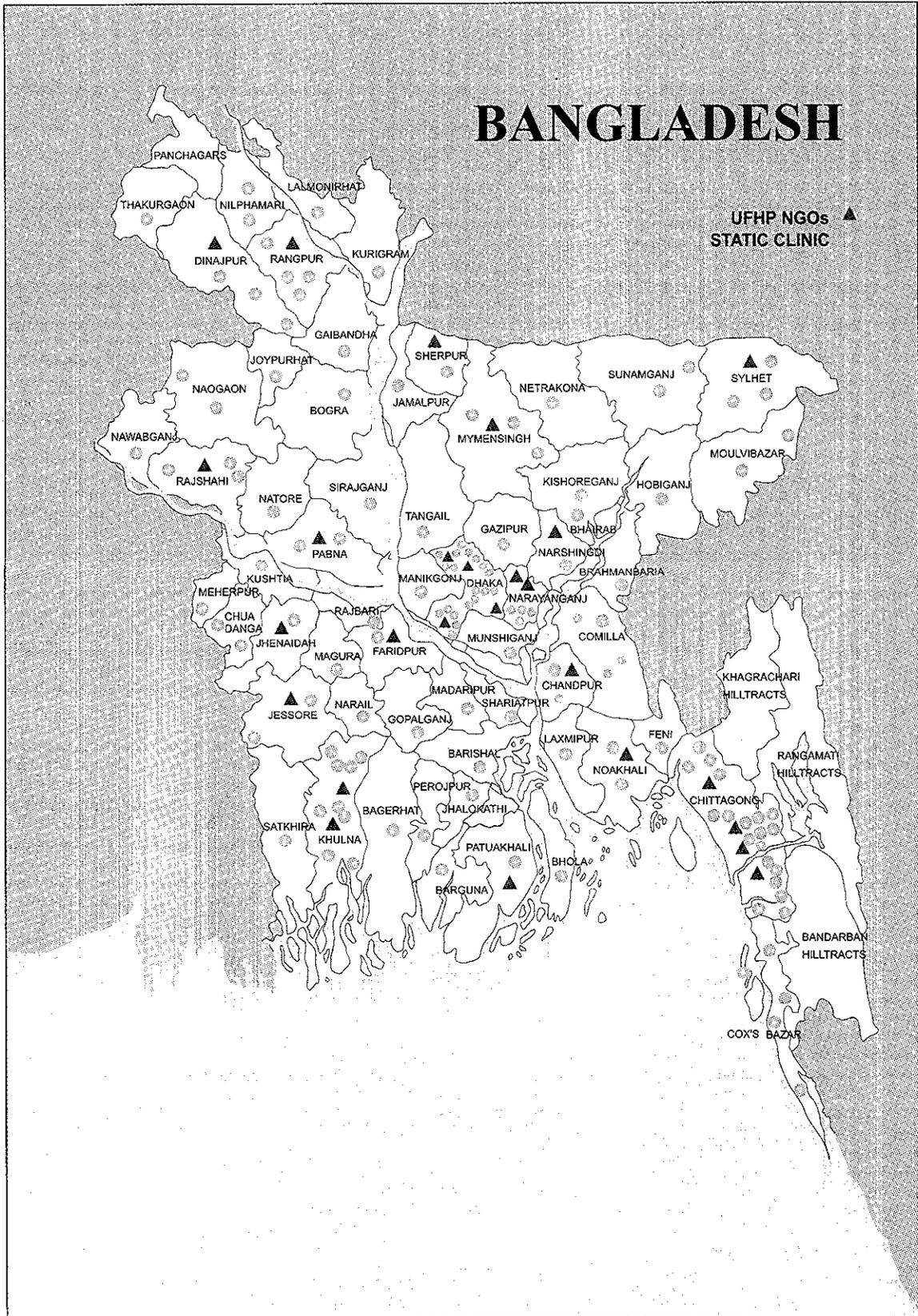
By June 2002, the number of municipalities having ESP services meeting the standards was 84, along with four City Corporations. A total of 146 static clinics, 70 upgraded satellite clinics and 350 satellite teams operating through 8,436 satellite sessions per month catered to the family health needs of urban populations all over the country.

Percent of population covered in the target area

The overall UFHP catchment population was approximately 14 million. According to the Preliminary Report of the NIPHP Evaluation Survey (Mitra et al., 2002), almost 91 per cent of the women in the UFHP areas were able to identify a service delivery point (SDP) in the area from where they could obtain ESP services. One fifth of all the women in the UFHP catchment population could identify a UFHP SDP specifically, while these SDPs catered to 11 per cent of the UFHP catchment population and almost six per cent of the non-UFHP catchment population.

It might be worthwhile to mention that, according to the performance statistics, the SDPs in the UFHP network provided services to over 15 million customers (children, women and men) over the last five years. Besides, while the survey was conducted in 2000-2001, the NIPHP media campaign gained wider coverage between 2000-2002. At the same time, UFHP conducted special BCC campaigns at various levels between 2001-2002, with the nationwide Operation Big Push between October 2001 and January 2002 as the finale. Therefore it is expected that the overall population coverage in the target area may well have exceeded the targeted 50 per cent by end of project (EOP) in June 2002.

BANGLADESH



Number of clinics and clinical networks offering clinical contraceptive services

By June 2002, all the static clinics and a large proportion of the upgraded satellite clinics in the UFHP network were offering clinical contraceptive services. Of them, 112 static clinics had been actively providing at least two Long-Term Family Planning (LTFP) methods, comprising IUD and either Norplant or NSV.

Number of NGO clinics offering at least four high impact services –

All the clinics in the UFHP network were providing at least four high impact services, i.e. immunization and other child health, maternal health and family planning services, according to their levels of available technical skills and resources. Thus the targeted 100% of the clinics were providing these services by EOP.

CYP distributed (modern methods), by method and source

The overall CYP distributed by the UFHP service delivery network was 148,222 for the April June 2002 quarter. This was more than double of the expected CYP of 55,000 per quarter, as per the CA indicator.

For the same reference period, the CYP by method was 61,349 for long-term family planning methods (IUD, Norplant, tubectomy and NSV) and 86,873 for short-term family planning methods (pill, condom, injectable).

Contraceptive Prevalence Rate (CPR) by method, age and source

Although there has not been much of a change in CPR since the UFHP Baseline Survey, the CPR of modern methods is almost 51 per cent of currently married women (Mitra et al., 2002), which is about 8 percentage points higher than the current BDHS (1999-2000). On the other hand, the overall CPR, including traditional methods, stands at 60.7 per cent of currently married women.

Contraceptive Prevalence Rate (CPR) among married adolescents

According to the NIPHP Evaluation Survey (Mitra et al., 2002), the overall CPR among currently married adolescents was about 46 per cent, while that for modern methods was 41 per cent. The oral pill was the most widely used contraceptive method among this group (27 per cent) followed by condom (6 per cent), injection (6 per cent) and traditional method (5 per cent).

Immunizations provided to children under 1 at NIPHP clinics, by antigen

According to the UFHP service statistics, the total network achieved on an average

Figure 3

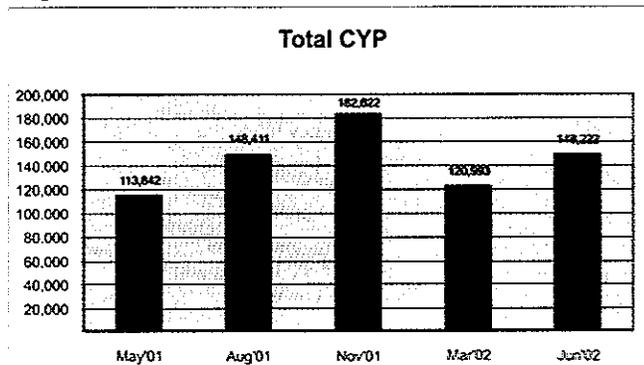
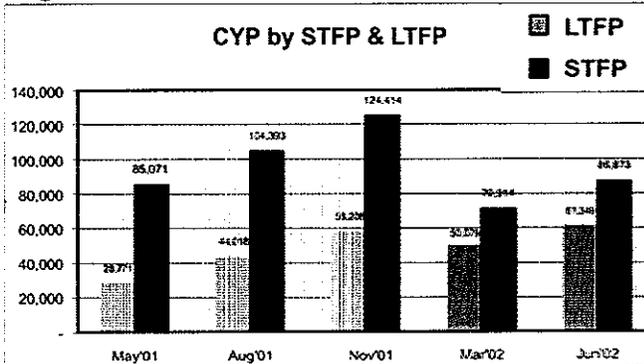


Figure 4



13,264 measles contacts per month between January and June 2002. Total immunizations provided by the other antigens in the same reference period are as follows-

- BCG - 15502 contacts per month
- DPT1 and Polio 1 - 31,945 contacts per month
- DPT2 and Polio 2 - 30,690 contacts per month
- DPT3 and Polio 3 - 29,779 contacts per month
- Polio 4 - 13,251 contacts per month

Immunization rates for children under 1, all antigens, in target populations

According to the NIPHP community survey (Mitra et al., 2002), the proportion of children receiving all the vaccines by the recommended age of 12 months in the UFHP areas was 56 per cent. This was about three percentage points higher than the corresponding rates in the BDHS (1999 - 2000).

Per cent of children receiving Vitamin A capsules semi-annually

Almost three quarters of the children in the UFHP areas (70.6 per cent) had received Vitamin A supplementation in the last six months (Mitra et al., 2002). This was slightly lower than the coverage reported in the BDHS (1999 - 2000), which was 73.3 per cent.

Number of Plan B child ORT treatments at NIPHP clinics

The average number of Plan B ORT treatments was 3,927 per month between January and June 2002, as reported in the UFHP service statistics.

Sales of ORS

As per the conditions of the CA agreement, all UFHP clinics (including all service delivery points) have been offering ORS (both SMC and GOB brands) for the last couple of years.

Number of child ARI treatments in NIPHP clinics

The UFHP network has been managing on an average 56,323 child ARI cases monthly during the reporting period January - June 2002. By severity of the illness, this was

- 45,296 cases of No Pneumonia per month
- 10,269 cases of Pneumonia per month
- 758 cases of Severe Pneumonia per month

Number of ANC visits in NIPHP clinics

The average monthly ANC visits in the UFHP service delivery network during January - June 2002 was 72,348. Among them, the ANC contacts by number of visits was -

- ANC 1 - 24,995 per month
- ANC 2 - 19,692 per month
- ANC 3+ - 27,660 per month

Number of private/franchised hospitals/clinics with which UFHP collaborated to provide ESP services

UFHP collaborated with 2 private hospitals in the delivery of ESP services. These included Aurobinda Shishu Hospital in Dinajpur and Khulna Shishu Hospital in Khulna.

Number of factories with which UFHP collaborated to provide ESP services to workers

Over the duration of the project, UFHP sub-grantee NGOs collaborated with 96 garment factories to provide primary health care including TT immunization to the workers. The factory workers included women of reproductive age (15-49 years), adolescents and males.

SUB RESULT 1: PRIORITY ESP SERVICES OFFERED IN AN INTEGRATED MANNER TO MEET CUSTOMER EXPECTATION OF 'ONE-STOP SHOPPING' IN APPROXIMATELY 90 MUNICIPALITIES /CITY CORPORATIONS

Major Activities Implemented:

In order to achieve this sub result, UFHP followed a three-pronged strategy. The first of these was that UFHP recognized the need to gradually roll out the range of services contained in the Essential Services Package, in order to ensure quality. UFHP-network NGOs introduced new services only after they were able to achieve an acceptable level of

Figure 5: ESP Roll-out plan

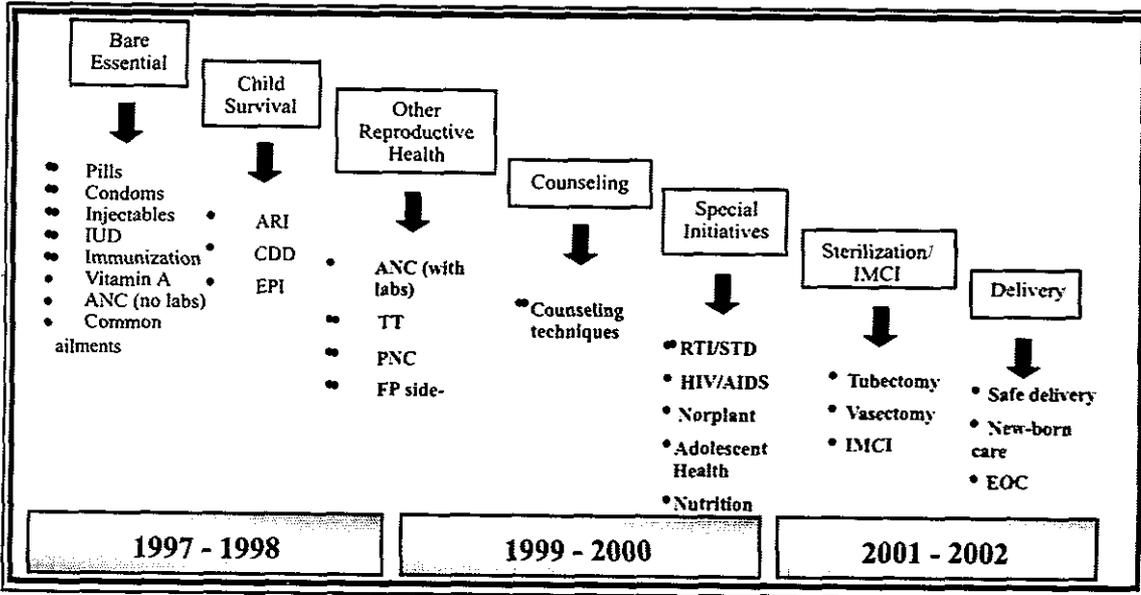
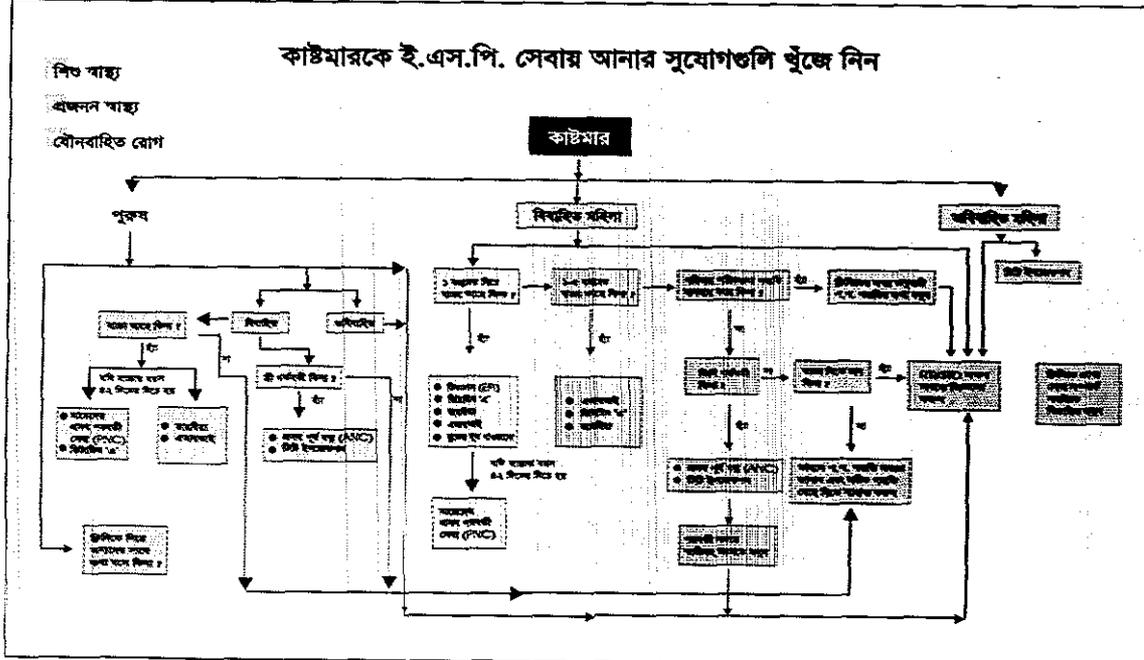


Figure 6: Addressing UFHP Missed Opportunities



quality for those services that were already being offered. By the end of 1999, all UFHP clinics were offering majority of the standard ESP services at an acceptable or better level of quality.

The second prong to UFHP's ESP roll-out approach was a focus on missed opportunities. "One-stop shopping" is not only a demand-driven concept. UFHP recognized that in order to ensure that customers received the needed high-impact ESP service components, an effort would have to be made from the supply side. UFHP providers, whether counselors, paramedics or doctors, were trained from the outset to take a holistic approach to care. The clinic-based, family-focused design of the NIPHP program required that providers think beyond family planning and learn to use each contact with a customer as a bridge to ensuring that the health needs of all family members are being met. UFHP-designed training programs and job aids helped to orient providers to this new, integrated way of doing business.

While these first two strategies aimed specifically at increasing the use of the high impact elements of the ESP among target populations, UFHP also knew that urban populations had other health needs, which were directly related to the priority ESP components. An integrated, customer oriented approach meant finding a way to meet these needs and demands. As a result, UFHP rolled out its Special Initiatives: the Safe Delivery Program, the Nutrition Promotion Program, the HIV/AIDS/STI Prevention Program, the Adolescent Reproductive Health Program, and the Tuberculosis Prevention and Control Program.

Major Achievements under Sub Result 1:

The UFHP Special Initiatives:

The Safe Delivery Program :

Despite continued efforts at reducing maternal mortality, at 320 - 400 maternal deaths per 100,000 live births (BMMS, 2001), this still remains a major public health concern in Bangladesh, and complications of pregnancy and delivery are the main causes. Over 90 per cent births take place at home and are attended by Traditional Birth Attendants (TBAs) and relatives or neighbors, who are mostly untrained (BDHS 2000-2001).

Thus, in March 2000, six UFHP clinics began implementing the Safe Delivery Program to complement the ANC and PNC services offered under the ESP and combat maternal mortality. The Safe Delivery Program was designed to ensure that women have access to a safe place for normal delivery, attended by trained staff who can recognize, stabilize and refer (with necessary drugs and transport) complications.

Major program activities

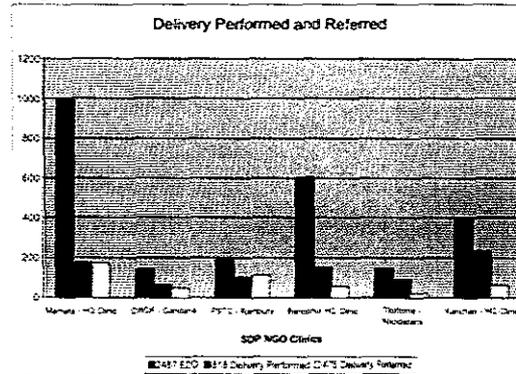
- Physical facility - Appropriately equipped and staffed physical facility offering safe delivery services at low cost, with the necessary linkages established and made functional for ensuring rapid and smooth referral.

- Technical skills - Teams of highly skilled and trained service providers, including doctors, nurses and clinical aides, were developed to address pregnancy, normal delivery and post-delivery care as well as identification, stabilization, and referral of complications.
- Post-training follow up - This was an intensive activity that served not only to ensure provider competence for service delivery but also acted as a confidence building exercise for service providers in their respective workstations. The activity included,
 - Base line information on each trainee including training pretest/post test scores
 - Knowledge test
 - Practical exercise, including external/internal bimanual compression, newborn resuscitation, partograph case study, complication audit
 - Separate interview questionnaires for providers, supervisors/project directors
 - Overall conclusion and recommendations/suggestions for improvement
- Quality of care - The highest level of quality with regard to infection prevention practice and provider technical skills was ensured, along with appropriate monitoring mechanisms. The Quality Assurance (QA) visit tool used were,
 - Knowledge test
 - Observation checklist for practical demonstration and case study on admission in labor, infection prevention, monitoring of labor using partograph, management of the different stages of labor, care of mother and baby during first six hours, three days and 2-6 weeks after birth, manual removal of placenta, etc.
 - Separate interview questionnaires for providers and supervisors/project directors
- Create awareness in the community (at both mass media and local level) regarding the need for safe and preferably institutional delivery, along with preparation for delivery and recognition of the symptoms of impending complications.
- Special issues addressed - Strong partnership with GOB and other NGO and private sector, use of partograph and doppler, infection prevention practice, delivery in different positions, homely environment, allowing attendant to be present during labor, provider accompanying referred cases to the referral centers and ensuring three PNC visits.

Best achievements

- According to Figure 7 after launching of the safe delivery clinics, 52 per cent of the women who were identified as pregnant at these clinics, between March 2001 and March 2002 returned to seek assistance in childbirth. This bears special significance for a country where a very small proportion of the births takes place outside the home. Though more scientific evidence is

Figure 7



required, it may not be incorrect to assume that access to low cost high quality pregnancy and safe delivery care, coupled with a functional referral network and adequate awareness-raising activities might go a long way towards improving maternal health. This would in turn help to reduce maternal mortality.

- The safe delivery clinics in the UFHP network have successfully implemented the use of the partograph and Doppler. Thus both monitoring of labor and the fetus are intensive and the chances of prolonged/obstructed labor or fetal distress have been minimized.
- Nationwide post-natal coverage (PNC visit) is only 2 per cent (BMMS 2001). Through this pilot project, the safe delivery clinics in the UFHP network have reported that about 95 per cent of those who delivered at these clinics returned for PNC.
- The current average cost recovery rate of the SDP is 20 per cent (excluding start up cost). Though the direct impact of the safe delivery program as of today could not be measured appropriately, with the increased volume of deliveries, it is expected that the program may contribute significantly to the overall revenues in the future.

Points to note

- The average knowledge and practice scores of the service providers was 96.5 per cent in the post-training evaluation and skill-based QA visits. Therefore continuous monitoring and mentoring are integral to ensuring the quality of service delivery.
- All service providers should follow appropriate counseling techniques.
- Nurses and paramedics involved in the program require on-going coaching from the doctors to boost their levels of confidence and competence. Regular meetings on various safe delivery related issues also need to be held.
- Project Director's involvement in program strengthening plans and activities with all providers is integral to ensure program ownership by all staff

Post-Abortion Care (PAC) Program:

Unsafe abortion performed by untrained practitioners under unhygienic conditions account for 50000 - 100000 preventable deaths of women each year (WHO, 1993). It is evident that these women are in a desperate situation where they would do anything possible and take any risks necessary to delay or avoid having children. Many of them suffer severe life-threatening complications, including infections (ranging from localized pelvic infections to generalized sepsis), injuries, hemorrhage, severe vaginal bleeding, shock and even death.

UFHP, with technical assistance from EngenderHealth, implemented the PAC program specifically for the treatment of incomplete abortion. This includes training in infection prevention, Manual Vacuum Aspiration (MVA) skills, counseling, post abortion family planning and referral for other reproductive health services. The initiative was undertaken in clinics that were already implementing the safe delivery program.

Major program activities

- Set up a referral system, with limited input to referral centers for offering better

standard of care (Staff training in infection prevention, MVA skills and counseling)

- Communication messages to urban areas to increase awareness of PAC services and the dangers of unsafe abortion.
- Six days' providers' training on use of MVA, post abortion counseling and FP.

Best achievements

A total of 126 women have received post-abortion care from the six UFHP clinics providing the service. Another 45 women have been referred to facilities for higher level care and management of complications of incomplete/unsafe abortion.

Nutrition Promotion Program:

UFHP's nutrition program aimed to prevent malnutrition in children under two and improve the nutrition of pregnant and lactating women, adolescent girls and women of reproductive age by integrating nutrition counseling with other maternal and child health programs. In Bangladesh, over 60 per cent of the children are malnourished and over 70 per cent women, anemic; these rates are among the highest in the world. Malnutrition in children and anemia in women are important underlying causes of child and maternal mortality.



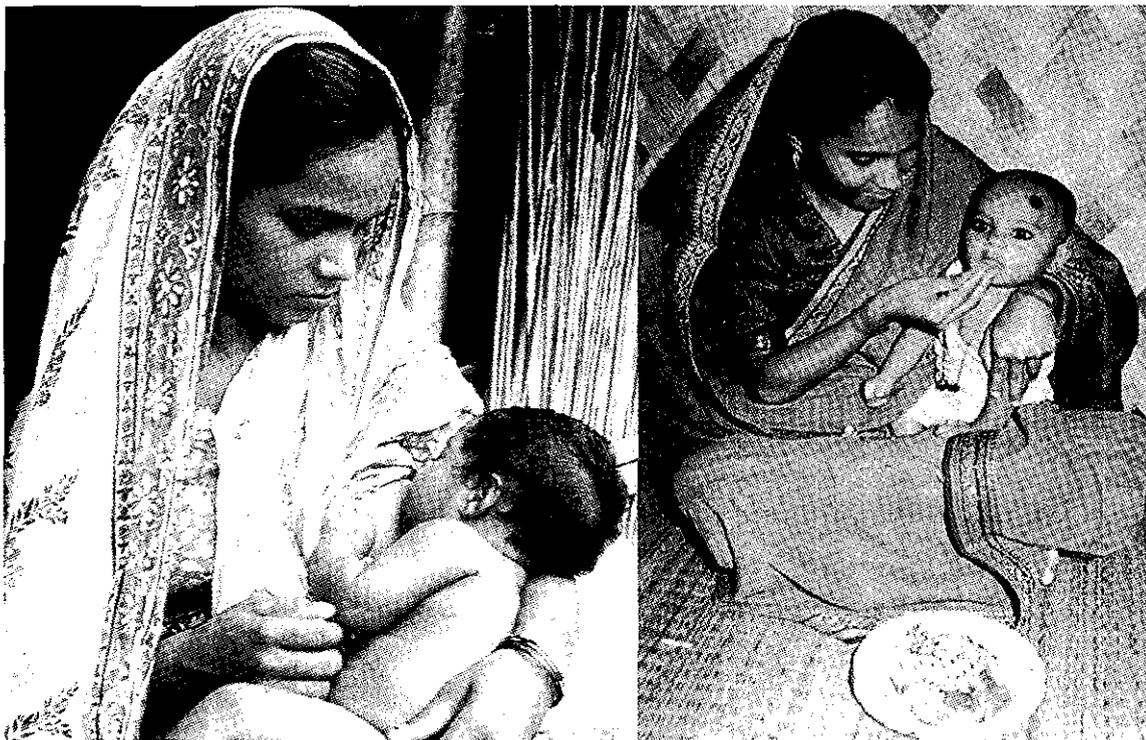
Counseling session on nutrition

UFHP offered its practitioners additional training on nutrition counseling to combat malnutrition and help them to provide more holistic maternal and child health services. Training programs emphasized exclusive breast-feeding for 6 months; appropriate complementary feeding in addition to breast-feeding from 6 months to 24 months; recording weights for growth promotion; adequate vitamin A intake for women, infants and children; iron and folate tablets for pregnant women; and annual deworming for children.

Major program activities

- Training - UFHP offered training on nutrition and counseling for different levels of staff within its NGO network. These were as follow:
 - ToT on 'Integrated Counseling and Nutrition' for NGO managers and the Senior Service Promoters (SSP). The latter were the main BCC/M staff at the clinic level. These trainers were expected to train the staff of each clinic in their respective clusters on providing information and counseling on nutrition. All 27 clusters were covered in the training.
 - Training on 'Integrated Counseling and Nutrition' for Counselors at the clinic level.

- On-the-Job Training on "Integrated counseling and Nutrition" for clinic-based service providers, including doctors, paramedics and counselors.
- Follow up of the ToT was conducted at five different sites by one of the UFHP partners, Population Services and Training Center (PSTC). The objective of this follow-up was to provide on-site TA in implementation of the skills developed by NGO managers and SSPs during the ToT.
- Research – UFHP collaborated with CDDR,B in an operations research focusing on severely malnourished children at three clinics in Dhaka. All staff of the clinics (doctors, paramedics, SSPs and SPs) were trained on "Management of severely malnourished children". The intervention is still underway and anecdotal evidence shows that the community, particularly mothers are very receptive to it.



Exclusive breast feeding for six months & additional food after six months of the baby.

The HIV/AIDS/STI Prevention Program:

According to UNAIDS/WHO estimates, there are as many as 21,000 HIV positive people in Bangladesh. Despite the low reported prevalence of the disease risk factors that could lead to a full-blown epidemic are abundant. These include large numbers of sex workers, high prevalence of STI, a large flow of migrant workers, increasing numbers of intravenous drug users, low HIV/AIDS awareness, high prevalence in neighboring countries and use of un-screened blood for transfusions.

UFHP's HIV/AIDS Prevention Special Initiative was designed to respond to the threat of HIV/AIDS. The program worked with at-risk populations such as sex workers, long distance drivers, transport workers, garment workers, adolescents and students to increase awareness of HIV/AIDS and prevention strategies, distribute condoms, and to treat RTI/STIs. The program was implemented through 43 clinics operated by the UFHP service delivery NGOs in different pockets of three City Corporations and 21 Municipalities that had higher proportions of at risk population. Thus the target beneficiaries were:

- Commercial sex workers (female), both brothel based and floating
- Long distance drivers and helpers
- Local transport workers
- Labors (dock/port, small factory, brick field workers)
- Youth (university/college students)
- Intravenous Drug Users (IDU)
- Garment factory workers
- Adolescents

Major program activities

Various initiatives were taken in a phased manner to strengthen the program. These include the following:

- Awareness raising and BCC
 - Advocacy meetings with formal and informal community leaders
 - Group meetings and Inter Personal Counseling (IPC) with target audience
 - Distribution of STI/HIV/AIDS BCC materials, including flip charts, leaflets, take-away brochures, STI posters and instructional strips on condom use and audiocassettes
 - Film on STI/HIV/AIDS - UFHP provided financial and technical support for the full-length feature film " Meghla Akash" focusing on STI/HIV/AIDS
 - Street Drama (for the sex workers and by the sex workers)



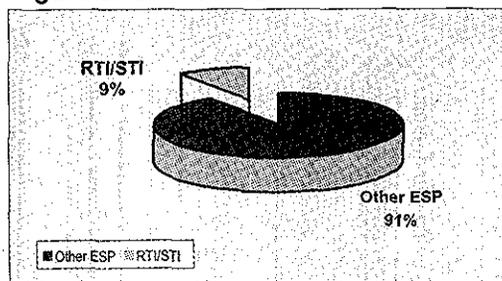
Awareness raising activities among truckers

- Condom promotion and distribution - Directly by UFHP service providers and in collaboration with partners (Bandhu, Srishti & Bangladesh AIDS Prevention Society)
- Training - Various levels of service providers and BCC staff were trained on HIV/AIDS communication and counseling, how to conduct group meetings, as well as special RTI/STI training for service providers working with at-risk populations
- STI screening and management - Through trained paramedics and doctors at 61 spots, directly by UFHP service providers and in collaboration with partners (CARE, Bangladesh, HASAB and SMC). This included syphilis screening services (RPR and Rapid Syphilis test) both for pregnant women and at-risk populations

Best achievements

- Strong BCC activities - Appropriate counseling and communication activities for behavior change with regard to HIV/AIDS were provided through 1744 organized institutions or fora of at-risk populations, like bus and truck drivers and rickshaw pullers associations, garment and other factories, brothels, schools, colleges and universities. About 700,000 at-risk individuals were affiliated with these entities and over 5,000 group meetings in this regard were conducted monthly. So far, approximately 94,800 customers from target groups have participated in these meetings. On average 1,500 men and 1,800 women have received IPC monthly on STI/HIV/AIDS from UFHP service providers.

Figure 8: Service mix



- High customer numbers - According to the UFHP service statistics, monthly RTI/STI contacts totaled at 64,150, which was roughly nine per cent of the total ESP contacts.



Customer at a brothel-based satellite

- Making services available - UFHP made high quality STI services accessible and available for the particularly vulnerable at-risk populations through their own involvement and sharing of these initiatives. In most cases, these marginalized communities provided the physical facilities and UFHP service providers provided their technical expertise to address the problem. Through this joint effort, on an average 93,882 condoms were distributed monthly among these at-risk populations.
- Ensuring technical skills - This was ensured at both central and service delivery levels. Existing STI curriculum was reviewed jointly by the UFHP partners and revised in

accordance with International Diploma courses before it was used to train service providers.

- Networking and linkage - Strong linkage was established with the GOB as well as other stakeholders, like ICDDR,B, FHI, CARE, Bangladesh and other international and national organizations.

The Adolescent Reproductive Health (ARH) Program:

This special initiative was designed to improve overall health status and encourage health-seeking behavior at an early age, using community-based education approaches and clinic-based service delivery, including counseling. The program provided information and training to adolescents on personal hygiene, nutrition, environment and safe water, changes during and after puberty, gender relations, understanding sexual relationships and abuse, safe sex and preventing STI, RTI and HIV/AIDS. It was aimed at helping to prevent young people from drifting into or continuing with unhealthy practices that could adversely affect their health. Young women were also encouraged to receive tetanus toxoid immunizations and adequate antenatal and postnatal care through this initiative.

The initiative began as a pilot program on a relatively small scale in order to identify and address any inherent weaknesses in design and implementation prior to nationwide implementation. Therefore 16 static clinics were carefully selected from all over the country for the piloting in 1999.

Major program activities

- Two-pronged program approach
 - The "education approach" comprised the school and community components, aimed at producing clinic referrals; the former provided a "captive audience" in a formal setting. A spin-off of the latter was the selection and training of "Peer Educators" to continue information and education activities in the community and thus ensure maximum coverage among adolescent populations



ARH program in progress

The "service and counseling approach" concentrated on service delivery (including FP, ANC/PNC, TT immunization, RTI/STD, CDD) and counseling for referrals from group meetings and walk-in customers

- Staff training and orientation - Prior to implementation, key central UFHP level and all clinic staff were given relevant training and orientation on the program and efforts were made to ensure that the clinics were as adolescent-friendly as possible.

- Involvement of adults - Prior to starting the program, adults, i.e. parents/guardians and teachers were oriented on the program for educating and informing adolescents about reproductive health, aimed at sensitizing this group, which is considered one of the major barriers to reaching young people.

- Research initiatives - While the ARH program was being piloted, UFHP also developed research partnerships with Population Council, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and Concerned Women for Family Development (CWFD) to identify appropriate models for implementing ARH information and services program in Bangladesh. These are:



Adolescents taking part in a discussion

- The UFHP and Population Council collaboration as part of the 'Global study on adolescent health interventions', in a multi-country operations research to test the combined effect of interventions for improving adolescents' reproductive health (RH) knowledge and practices. The three interventions were:

- (i) Environment intervention to ensure supportive environment for improving adolescents' RH status
- (ii) School intervention to educate school-going adolescents on RH issues and help them develop appropriate RH behavior and practice
- (iii) Clinic intervention to provide information and quality services tailored to an adolescent favorable situation

These interventions were tested in different combinations in the Dinajpur and Pabna districts. The end-line survey has been conducted and data are being prepared for analysis and reporting.

- UFHP, ICDDR,B and CWFD collaborated in an operations research to test other models for improving ARH. These are briefly described as follows,
 - (i) To test and compare the relative benefit of an integrated adolescent development program to an RH program aiming to improve adolescents' knowledge on RH issues and utilization of clinics for services
 - (ii) Design and test a peer education strategy, with relevant supporting tools, and increase the utilization of clinic-based RH services

Best achievements

- As per a mid-term program review conducted in February 2000, the UFHP clinics were found to serve as a good platform for addressing the RH needs of adolescents. However, the school component was a more effective means of disseminating this RH information to adolescents, as this comprises a captive group.

The community component was harder to implement, as out-of-school adolescents are, in general a hard-to-reach group and dropouts are high. Besides, lack of privacy during the conduction of these sessions (in a homely non-formal setting), was found to

be a big barrier. Anecdotal evidence shows that the major reasons for high dropouts in the community groups include -

- Inadequate sensitization of community and parents prior to implementation
- Many adolescents are employed, so dropouts are high
- Some adolescents (female) get married and move elsewhere

■ Regarding the intervention with Population Council at selected sites -

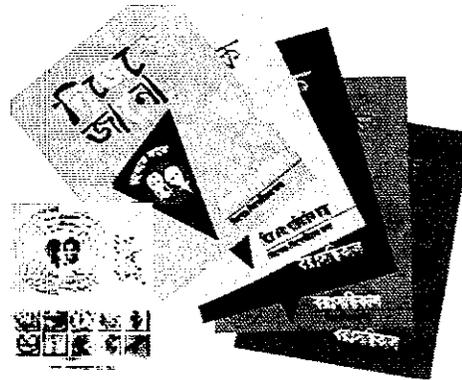
- Using teachers as facilitators for the school-based intervention was well accepted, with most teachers in agreement that there was need for disseminating RH information to adolescents and the teachers also owned the program



Teacher conducting ARH session

- Peer educators played the role of catalysts in ensuring appropriate dissemination of information, and to a wider audience
- An adolescent-friendly environment and good interpersonal communication are integral to the successful implementation of ARH programs

■ UFHP takes pride in having set the stage for imparting reproductive health education to adolescents at the school level with little or no extra cost involved, thus being the first major NGO effort in this context. To this effect, UFHP has successfully imparted ToT to 108 school teachers in Dinajpur, Thakurgaon, Hilli, Khulna and Dhaka, from 36 schools. A total of over 7500 adolescents, both male and female, are expected to benefit directly from this initiative each year, as these teachers are conducting special classes on ARH issues during the school hours. The teachers' training curriculum, *Alor Pathey Amra*, a joint collaborative effort between UFHP and PC was used for the purpose. This may lead to incorporation of reproductive health education at the secondary school level nationwide in future. It would also pave the way for generating reproductive health awareness at an early stage in life, that would in turn foster better reproductive health status of the future population.



Alor Pathey Amra & FAQs Compendium

■ UFHP participated actively in the conceptualization, design and development of the ARH Frequently Asked Questions (FAQs) Compendium (an NIPHP initiative), a series of booklets addressing adolescents' RH issues and concerns, as expressed by them. The first three components of the booklets have been distributed throughout the UFHP network. These tools were also distributed among relevant non-UFHP sites where adolescent could access them easily.

- UFHP ARH program Though designed as a pilot program, which thus did not have any specific impact/evaluation indicators built into it, according to the UFHP service statistics, there appear to be some program changes. Between January 1999 and June 2002, adolescents comprised almost 15 per cent of the total customer volume in the clinics where the intervention was piloted. That there has been a definite increase in the total number of adolescents coming to the clinics where the ARH intervention was implemented can be seen from the Fig.9. All the clinics experienced a marked increase in their adolescent customer flow between January 1999 and June 2002.

Figure 9

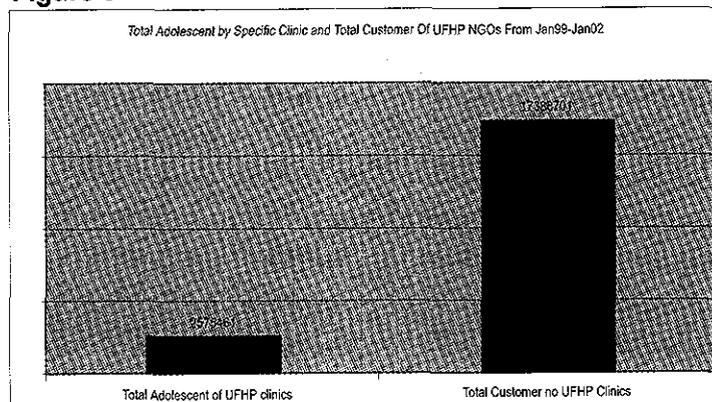
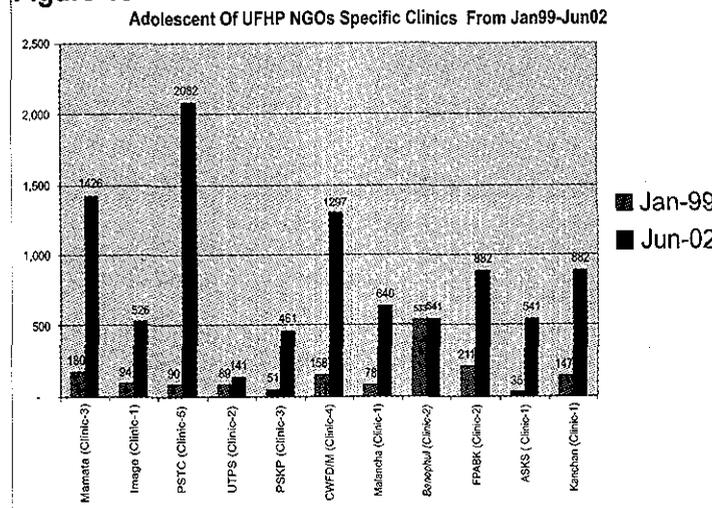


Figure 10



Points to note

However, there still exist issues that need to be addressed in order to ensure greater participation of adolescents in achieving the overall objective of improving family health and reducing fertility. These include -

- Determine relevant indicators to track and monitor program implementation and output
- Develop relevant MIS support for tracking performance
- Advocacy and generation of greater stakeholder support, especially GOB, along with inter-agency coordination (different ministries as well as agencies, e.g. Education, Social Welfare, etc.)
- Stronger sensitization efforts for the gatekeepers of adolescents, i.e. adults

The Integrated Management of Childhood Illness (IMCI) Program:

UFHP collaborated with the Government of Bangladesh (GOB) in introduction of IMCI into the national service delivery system on a pilot basis. This is an integrating strategy that combines existing protocols into a single master protocol to make it highly effective, both in terms of meeting patient needs and reducing costs and waste. As integration of

various health and population-related initiatives has been its functional objective, IMCI was a natural enhancement to UFHP's existing child health activities.

The GOB-UFHP collaboration to pioneer implementation of the global child health initiative, IMCI in Bangladesh led to UFHP being a member of the IMCI core committee chaired by the Joint Secretary, Ministry of Health and Family Welfare (MOHFW). Thus the IMCI strategy was implemented in 15 locations in the UFHP network on a pilot basis.

Major program activities

- IMCI training - Coordinated by the MOHFW and WHO, a core group of IMCI facilitators was developed, which included two UFHP professionals as well. The core group then worked on development of IMCI training mechanisms and tools for field-level service providers and conducted training.
- Ensuring logistics and referral mechanisms - This included incorporating IMCI drugs into the UFHP Standard Drug List for procurement, followed by orienting senior pediatricians and program managers on IMCI to establish and strengthen the referral and linkage mechanism.
- Monitoring the implementation - The implementation of the pilot program required intensive follow-up and on-site skills observation to identify gaps in program implementation methodology and develop appropriate solutions in the National Debriefing Meetings organized by the MOHFW.

Best achievements

- On follow-up, it was found that UFHP service providers had implemented the strategy according to guideline. The clinics were well organized and equipped and staff had the relevant skills.
- In most of the pilot clinics the flow of under-5 children was increasing after implementation of IMCI at the rate of 20 per cent.
- Trained health workers recognized that IMCI responded to their needs. The case management protocol improved the technical quality of service for children. Parents were also satisfied with the care their children received.

The Tuberculosis Prevention and Control Program:

UFHP and the Government of Bangladesh (GOB) collaborated to achieve the national goal of the Tuberculosis (TB) treatment and control program, which envisages curing 85 per cent of the detected new smear positive TB cases and detecting 70 per cent of existing cases of sputum smear positive TB. This collaboration was for urban populations only, using the World Health Organization's (WHO) treatment strategy, DOTS (directly observed treatment short-course). This initiative was formally begun in May 2000 with an MOU signed between Director General of Health Services (DGHS), Ministry of Health and Family Welfare (MOHFW) and UFHP.

While GOB has a very strong network in rural Bangladesh in this connection, there exists a lack of a similar elaborate government network in the urban areas. Thus UFHP was the

linkage between the GOB and UFHP sub-grantee NGO network. The role of UFHP was to play a supportive and facilitative role with the GOB. The network complemented GOB's efforts in urban areas specifically to achieve the overall national goal, with specific activities within the catchment areas.

Major program activities

- Phased-in implementation - Initially, the program was piloted in Chittagong City Corporation areas only and later phased on to Khulna and Rajshahi City Corporations over time. This included the following activities -
 - Training of relevant NGO staff at the UFHP service delivery points (SDP).
 - Supply of national manuals/guidelines/other publications, essential equipment (e.g. microscopes), drugs, laboratory reagents and other consumables, recording and reporting forms as well as communication and awareness raising materials to the SDPs.
 - Establishing linkage with and ensuring access to GOB referral facilities for consultation and hospital-based care.
 - Supporting quality control of laboratory services through cross checking slides
 - Overall supervision, monitoring, evaluation and feedback
- Technical assistance (TA) to UFHP NGOs for -
 - Implementing the program according to national guidelines for control of TB in urban areas of the country
 - Assuming financial responsibility for staff training and operating running costs
 - Working in co-ordination with relevant authorities, ensuring smooth and effective communication between GOB and NGOs
 - Appropriate use of drugs, laboratory reagents and other supplies, and ensuring appropriate record keeping of stocks and commodities
 - Monitoring and supervising program implementation and reporting quarterly to DGHS at each designated level
 - Supporting and participating in observation of national/international events and execution of special initiatives undertaken from time to time

Best achievements

- A total of 17 clinics under seven UFHP NGOs in three City Corporations were collaborating with GOB and WHO to intensify the efforts of the TB control and treatment initiative in urban areas of Bangladesh. These clinics provided services for TB patients (treatment using DOTS and drugs) as per national



Discussion session on world TB Day

guidelines. Among them, four clinics had functional laboratory facilities for sputum examination.

- Strengthened linkage - Through this collaboration, the NGOs within the UFHP network gained entry into the GOB TB initiative and also helped to strengthen GO-NGO relations and partnership.
- Increase in performance and higher rates of conversion and cure - Appropriate program design and implementation along with intensive monitoring and supervision of service delivery at all levels helped to ensure high quality of services. Thus the number of patients seeking DOTS at UFHP clinics gradually increased over time, as shown in Fig. 11. Also, the cure rate was 90 per cent in UFHP network.

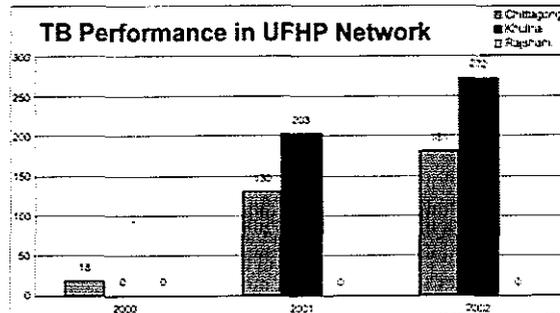


Figure 11: Number of TB patients in UFHP Clinics

- Compliance to treatment - As per the National Guideline, the smear positive TB cases need to be converted into smear negative within 2-3 months of treatment, whether registered 4-6 or 9-12 months back. Conversion proves compliance to treatment and it is expected to be 85 per cent or more. Table 1 shows that conversion in the UFHP sites was much higher than the national standard, indicating better compliance to treatment.

Table 1: Treatment compliance of PTB+ cases

New (+) patients registered 4-6 months ago converted to smear (-) at 2-3 months			New (+) patients registered 9-12 months ago converted to smear (-) at 2-3 months			New (+) patients registered 9-12 months ago completed treatment:		
# PTB (+)	Converted to (-)	Conversion (%)	# PTB (+)	Converted to (-)	Conversion (%)	# PTB (+)	Completed treatment	Conversion (%)
47	45	96	35	33	94	34	29	85

Points to note

- Program internal review - This revealed some limitations or problems that need to be addressed to ensure better performance and smooth replication in future. These include -
 - TB did not receive adequate program importance, as did other high priority ESP components. Thus greater emphasis needs to be given to raise provider awareness at the grassroots level to the fact that TB also cuts across the high priority ESP components that need to be addressed to achieve the program goal.
 - Inadequate counseling and communication skills of service providers at the clinic level for diagnosis and treatment of TB.

- Most of the clinics did not operate as per guideline regarding DOTS, adapting 'Family DOTS' by assigning family members and distributed drugs on specific days only; strict adherence to guidelines is essential
 - Record keeping and reporting skills varied between clinics and between providers
- Follow-up of cases - The system of patient follow-up over time needs to be made more systematic and functional. Since inception there have been 20 defaulters for the DOTS, eight patients suffered a relapse and four died. This could also be partly attributable to the lack of adequate awareness or failure to counsel appropriately, as many of the patients belonged to migrating populations.
 - Positive TB case detection rate - This was a major program weakness, as it amounted to only 10 per cent, whereas the National TB case detection rate is currently 30 per cent. The Government hopes to increase the rate to 70 per cent through its intensive and integrated approach using both GO and NGO partners. Table.2 gives an overview of the laboratory performance in the relevant sites with regard to TB case detection.

Table 2: Laboratory performance

Laboratory Location	# of PTB (+) cases identified		# of PTB (+) cases identified		Total lab tests done
	Diagnosis	Follow-up	Diagnosis	Follow-up	
Mamata/Clinic # 1	09	03	80	116	208
Banophul/Clinic # 1	01	00	28	25	54
FPAB/K/Clinic # 1	03	00	23	47	73

UFHP's special initiatives brought much needed services to urban Bangladeshis. As a result of these special initiatives, USAID became involved in programmatic areas that have now moved to the forefront of the Bangladesh public health agenda.

SUB RESULT 2: SERVICE DELIVERY INFRASTRUCTURE FOR MORE CLINICAL AND LONG ACTING METHODS EXPANDED

From the beginning UFHP has been committed to developing a high quality and high impact service delivery network with a highly skilled work force that can cater to the family planning needs of the population. It was underscored from very early on that there was a dire need for safe family planning services and for greater access to a broader range of family planning methods, and UFHP planned to fulfill that need. With this view in mind, UFHP implemented its long-term family planning (LTFP) program in a phased in manner.

Major activities implemented:

Training to broaden service offerings and ensure quality: From the outset, UFHP worked to ensure that service providers, particularly paramedics received training on IUD insertion and removal through the Government's Family Planning Clinical Contraception Course (FPCC). In November 1998, UFHP supplemented this initiative, again linking with the GOB's training system to provide Norplant training to clinicians and counselors. A total of 217 service providers were trained to provide Norplant service.

With a view to increasing the family planning options available to urban populations, UFHP organized non-scalpel vasectomy (NSV) training for clinicians and paramedics beginning in February 1999. By EOP, a total 129 service providers were trained. Between September 2000 and May 2002, 87 service providers were trained in the provision of tubectomy services. For those physicians that had already received On-The-Job (OJT) Training and skills development at the local level, UFHP arranged a special condensed course on voluntary surgical contraception (VSC) to have their skills tested and certified.

Special support

From February 2000, UFHP began its need-based OJT initiative for clinics providing LTFP services. A team of trainers provided on-site, hands-on technical support in the provision of LTFP services whenever the need arose. This initiative helped to build confidence and provided moral support among new trainees with corresponding increases in overall LTFP performance. In the period from November 2000 to September 2001, the total number of non-IUD LTFP services increased six fold in clinics where OJT was provided, compared with an only 3-fold increase in clinics that did not receive OJT.

Establishment of Comprehensive clinics

In November 2000, UFHP rolled out its comprehensive clinic program, which was designed to offer customers a full range of choice for family planning methods, including the four long-term methods. The comprehensive clinics were selected for equipment and staff skills upgrade based on the outcome of a base line survey, following which UFHP selected 41 clinics for upgrading to comprehensive clinics.

Activities to promote LTFP

A special LTFP BCC/M strategy linked with the on-going NIPHP BCC Strategy related to LTFP was developed by UFHP. A number of BCC materials were developed to support long term family planning initiative, including billboards, posters, and a brochure on NSV. A wall chart containing comprehensive information on all family planning methods was supplied to all the static clinics to promote a wider range of method choice. Special sessions on Informed Choice and the Tiaht Amendment were incorporated into the Interpersonal Communication/Counseling (IPC/C) and Clinic Management Courses (CMC) for Counselors and Clinic Managers (CM).

Other BCC/M activities in support of the LTFP initiative at the clinic level included establishing a functional customer follow up system through ESP card flagging and using satisfied customers to promote LTFP. These efforts were intensified in the comprehensive clinics during the 'Operation Big Push', a special BCC nationwide campaign organized between October 2001 and January 2002. A brochure on LTFP methods was also distributed as a job aid throughout the network and TV and radio spots promoting LTFP were also aired as planned.

Collaboration with GOB

UFHP collaborated actively with the Government of Bangladesh (GOB) to increase LTFP performance. A UFHP/GOB/QIP joint LTFP working group was constituted and the group met on a regular basis to foster collaboration and to discuss policy changes, among them, the phase out of the GOB's long-standing LTFP incentive payment system. As a result of this close collaboration, UFHP was able to make best use of GOB training resources and opportunities for training new service delivery teams or to train new staff. UFHP also established an agreement with the Directorate of Family Planning to centrally procure Norplant as needed, helping UFHP clinics to overcome local-level supply shortages. In addition, at UFHP's request, the ESP Line Director issued letters to the local level FP senior staff to permit UFHP clinics to provide LTFP services once staff had received training from any of the GOB-recognized training institutions. These letters helped to speed the District Technical Committee (DTC) approval process, without which the clinics would not be able to perform LTFP procedures.

With the objective of strengthening the GO-NGO collaboration at the peripheral as well as central levels, UFHP organized four joint GOB-UFHP Divisional Workshops on LTFP. These workshops focused on the importance of LTFP in the UFHP program and on improving coordination between UFHP clinics and local government officials and units. UFHP clinic staff, Civil Surgeons, Deputy Directors of Family Planning (DDFP), Assistant Directors of Clinical Contraception (ADCC) and Upazila Health and Family Planning Officers attended the workshops.

An effective referral network between GOB and the UFHP NGO clinics that did not

provide LTFP services was also established and made functional at the local level with the corresponding GOB service and also among other clinics in the network for back-up support in complications management.

Major Achievements under sub result 2:

Figure 12

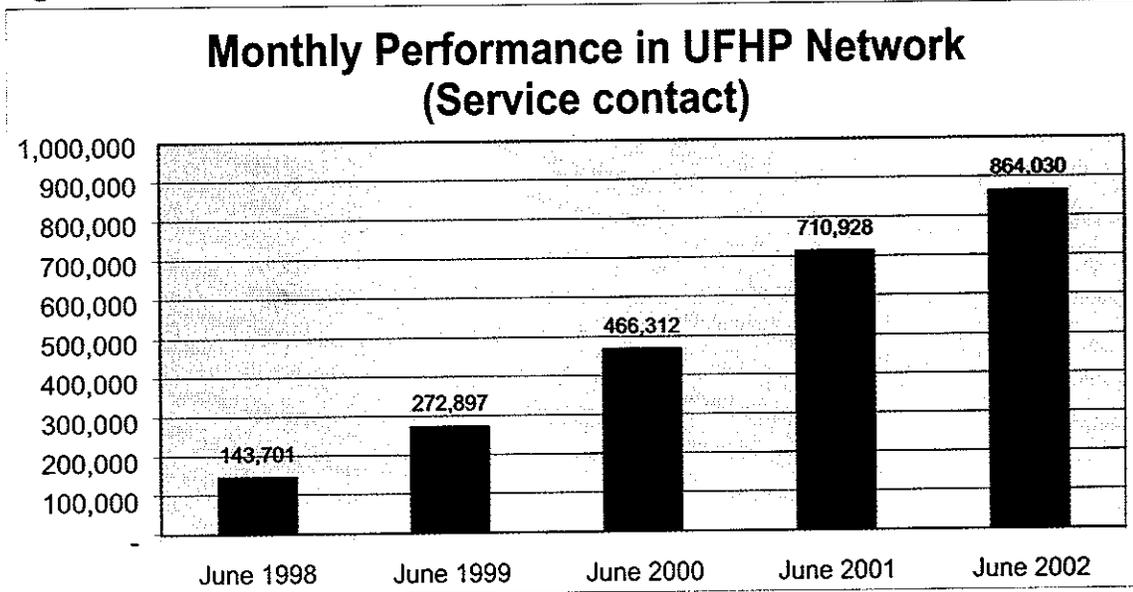


Figure 13

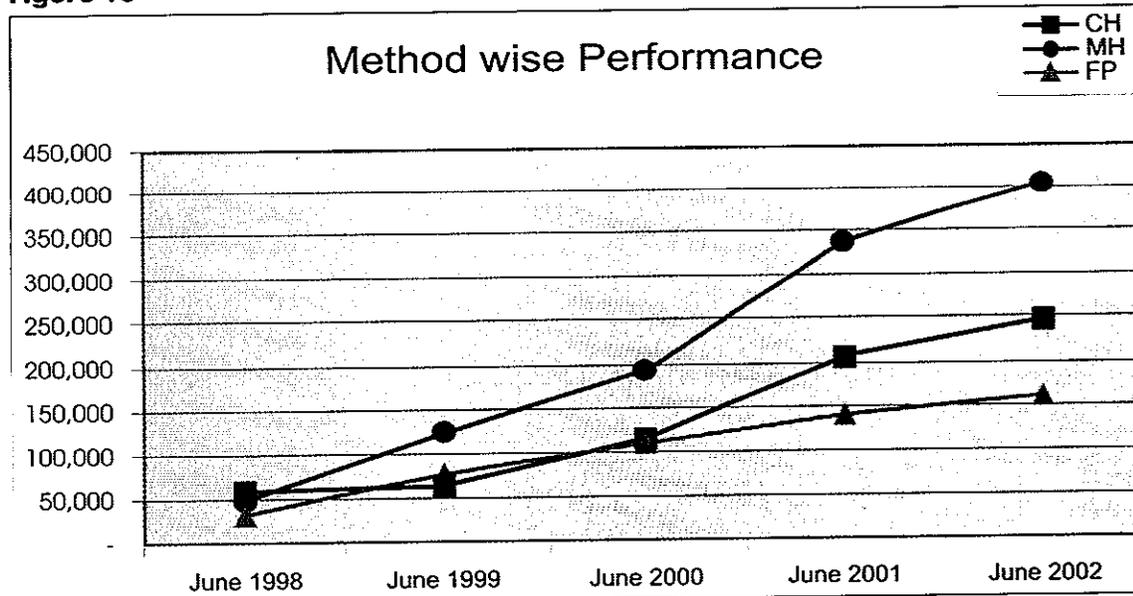


Figure 14:

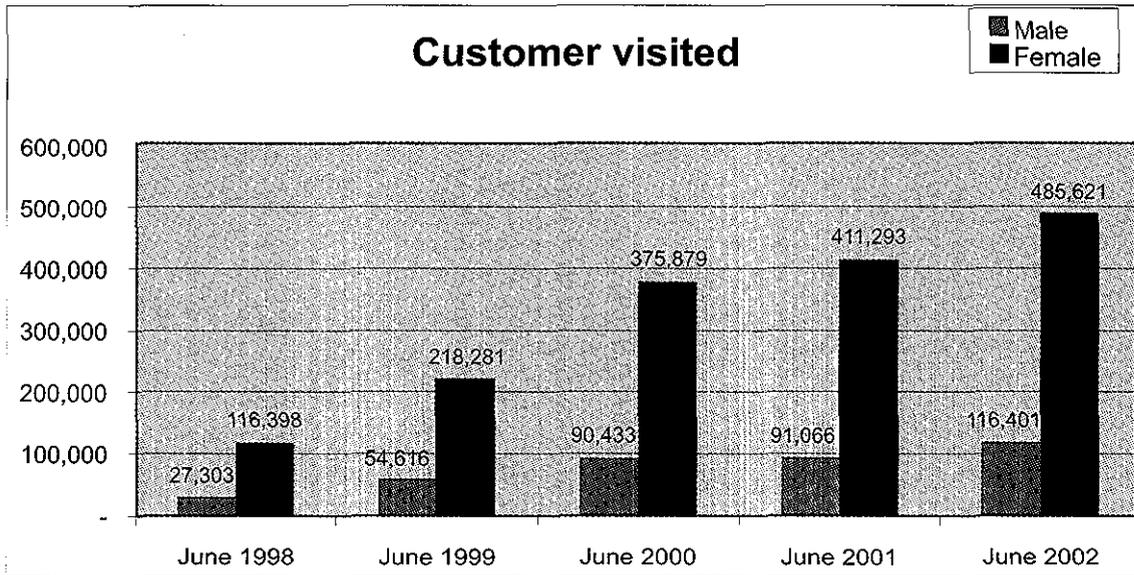


Figure 15:

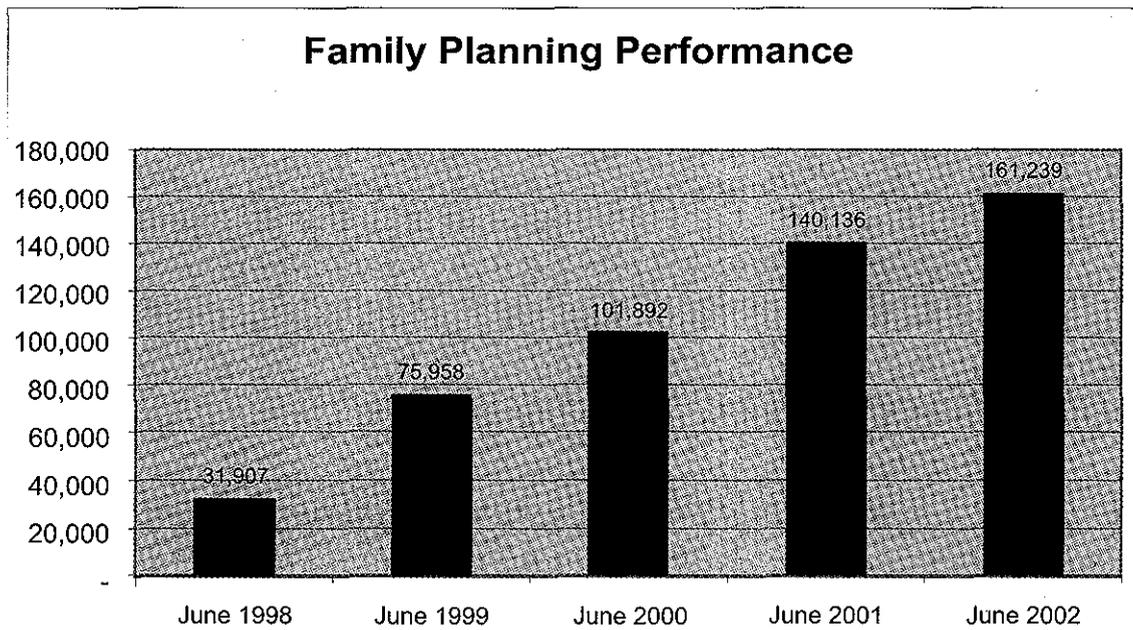


Figure 16:

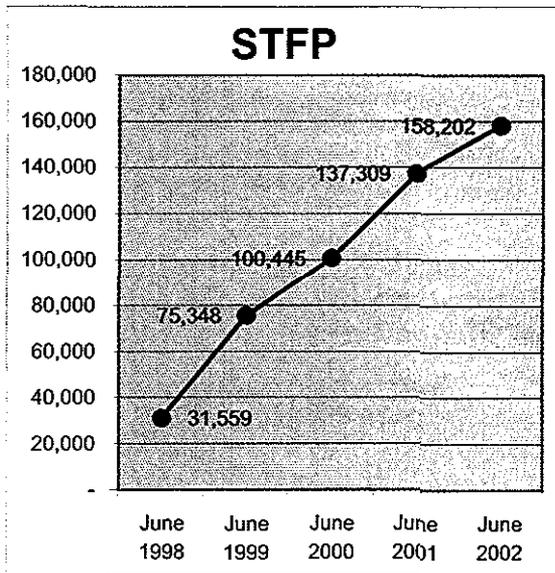


Figure 17:

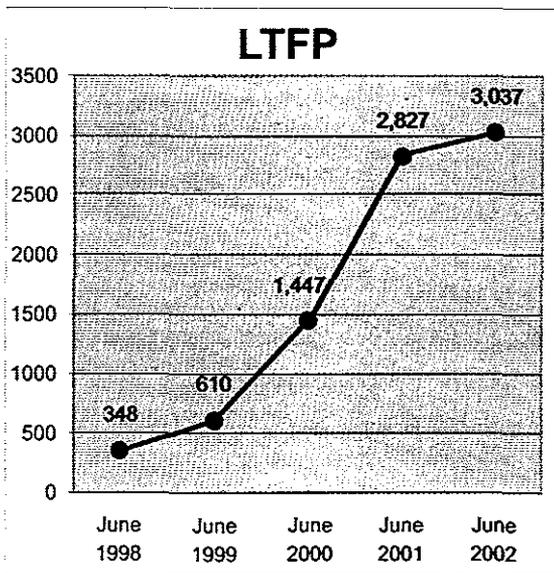
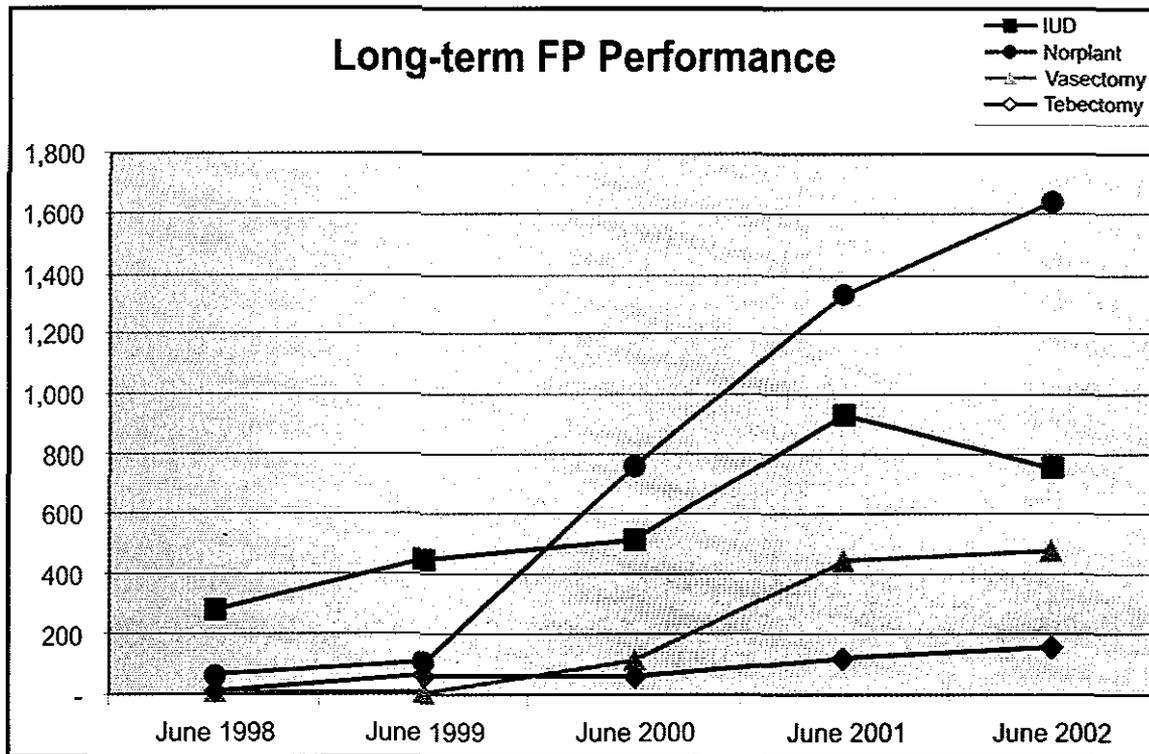


Figure 18:



INTERMEDIATE RESULT 2: INCREASED KNOWLEDGE AND CHANGED BEHAVIOR RELATED TO HIGH-PRIORITY HEALTH PROBLEMS, ESPECIALLY IN LOW PERFORMING AREAS.

UFHP's Behavior Change Communication and Marketing (BCC/M) activities were driven by its commitment to the second Intermediate Result (IR) of the NIPHP. Since inception in July 1997, UFHP focused its BCC/M efforts on the NGO program to create awareness and demand for services within and from the community. The main thrust of the initial activities was to empower NGOs to plan and undertake BCC/M activities according to their local needs and considering the local socio-cultural norms. IR 2 had only one sub result (SR) and this was:

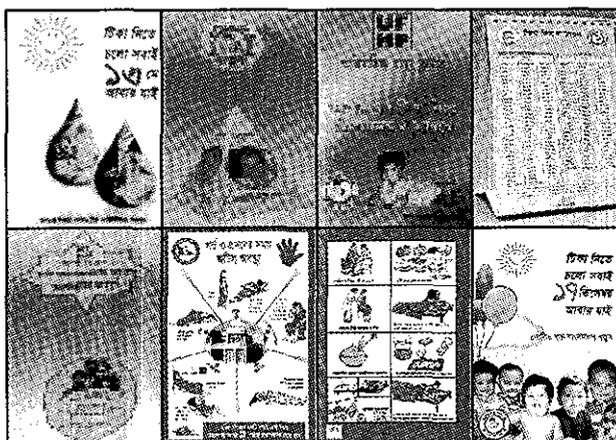
- Sub Result (SR) 1 - BCC/M strategy for ESP designed and implemented

Major Achievements under IR 2 as per the CA performance indicators:

Developing an appropriate BCC and Marketing strategy and helping the UFHP NGOs to fully understand the concept and tailor it according to their local needs was the driving force behind UFHP's BCC/M activities.

Number of UFHP facilities using BCC materials

Based on the various monitoring visits made to all UFHP clinics over time, e.g. management support and QA visits, 100 per cent of the clinics were using BCC materials. Of course there were some clinics that were not making best use of all the BCC materials available to them, but they were certainly using at least some of these materials.



Percent of married women in catchment populations that could name available ESP services related to maternal health, reproductive health and child health

According to the Preliminary Report of the NIPHP Evaluation Survey (Mitra et al., 2002), there was no single aggregate measure for this indicator. The survey explored the knowledge of married women about specific ESP service components. The findings are as follows -

- Per cent of married women in catchment populations that could name maternal health as an available ESP service was 63 per cent
- Only 43 per cent of the married women in the catchment populations could name Family Planning as an ESP service
- Surprisingly, only 0.95 per cent of the respondents could identify Other Reproductive Health as an ESP service
- Majority of the married women in the UFHP catchment populations (80 per cent) could identify child health as an ESP service

Percent of potential clients who could describe 3 modern family planning methods, including indications for use

The UFHP service delivery network demonstrated considerable achievement in this regard. This may be partially attributed to the intensive BCC efforts generated in the UFHP BCC strategy during the last five years. While the NIPHP target for this indicator was 65 per cent, almost all the married women in UFHP catchment populations (98.6 per cent) could describe three modern FP methods along with the indications for their use (Mitra et al., 2002).

Percent of mothers who knew when their child's next immunization was due, the importance of vitamin A, and how to respond to childhood diarrhea and ARI

Both anecdotal evidence and demographic data show that the proportion of dropouts for child immunization and Vitamin A supplementation are still high in Bangladesh and generating the appropriate response to diarrhea and ARI is still a national concern. This is also evident from the decline in the overall percentage of children vaccinated at any time, which was 5.5 percentage points lower in 2001 than in 1998 in UFHP areas (Mitra et al., 2002).

The findings of the Preliminary Report of the NIPHP Evaluation Survey (Mitra et al., 2002) in this indicator are as follows:

- Percent of mothers who knew when their child's next immunization is due was 78.6 per cent
- Percent of mothers who knew the importance of Vitamin A was 94 per cent
- Percent of mothers who knew how to respond to childhood diarrhea and ARI was 82.4 and 77.3 per cent respectively

The same study reported that level of education was an important factor in relation to correct knowledge among the women in the sample.

Percent of married women who knew the danger signs of pregnancy and how to respond

In a country where 92 per cent pregnant women still deliver at home and only 12 per cent of all pregnant women receive delivery assistance from a doctor/nurse/midwife (BDHS 1999-2000), increasing women's knowledge about the danger signs of pregnancy and how to respond to these is quintessential. Thus the UFHP BCC strategy addressed this as a major concern. According to the Preliminary Report of the NIPHP Evaluation Survey (Mitra et al., 2002), 93.6 per cent of the pregnant women knew the complications threatening the life of a mother during pregnancy, delivery or post delivery. While 71 per cent knew about the appropriate complications, 22.6 per cent mentioned other complications as well. It was also encouraging to find that almost all the women (99.7 per cent) knew that they should seek medical care in case of a pregnancy complication.

Percent of married women who knew recommended number of TT vaccinations

In the UFHP areas, only one-fifth of the respondents (20.2 per cent) knew about the recommended number of TT vaccinations, while in the non-UFHP areas this was only

10.9 per cent. However, only three-fifths (60.3 per cent) of the respondents had received two or more injections at the time of the survey (Mitra et al., 2002).

Percent of women who exclusively breast-fed, by 2 month intervals, up to six months

While breast-feeding is widely practised in Bangladesh, the proportion practising exclusive breast-feeding (EBF) is comparatively low. While UFHP service providers were given special training on counseling for EBF during their foundation training on maternal health, numerous BCC activities were also conducted in this regard. The percent of women who exclusively breast-feed, by 2 month intervals, up to six months, according to the Preliminary Report of the NIPHP Evaluation Survey (Mitra et al., 2002) is given below -

- Almost 45 per cent of the children aged below 2 months were exclusively breast-fed
- Among those aged 2-3 months, 27.6 per cent were exclusively breast-fed
- Of the children aged 4-5 months, 11.7 per cent were exclusively breast-fed
- Only 1.9 per cent of children aged 6-7 months were exclusively breast-fed

SUB RESULT 1: BCC/M STRATEGY FOR ESP DESIGNED AND IMPLEMENTED

Major Activities Implemented and Related Achievements:

Capacity Building

Capacity building on BCC/M for the NGOs was a challenge that UFHP undertook during the first one and a half years of program implementation. The challenges of empowering local organizations were multiple and daunting. NGOs, hardly exposed to planning their activities locally in the past and almost always depending on the donor for any and all forms of guidance and instruction suddenly found themselves in a state of utter confusion. They had almost no experience or idea of the concept of BCC and Marketing, let alone dealing with local level BCC/M as an integral part of the program activities. That this would contribute substantially to promoting their services in the community and in raising their customer number, not to mention popularizing their services was beyond their comprehension and capability. The paradigm shift from home-based service delivery to a clinic-based one necessitated a massive change in the mindset of those dealing with communication and marketing. This in turn required that they also develop and acquire new skills to act upon the changed situation.

- BCC and Marketing capability and materials inventory - The first step in meeting the new challenge was the development of this inventory in collaboration with Bangladesh Center for Communication Programs (BCCP). At the same time, UFHP commissioned different national and local level studies to have an in-depth knowledge and concept of the potential BCC/M plans and activities.
- Involving community leaders and formal and informal stakeholders at local level - This was an integral part of UFHP's initial BCC/M activities. A series of orientations were conducted to inform the community about UFHP and its innovative new service delivery strategy of 'one stop shopping', as well solicit their support for utilization of the services offered at these clinics.
- IEC Blitz - The first of its kind, an IEC (as BCC was called at that time) Blitz was conducted with all sub-grantee NGOs in developing their local level plans and

activities to enforce and enhance their BCC and Marketing capabilities. These included market analysis and understanding their mission and vision regarding attracting different groups of the population to the clinics for service utilization. All Senior Service Promoters (SSP), Service Promoters (SP) and Project Directors (PD) were the target audience for the IEC Blitz. The four-day event was aimed at helping NGOs to come up with their own BCC and Marketing plans that would cater to the needs of the local community. Through this effort, the NGOs were also able to have a better understanding of the concept and rationale behind analyzing their market so that they could strive to achieve higher customer flow to their clinics.

- Hands on and classroom training - This highly intensive and hands on training was designed and imparted to improve knowledge and capacity of the BCC personnel at the NGO and clinic levels. The BCC activities, in terms of planning and implementation were found to be more systematic and planned after people received this training.

UFHP Branding campaign:

A two - pronged NIPHP Behavior Change Communication (BCC) Strategy was developed in 2000 to improve health-seeking behavior of potential customers and increase the number of customers into the clinics. Thus the focus of the strategy was basically improving the health behavior and promoting the clinics, and it was thus reflected in the Health Category and Branding campaigns.

- A comprehensive, orchestrated and multi-channel approach was used to promote UFHP as the brand of 'quality' which was explained as 'caring and friendly services'. The strategy used both push and pull to gain and reinforce greater involvement of providers while focusing on potential customers for building customer expectations, generating demand and increasing clinic traffic.
- A new symbol, the 'Smiling Sun' was developed to popularize UFHP clinics so that people could associate with, visualize and recall the 'Smiling Sun'-marked Paribarik Shashthya Clinic' in their times of need. The campaign was launched in October to December 2000 in all local and national media.

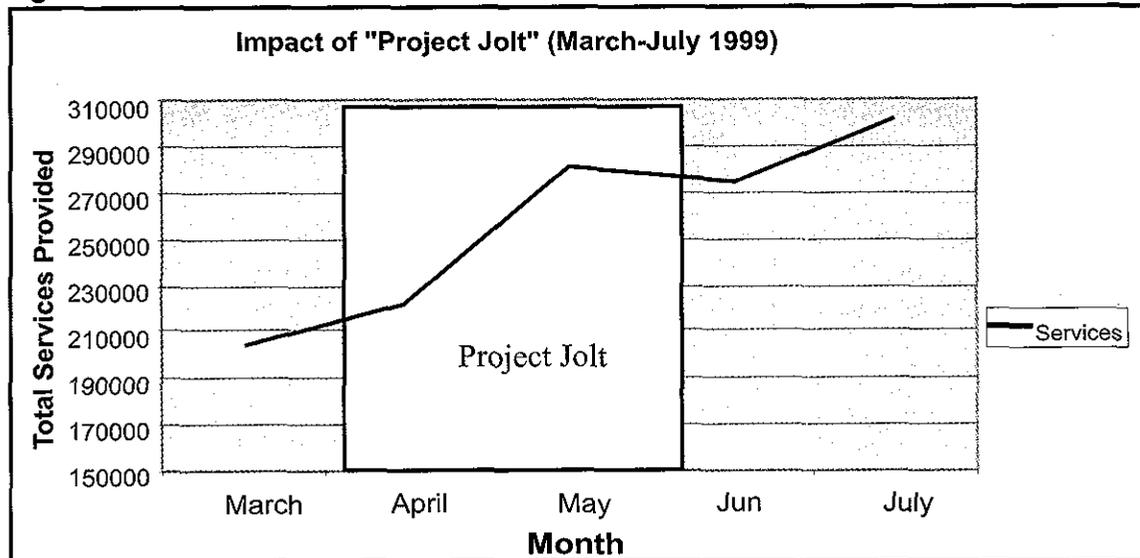
Jolts:

Promotion of the UFHP brand and clinics in the community was one of the major challenges. From inception, UFHP recognized the need for local NGOs and clinics to attach and identify themselves with the national media campaign. Thus a concerted and orchestrated local campaign was developed, which was also expected to rebuff the decaying trend of the rate of increase in performance at the time.

- The local campaign, 'Project Jolt' embraced a wide range of activities, including raffle draw, essay competitions, baby shows, discount for services for the customers and also involving community leaders and stakeholders. 'Project Jolt' proved its effectiveness and drew customers in large numbers. The total contacts grew by 19 per cent, from 449,409 in April 1999 to 536,085 in July. Since then, such local level campaigns became a yearly event, though each event had a new and attractive name, like 'Operation Big Push'. 'Operation Big Push', conducted between October 2001 and January 2002 raised the UFHP clinic performance from 504880 to

559606, a difference of 54726 customers in the given time period. The effects of the campaign were still visible from the UFHP service statistics for the following months, through to end of project in June 2002.

Figure 19:



BCC and Marketing Materials:

- A variety of communication materials on all ESP components were developed to reach customers and as well assist service providers to be more effective in disseminating information and communicating and interacting with customers. Relevant Job Aids were also developed simultaneously for the purpose. The materials included leaflets, posters, NID reminder cards, videos, take away brochures, billboards, flip charts and group meeting materials. The methodology for developing these materials followed the necessary processes and steps from needs assessment through pre-testing and making relevant changes prior to finalization.



Job Aids

Clinic Promotion Campaign (CPC):

Around the middle of the project implementation phase, in 2000, UFHP designed a comprehensive Clinic Promotion Campaign (CPC) to promote the ESP. The campaign design incorporated local and national level BCC/M activities through interpersonal local level communications channels.

At the local level, the CPC used volunteers from the community to visit households in UFHP catchment areas to:

- inform the household members about the services at UFHP clinics
- Market a prepaid health card for promoting use of ESP services at UFHP service delivery points

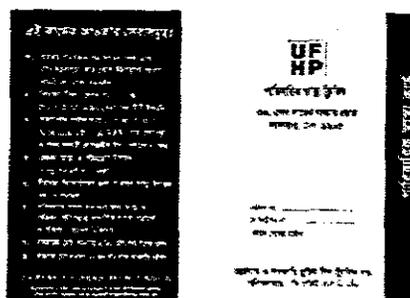
- Collect base line information on the residents of the households, information that could be used in future UFHP BCC/M and research initiatives

The volunteers used leaflets and interpersonal communication to inform potential customers in clinic catchment areas about the services available from the local UFHP clinic. These volunteers then marketed three categories of UFHP health cards to the households, based on family income, in an effort to promote prospective payment for ESP services for encouraging the use of preventive and routine services. Thus UFHP was able to collect data about potential customers as well as routine services.

Health card:

In 2000, three different types of Health Insurance Cards were introduced in the nationwide UFHP network to accelerate programmatic and financial sustainability. This innovative strategy helped UFHP to generate a captive customer group for a one-year period that in turn helped to explore options for more services, including long term family planning (LTFP) services. The three-category health cards are briefly described below:

- RED card - Targeted to reach high-income customers and thereby subsidize low-income groups/poor customers. It cost only Taka 100.00 per person and no co-payment was required each time the cardholder sought services at the clinic.
- YELLOW card - Targeted to attract a higher number of customers from the middle income group and minimize discounting to reduce missed opportunities. It cost Taka 100.00 too, but per family, with some co-payment each time the cardholder or a family member sought services at the clinic, the amount being determined by the concerned NGO or clinic management.
- BLUE card - Targeted to capture the low income, hard to reach and under served populations to improve their health care and service seeking behavior. Each card cost Taka 20.00 per family, with some or no co-payment each time the cardholder or a family member sought services, the amount being determined by the concerned NGO or clinic management.



UFHP Health Card

As of February 2002, more than 83,000 Health Cards have been sold, generating a revenue of Taka 5,573,745.00. Cost recovery was highest from the yellow cards, being at least comparable with the current network-wide rate of 12 per cent - reaching as high as 19 - 40 per cent in some clinics. However, NGOs are now more inclined to market the blue cards too alongside the yellow, the latter being a major contributor to the cost recovery component of the initiative. They agree that the blue card can enhance the care-seeking behavior of the poor customer group and the socially disadvantaged.

Participation in National days:

- UFHP NGOs have celebrated all health related national days in close coordination and collaboration with the GOB. Through these activities the NGOs have successfully built a strong linkage with the government and other local institutions and

stakeholders, and also been able to sensitize the community on each specific issue. The NGOs participated and assumed a lead role in various special days and events like, National Immunization Days (NID), World Health Day, TB Day, Safe Motherhood Day, World Population Day, World Breast-Feeding Day, World AIDS Day, among others.

Major achievements:

Quality Comes First - This thrust was central to the business strategy and UFHP believed that, if the level of quality of the physical aspects of the clinics and that of the services offered by the service providers was high, it would automatically attract customers. Quality service encompasses attitude and effective communications with customers (potential or current) and of course a customer-friendly physical environment. With this objective, UFHP launched its series of Team-Building Workshops that were conducted nation-wide even before its Quality Assurance initiatives. The workshops were aimed at generating smooth and supportive provider dynamics and teamwork, which in turn helped to bring about a change in staff attitudes amongst themselves and with the customers. The resulting customer-friendly environment appealed to the customers and played an integral role in carving the clinics' presence in the community.

It's not business as usual - It was altogether very difficult to change customers' mindset, particularly regarding the paradigm shift from home-based to clinic-based service delivery, especially paying for services. With the introduction of the elements of quality and range of service from a single service delivery point, along with the extensive effort in informing the community about the benefits of clinic-based services made UFHP successful in drawing over 850 thousand customers in a month in March 2002.

Use of communication materials - UFHP produced numerous communication materials both for end users as well as service providers. However, these were not used as effectively as expected. This was mostly due to the fact that providers often perceived communication to be an easy activity that could be performed by anyone, either service provider or sales personnel. This was more of an attitudinal issue, which lacked field-level monitoring and hands-on assistance, to efforts integral to ensure their proper understanding of the benefits of effective utilization of communication materials.

Community mobilization - UFHP focused on community mobilization from inception. It was always exerted that effective communication would help communities to own the clinics and thereby make them sustainable. Besides, this was also projected as the clinics' commitment to the community. However, despite UFHP's top-down planning mechanisms, there was a huge lacking in community participation, in terms of disseminating and sustaining information. Community mobilization requires focused and participatory activities from all quarters and levels of the program, which UFHP was unable to provide or ensure. Although UFHP had also started focussing on community mobilization through an innovative and effective group meeting package, it still required greater attention and policy level commitment and support, along with the required amount of flexibility.

Cost versus Quality - This has been a topic of many debates within and without the

UFHP network. It was argued that UFHP communication materials were expensive and their cost efficiency was often under questioning and scrutiny. However, UFHP still believes that 'Quality Costs Less', if appropriate monitoring mechanisms can be instituted to ensure utilization of these materials at the grassroots level.

Marketing - The concept of introducing the idea of 'Marketing' into the primary health care business in Bangladesh was unique and well timed. However, it was unable to generate adequate support and accolade from relevant stakeholders. Despite this lack of enthusiasm, UFHP firmly believes that marketing has helped UFHP to widen its horizons, along with generating conceptual clarity regarding the business. Marketing has also helped clinics to focus more towards attaining sustainability, both programmatic and financial.

At both UFHP and NGO levels, BCC/M became an important issue for clinic promotion and functions. It appeared that most UFHP staff were able to internalize the concept and ideas in this regard, an achievement which helped UFHP to filter the idea and concept of BCC/M to the field level in the earliest possible time.

Urban Star

A quarterly newsletter 'Urban Star' was published throughout 2001-2002 to share the lessons learnt and success of UFHP and its member NGOs. Each issue highlighted UFHP's efforts in the program area. The first issue was devoted to Maternal Health, the second on Long Terms Family Planning, the third on HIV/AIDS/STIs and the fourth issue focused on NGO Performance Analysis Report results and Child Health. Urban Star helped disseminate information about UFHP's activities relating to ESP service delivery in the urban areas.

Collaboration with GoB and international agencies

The Asian Development Bank launched the Urban Primary Health Care Project (UPHCP) in 1999 through agreement with the city corporations of Dhaka, Chittagong, Rajshahi and Khulna. Since UFHP was already working in the project areas, it became necessary to delineate the working areas in order to avoid duplication. UFHP initiated dialogues with the UPHCP and the city corporation and an MOU was signed between UFHP and UPHCP earmarking the city corporations wards for both the organizations.

UFHP signed an MOU with the Directorate of Family Planning of GoB to undertake a project on Building Urban Slum Teams Towards Health Initiatives (BUSTTHI). Under the project, 25 satellite teams would serve 100 selected slums in Dhaka, each team comprising a paramedic from the Directorate of Family Planning, a service promoter from the local UFHP NGO and an EPI vaccinator from Dhaka City Corporation. UFHP's four NGOs would provide the management training and supervision.

UFHP clinics had their limitations in dealing with suspected tuberculosis patients. As such an MOU was signed with GoB (Directorate of Health Services) instituting a referral system for UFHP tuberculosis patients for treatment at Government TB clinics, patient follow up and monitoring.

INTERMEDIATE RESULT 3: IMPROVED QUALITY OF SERVICES AT NIPHP FACILITIES

From the very inception of the UFHP program, establishment of quality has been a high priority. Within months of start up, UFHP's Quality Comes First campaign set the tone for UFHP's quality focus. This campaign aimed to establish quality in services at all UFHP sites by controlling the NGO urge to expand into new areas of ESP services provision before they had managed to achieve a predefined "acceptable" level of quality in the provision of services currently offered. The components were determined based on both the perspectives of the clients, providers, and established best practices. The components are as follows:

Quality from the <u>client's</u> perspective	Quality from the <u>provider's</u> perspective
<ul style="list-style-type: none"> - Effective service - Reasonable waiting times - Convenient hours - Availability of information and informed choice - Privacy - Cleanliness - Friendly staff - One-stop shopping - Availability of drugs 	<ul style="list-style-type: none"> - Appropriate and safe working environment, with sound infection prevention procedures in place - Availability of necessary equipment and supplies - Adequate and appropriate skill development and training - Continuous support, both technical and managerial

Intermediate Result 3 had three sub results, as follows:

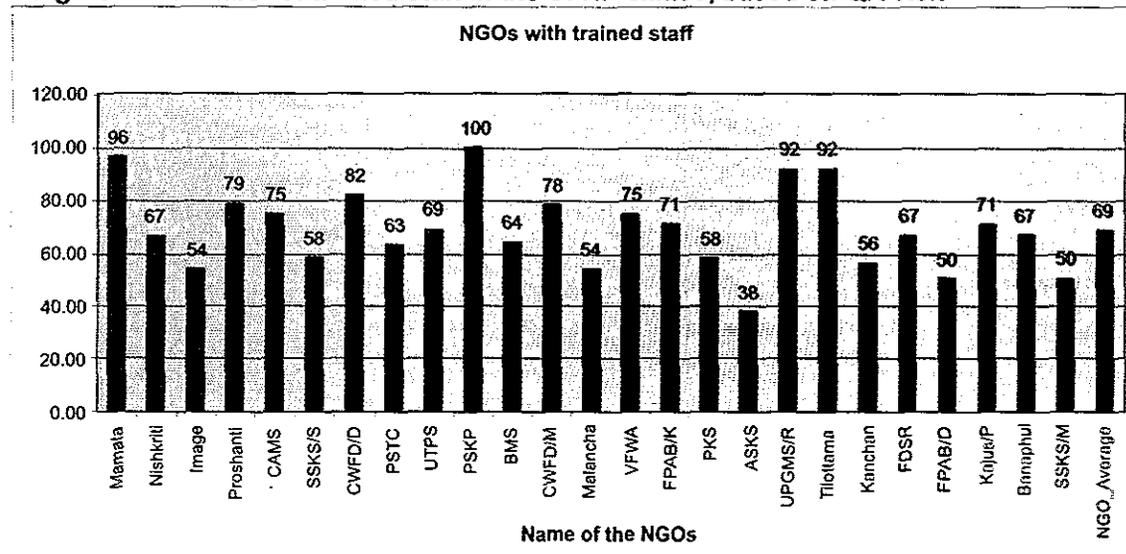
- Sub Result (SR) 1 - ESP quality assurance and reporting system installed at / for NGO service delivery points in target municipalities
- Sub Result (SR) 2 - Quality of counseling services improved and missed opportunities minimized; and
- Sub Result (SR) 3 - NGO service providers trained to provide ESP services in compliance with UFHP quality standards

**Major Achievements under IR 3 as per the CA performance indicators:
Per cent of NIPHP clinics with at least "acceptable" compliance with service delivery standards, including counseling:**

In the last round of QA visit, 73 percent of the clinics were found to have at least acceptable compliance with existing service delivery standards, scoring at least 60 percent on the QA visit report, while 90 percent had at least acceptable compliance with counseling standards.

**Per cent of NIPHP clinics with full complement of trained staff:
High quality provider network**

Figure 20: Number of trained staff in the UFHP clinics, based on QA visit



"Crude" and "Valid" immunization coverage, all antigens, children under one:

According to the NIPHP Evaluation Survey (Mitra et al., 2002)

- Crude immunization coverage, all antigens, for children under one in the UFHP service delivery areas was 62.4 percent.
- Valid immunization coverage, all antigens, for children under one in the UFHP service delivery areas was, however, 56.2 percent.

Drop-out rates for EPI; discontinuation rates for OCs, IUDs and injectables:

According to the NIPHP Evaluation Survey (Mitra et al., 2002)

- Drop-out rates for EPI - The EPI drop-out rate among all children aged 12-23 months in the UFHP areas was 37.8 per cent, while it was 19 and 21 per cent for DPT third dose and polio third dose, respectively. However, for children receiving all EPI vaccines by the first birthday, the dropout rate was 44 percent.
- First year contraceptive discontinuation rates -
 - Slightly over half (51.8 per cent) the women in the UFHP service delivery areas using Oral Contraceptives (OC) discontinued within the first year of method use.
 - Among users of injectable contraceptives too, over half (54.8 per cent) dropped out.
 - The survey could not measure dropout rates for IUD.

Increasing number of ANC visits per pregnancy:

Among women in the UFHP areas that had a live birth in the last 36 months preceding the survey, almost three-fourths (73.1 percent) had received at least one antenatal care (ANC) visit. Compared to them, among those who had a live birth in the last one year prior to the survey, almost four-fifths (79.2 percent) had received at least one ANC visit.

SUB RESULT 1: ESP QUALITY ASSURANCE AND REPORTING SYSTEM INSTALLED AT / FOR NGO SERVICE DELIVERY POINTS IN TARGET MUNICIPALITIES

Major activities implemented:

Quality Assurance (QA) Visits

UFHP initiated a QA visit planning and implementation process in collaboration with the Quality Improvement Partnership (QIP) of the NIPHP in October 1997. The focus of the QA initiatives was to study UFHP clinic operations, identify gaps in quality and compliance with service delivery standards and develop and implement action plans for filling these gaps. The overall goal of the initiative was 'To ensure the highest level of service quality within the UFHP network, to improve the quality of information, services and products as well as customer satisfaction'.

A two-member QA team comprising professionals from QIP and UFHP conducted the QA visits per UFHP static clinic annually. The general QA visit methodology was as follows:



Infection prevention poster

- Direct observation of providers' service delivery skills while on the job;
- Use of role play, case studies, demonstration and dummy exercise (when specific types of customers were not available);
- Discussion and question and answer sessions to assess providers' technical knowledge;
- Documents review for retrospective cross checking and validation of records, including randomly selected ESP cards (patient records), clinic registers, prescription and referral slips.

The QA Teams used standardized tools including:

- QA Observation Checklist for static, satellite and upgraded clinics;
- QA Guideline; and
- A Knowledge Quiz and Records review checklist

Four rounds of QA visits were completed between 1998 and 2002, corresponding with the phased roll out of ESP components:

- Round 1 (1998-1999) aimed at ensuring quality of the physical service delivery facility, along with its spatial distribution, -including:
 - Clinic layout and customer flow management;
 - Accessibility and visibility of the clinic;
 - Availability of service providers at each service delivery point;
 - Availability of appropriate furniture, equipment, supplies and emergency drugs;
 - Availability and use of existing standards and guidelines; and

- Local level problem identification and solving, through use of periodic COPE exercise with follow up on recommendations.
- Round 2 (1999-2000) focused on service provider technical and included -
 - Ensuring foundation training of new recruits on ESP components;
 - On-the-job orientation and skills updates for those without foundation training;
 - Infection Prevention Orientation for Clinic Aides and all relevant staff; and
 - Continuous quality improvement through local level QA visits and supervision.
- Round 3 (2000-2001) shifted focus more towards developing NGO QA capacity management, with a view to promoting long-term sustainability and building ownership and accountability within the NGO infrastructure. This was achieved by involving NGO managers and clinic staff in the QA process, through -
 - Ensuring participation of NGO clinician managers in the QA skills observation process; and
 - Ensuring participation of Clinic Managers by transferring responsibility for completion of the equipment and inventory component of the QA checklist.
- Round 4 (2001-2002) moved to further develop local-level QA skills, particularly in the area of technical competence supervision by involving NGO clinician managers and Clinic Managers in observing provider skills and identifying areas for TA and skills update. Major elements of the process included :
 - UFHP and QIP jointly conducting QA visits in roughly 50 per cent (80 clinics) of the clinics in the overall UFHP network;
 - The clinician PD/PM of each NGO and the respective Clinic Manager jointly conducting and completing QA visits for the remaining clinics; and
 - Emphasis on facilitative supervision at both NGO and clinic levels.

Dissemination of Quality Manuals/Standards

In the first three months of the program, UFHP took its first step towards ensuring quality service by developing and distributing the standards for physical facility requirements, location and clinic lay-out (Appendix F, 1997-98 Annual Report)

Later, with the phased roll out of the ESP service delivery components, UFHP collaborated with QIP in the development of the technical service delivery standards and guidelines. Distribution of each set of standards was followed by a series of dissemination sessions at the regional level, which focused on introducing the standards, discussion of the importance of the standards and their use in technical updates and on-the job provider training; and fielding questions related to the standards from the local level to foster a standards-friendly environment within the UFHP service delivery network.

By March 2000, the technical standards and service delivery guidelines on Child Health, Maternal Health, RTI/STD, Rational Drug Use (RDU) as well as the Infection Prevention Pictorial Job Aid were disseminated to all SDPs. By the end of the same year, the standard on Family Planning was also distributed to all SDPs. The Limited Curative Care (LCC) and

Common Ailments technical standards and HIV/AIDS Prevention Manual were introduced in 2001. Finally, in 2002, the Essential Obstetric Care (EOC) technical standard and Post Abortion Care (PAC) manual and service delivery guidelines were developed and distributed to relevant SDPs.

Technical Support Improvement

Local level Capacity Building:

To institutionalize local level monitoring of both the managerial and technical aspects of service delivery, UFHP emphasized local level capacity building. As a part of this process:

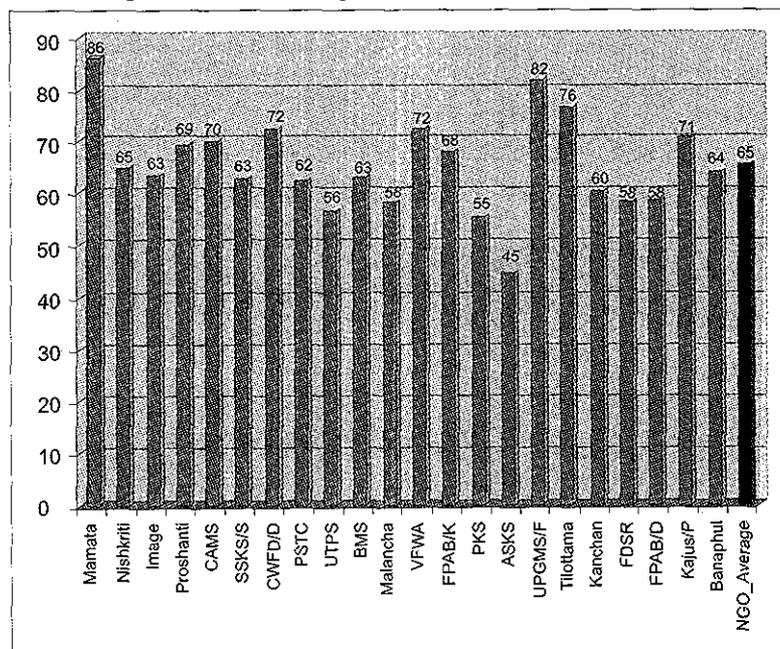
- Clinic Managers were responsible for monitoring quality and providing TA and support to staff at either own static clinics, as well as at upgraded satellite and satellite clinics operating under their management using the QA checklist. Clinic Managers were also asked hold regular technical update sessions to improve providers' technical knowledge and skills and improve their compliance with quality standards.
 - The NGO Management Team (NMT), a UFHP cluster management team consisting of a Non-clinician Project Director (PD) or Program Manager (PM) a clinician PD/PM, and a Finance and Administration Manager (FAM), was molded into a resource that could provide clinical skills updates, or BCC/M and financial management support.

Major achievements under IR 3

High quality provider network

Results from QA visit reports: All the clinics in the UFHP network were visited at least 3 times by the UFHP-QIP QA teams between 1998 and 2001. Quality scores as measured by the Quality Compliance Coefficient (QCC) derived from the QA reports improved from 39 percent, to 86 percent.

Figure 21: QCC (by UFHP-QIP teams) by NGO



SUB RESULT 2: QUALITY OF COUNSELING SERVICES IMPROVED AND MISSED OPPORTUNITIES MINIMIZED

Major Activities Implemented:

Counseling training:

UFHP trained more than 1100 service providers to ensure the delivery of quality counseling services at all SDPs in the network. UFHP placed a premium on developing practical, interactive counseling training programs that stressed the importance of addressing missed opportunities, moving providers beyond the family planning focus of the past to a more holistic family focus that the ESP necessitated.

Addressing Missed opportunities

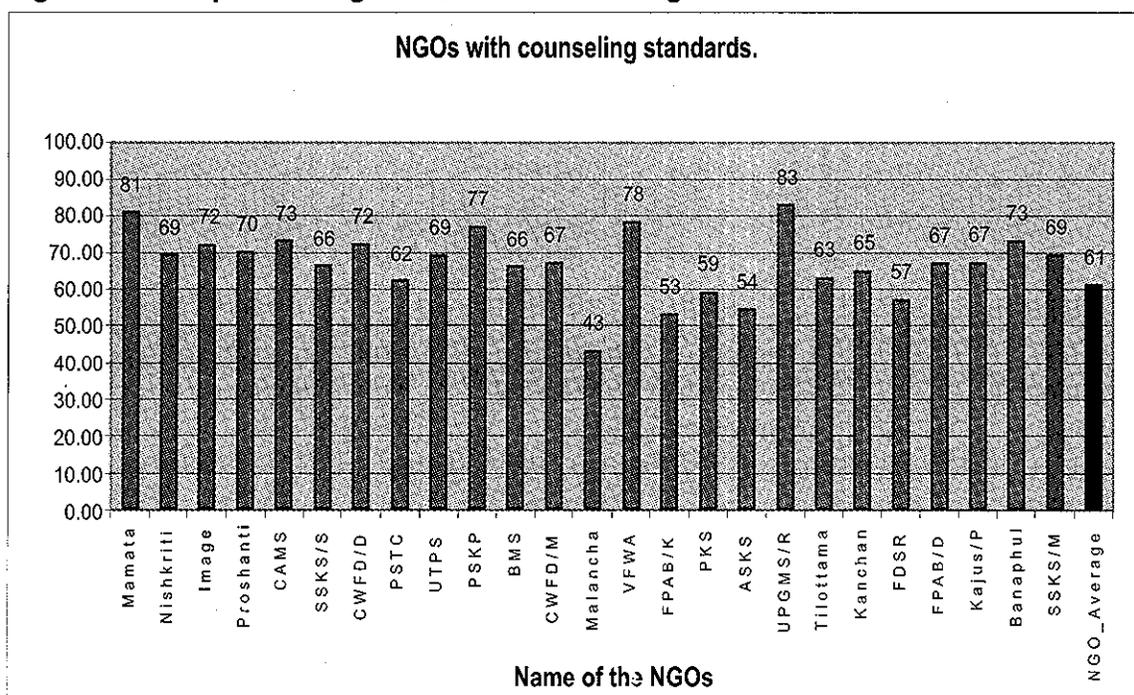
UFHP placed a premium on addressing missed opportunities in all of its practitioner training programs. UFHP developed tools to assist service providers in identifying missed opportunities, working, for example, in collaboration with QIP to develop a simple one-page 'missed opportunity' checklist in the form of a flow-chart for service providers. Similarly, UFHP revised the ESP card (the patient record card) to provide prompts for providers so that missed opportunities could be minimized. These job aid supplemented training, and served as a reminder for clinic staff to evaluate the additional health, needs of a customer. UFHP's missed opportunities focus was reinforced through routine management support and QA visits to the service delivery sites as well as through the introduction of a tracking system capable of calculating the average number of services provided to a customer (see Intermediate Result 4).

Major achievements:

High quality counseling

From start-up, UFHP strived to ensure that all customers received high quality counseling services. This included ensuring audio-visual privacy, informed choice, effective communication, providing correct information about available service/s in language the customers could understand, and addressing missed opportunities, and ensuring that customers understood treatment provided, drugs prescribed, and the need for and benefits of follow up as appropriate.

Figure 22: Graph showing the QCC for Counseling.



SUB RESULT 3: NGO SERVICE PROVIDERS TRAINED TO PROVIDE ESP SERVICES IN COMPLIANCE WITH UFHP QUALITY STANDARDS

Major Activities Implemented:

Training

Throughout the life of the project, UFHP offered and organized knowledge and skill development training courses and orientations on the ESP for its service providers, to ensure compliance with quality standards. These were organized by UFHP alone or in collaboration with the GOB and/or other NIPHP partners and stakeholders. These training courses can be categorized as follows:

- Core/Foundation courses required for all UFHP service providers. These included Clinic Management Course (CMC), the Child Survival Interventions/Other Reproductive Health (CSI/ORH) and Rational Drug Use (RDU) courses; ORH and CSI courses for paramedics, and the Interpersonal Communication and Counseling (IPC/C) for counselors.
- Special Initiative courses were arranged for providers involved in the implementation of the Special Initiatives only. These included training and orientation courses for doctors and paramedics in Safe Delivery, Post Abortion Care, NSV, tubectomy (minilaparotomy), Norplant (implantation and removal), Integrated Management of Childhood Illnesses (IMCI), HIV/AIDS Rapid Syphilis Testing, RTI/STI case management, and addressing ARH issues. Courses for counselors included a ToT

on Peer Education for HIV/AIDS prevention, an Orientation on HIV/AIDS Communication and Counseling, an ARH Counseling and Information Delivery training, and a, Peer Education for ARH Information Dissemination and Nutrition Counseling. UFHP also developed an RTI/STI training curriculum for at-risk populations, which was made available in 2002.

On-The-Job Training (OJT) for LTFP:

To offer on-site TA and hands-on skills development on LTFP methods service delivery, UFHP began using a roving facilitation team in 2001. In addition, the NGOs were also strongly encouraged to seek TA from local technical experts in the GOB and NGO sectors to provide OJT for newly trained staff till they were sufficiently skilled and confident in the procedures.

Localizing training:

UFHP placed emphasis on transferring training and skills upgrade capacity to the local level. These efforts included

- Organizing Basic ToT for clinician managers in collaboration with PRIME, with the expectation that the managers would then be able to lead local level OJT/ orientation processes;
- Developing an orientation guideline for paramedics on the various high-priority ESP components, which helped to expedite the process of conducting these local OJTs;
- Arranging ToT on Integrated Counseling and Nutrition at the NGO level with TA from PSTC, one of the UFHP management partners; and
- Organizing ToT on BCC and Marketing for NGO management, in collaboration with BCCP.

Distance-Based Learning (DBL):

In collaboration with PRIME, UFHP developed and introduced a distance-based learning mechanism for technical skills review and updates for UFHP service providers. Projanmo (a monthly publication from PSTC) was used as the medium for disseminating these modules. Six inserts were developed for use by clinic staff including questionnaires, Q and A, and review readings.

Major achievements

- Maintaining high service quality requires continuous QA and QI efforts. UFHP emphasized on quality as a key factor in establishing high impact service delivery points. Clear guidelines for physical facilities, clinical protocols and provision of training are essential to the process, while ongoing monitoring and technical assistance ought not to be compromised.
- It has been evident over the last few years that, 'Quality really matters', a lesson learned from UFHP's firm stand on not compromising quality. Ensuring appropriate and adequate equipment, furniture, logistics and commodities, along

with accessible clinic locations, exercise of COPE on a regular basis and, above all, establishing a customer-friendly clinic lay out are all important elements of quality service.

- On the job training - Foundation training is not sufficient to develop a confident and highly skilled pool of service providers. The on-site and hands-on skills development and updates provided by NGO managers and UFHP TA support staff made a major contribution to the process of improving providers' technical competence and confidence.
- Phased decentralization of monitoring is necessary to increase ownership and sustainability. UFHP clinics were imparted increasing responsibility for monitoring program performance and taking actions at the local level to improve performance. Skill building is needed to augment capacity at the local level for monitoring all aspects of the program, including clinical quality.

INTERMEDIATE RESULT 4: IMPROVED MANAGEMENT OF NIPHP SERVICE-DELIVERY ORGANIZATIONS

Intermediate Result 4 had four sub results. These were:

- Sub Result (SR) 1 - MIS systems implemented and used effectively;
- Sub Result (SR) 2 - Financial management systems implemented and used effectively;
- Sub Result (SR) 3 Logistics systems implemented and used effectively; and
- Sub Result (SR) 4 NGO planning and management capacity improved.

SUB RESULT 1: MIS SYSTEMS IMPLEMENTED AND USED EFFECTIVELY.

Major Activities:

UFHP, in collaboration with ORP and the GOB, began setting up an MIS in 1997. Initial components included the ESP Family Health Card (clinic level patient record), as well as a daily and monthly tally sheets, satellite clinic registers, and encounter form to track number of ESP services provided at each service location. In 1998, UFHP began generating computerized monthly and quarterly MIS reports for USAID detailing number of ESP services provided, logistics month of supply (MOS) and Service promotion through BCC/M meetings status. Beginning in 2000, UFHP rolled out an "Encounter Form", a data collection tool capable of supplementing the information on number of services provided collected by the existing MIS system with information on the number of customers per day, and therefore on the average number of services provided to each customer and the average revenue per customer. This tool had the added benefit of assisting with cost recovery by helping staff to capture the true cost of services provided, thereby facilitating collections and reducing unintentional discounting, and also recording the discounts provided to customers.

Computer-based reporting capability was transferred to the NGO level beginning in 1998; NGOs were expected to compile cluster-level information from each of their SDPs locally, review for accuracy, and send this information in electronic form to UFHP headquarters. This enabled UFHP to generate final, cleaned quarterly reports two weeks after the close of given quarter.

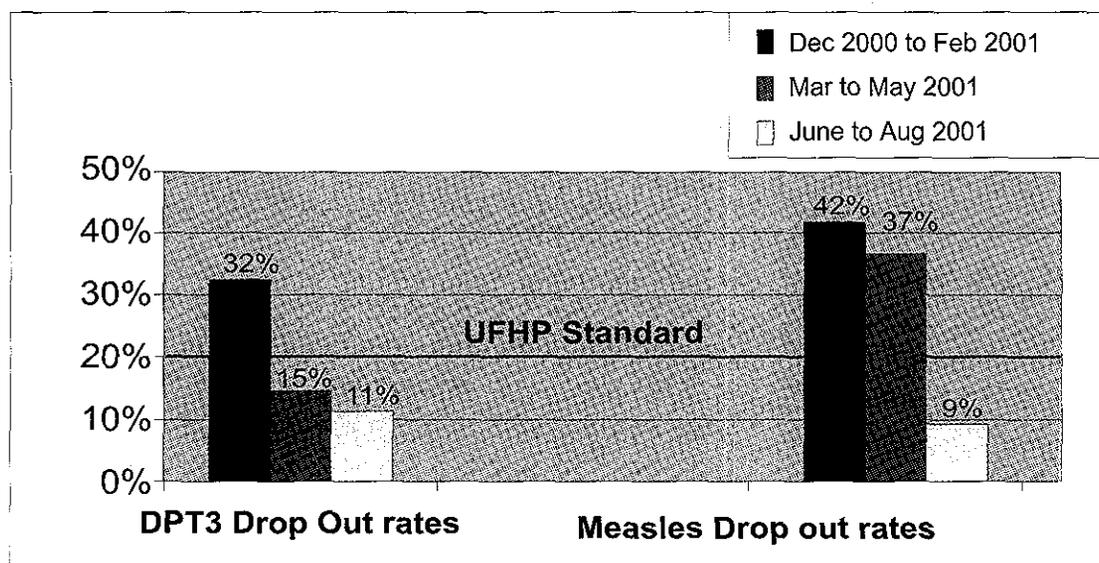
NGO Performance Analysis Report

In order to build NGO skills in using data for decision making, UFHP placed priority on giving NGO managers access to data which could provide an accurate picture of what was happening in their programs. The NGO Performance Analysis Report was designed to transform data already collected by the UFHP MIS into indicators of program success that would be useful to managers, that were reflective of all of UFHP's program priorities, and that would be comparable over time and between clinics and NGOs.

UFHP defined objective, transparent criteria for evaluating effectiveness and success at the NGO and clinic levels. The selected indicators balance competing priorities including

Figure - 23

UFHP Sub-grantee IMAGE decreased DPT3 and Measles drop out rates dramatically using the NGO Performance Analysis report and Institutional Development workshops.



cost-effectiveness, access to care for the most underprivileged, community health improvement, and financial viability. The *NGO Performance Analysis Report* was introduced as a quarterly report generated by UFHP from the MIS and feed back to the NGOs. Each report ranked clinic and NGO status and progress against each indicator, giving UFHP a way to identify and recognize those NGOs and clinics showing the most overall improvement. The first quarterly report was produced for the March 2001-May 2001 period, a new report issued every quarter thereafter through project end.

Institutional Development Workshops

In addition to having useful program data, NGO managers needed skills to be able to interpret what the data are saying and to respond to the message. Concurrent to the introduction of the *NGO Performance Analysis Report*, UFHP introduced the *Institutional Development Workshops*, a training series for NGO managers. The purpose of the series was to assist the NGO management teams in clarifying their roles and responsibilities and to promote a team approach to management. Participants learned about the six components of program success: building demand for services, improving quality of care, effective financial management, creative program development, strong leadership and governance, and efficient administration. The series used group processes, *brainstorming* and case studies to develop managers' skills in interpreting data to identify problem areas, strategize solutions, and develop concrete action steps for program improvement. With the needed data provided and the skills transferred, NGO managers were made accountable for improving their programs performance.

SUB RESULT 2: FINANCIAL MANAGEMENT SYSTEMS IMPLEMENTED AND USED EFFECTIVELY

Financial Management Manual:

UFHP developed a financial management manual for service delivery and provided an orientation to the manual and on-site TA to FAMs and PDs to build their financial management capacity.

Financial Management and Budgeting Software:

UFHP developed a user friendly budget development software for use by the service delivery NGO. The budget format consists of 3 worksheets which are linked so that clinic-level budgets are automatically summarized to arrive at budget totals for the whole NGO UFHP program

Regular Audits and Audit Follow-up:

UFHP commissioned 5 rounds of financial audits for the service delivery NGOs and the partners to review compliance with UFHP's financial management manual and USAID guidelines. Reports findings were reviewed and action steps for improvement identified in collaboration with NGO management.

SUB RESULT 3: LOGISTICS SYSTEM IMPLEMENTED AND USED EFFECTIVELY

Major Activities Implemented:

Central procurement of Norplant

In 2001 UFHP negotiated an agreement with the GOB Directorate of Family Planning to centrally procure Norplant implants. Under this agreement, UFHP procured implants centrally and distributed them to all NGOs as required. As a result of this initiative, UFHP clinics experienced no shortages of Norplant since April 2001.

Logistics Management Training:

In collaboration with DELIVER/Bangladesh, UFHP conducted regional workshops on family planning logistics management for all UFHP Clinic Managers, Senior Service Promoters (SSPs) and Documentation Officers (DOs). The purpose of the training was to familiarize clinic staff with Government family planning logistics record keeping and reporting systems and build relationships with local level Government warehouse managers to streamline procurement of family planning and medical and surgical requisites (MSR) supplies for LTFP services.

RDF training:

NGO Performance Analysis Report:

The NGO Performance analysis report contained a months of supply (MOS) indicator to assist managers to quickly assess stock levels of family planning commodities and respond to low levels. The indicator divided stock of a particular method on hand at the

end of the quarter by the average monthly consumption for the quarter, giving an indication of the number of months the existing stock would last at current consumption rates.

SUB RESULT 4: NGO PLANNING AND MANAGEMENT CAPACITY IMPROVED

Strategic Planning Workshop:

UPHF rolled out a Bangla strategic planning tool and held strategic planning workshop for NGO managers and Executive Committee members in August 1998 and again in May 1999. NGOs developed vision statements and strategic plans, as well as longer-term action plans after analyzing their individual organizational strengths, weaknesses, opportunities, and threats. The longer-term action plans were then fed into annual workplans, as well as into bids for program expansion.

Implementing Partners Strategic Planning Workshops:

The UFHP management partners developed and implemented strategic plans in the first year of project implementation, and made status reports and action plan revisions annually based on progress.

Executive Committee Retreats:

UFHP conducted on-site, half-day retreats with the Executive Committees at each of the partner NGOs. These retreats provided the first opportunity for UFHP to engage the entire leadership of the NGO in the UFHP program. The purpose of these retreats was to clarify the roles and responsibilities of the NGO leadership in program planning, monitoring and development and to build support for the UFHP program to promote long term sustainability of ESP health services.

Major Achievements Under IR4 according to CA Performance Indicators

Percent of facilities using data for decision making:

AT EOP, 100% of UFHP-funded NGOs were using data for management decision making thanks to the successful implementation of MIS system, and the institutionalization of the use of the BCC/M Plan and the NGO Performance Analysis Reports.

Average quarterly percent of UFHP facilities with no stock-outs of appropriate Standards Drug List commodities

Quarterly RDF stock out reports indicate that there were no stock-outs of standard drugs in 95% of the UFHP facilities in the April June 2002 quarter.

Percent of UFHP NGOs operating in compliance with an approved Financial Manual:

According to UFHP management support visit reports, quarterly financial reports and audit reports, more than 95% of UFHP NGOs were operating with an approved financial manual.

Percent of UFHP NGOs implementing an approved strategic plan and workplan:

Beginning in August 1998, all UFHP NGOs were implementing an approved strategic

plan and workplan. These workplans and strategic plans resulted from a participatory planning process facilitated by UFHP and designed to build NGO planning and management capacity.

Additional Achievements under IR 4:

NGO Performance Analysis Report brings speedy, tangible performance improvements: When data from the second, third and fourth quarterly reports are compared with the results of the first quarterly report, improvements in performance are seen in the major reporting areas of utilization, quality of care, efficiency and financial viability. Utilization : 93% (25 of 27) of the NGOs reported increased daily flow of customers for the four quarter reporting period. The average daily flow of customers increased 47.7% from an average of 40.5 in the first quarter to 59.9 customers per day in the fourth quarter. Significantly 78% of NGOs reported greater than a 20% increase in the daily flow of customers.

Immunization Drop out rate:

59% (16 of 27 NGOs) of NGOs still reported a decrease in their measles drop out rate from the first to the fourth quarters.

ANC Drop out rates:

100% of NGOs reported a reduced drop out rate for prenatal care for the reporting period. Only 3 (11%) of the NGOs in the fourth quarter reported drop out rates greater than the standard of 60% as compared with 18 (67%) in the first quarter.

INTERMEDIATE RESULT 5: INCREASED SUSTAINABILITY OF NIPHP SERVICE DELIVERY ORGANIZATION

Intermediate Result 5 had two sub results. These were:

- Sub Result 1: NGO revenues increased in accordance with target population's ability and willingness to pay; and
- Sub Result 2: NGO total operating costs contained

SUB RESULT 1: NGO REVENUES INCREASED IN ACCORDANCE WITH TARGET POPULATION'S ABILITY AND WILLINGNESS TO PAY

Major Activities Implemented:

Pricing policy guidelines and discounting tool:

UFHP undertook a number of studies aimed at establishing pricing guidelines for UFHP SDPs. The studies examined UFHP customer willingness and ability to pay for various ESP services, UFHP's cost per service provided, and the price the market would bear for the different services in the ESP. The result of this exercise was the development of a discounting tool designed to help UFHP SDPs to rationalize discounting while ensuring that those customers in need of a discount received a discount on service fees. The discounting tool used income and housing type (temporary or permanent, owned or rented) as indicators, and was disseminated through the Institutional Development workshop series and through the Counseling and Clinic Management Courses.

Revolving drug fund:

The RDF concept evolved out of a need to ensure the rational use of drugs and to ensure that customers have access to buy and take the correct medications. It was also designed to support UFHP's unique one stop shopping approach: making drugs available at the clinic means a quality, customer-friendly approach not available at most primary health care sites. Finally, the RDF had the capacity to contribute to clinic cost recovery. Previously, many of UFHP's NGOs had funds of their own but they were small and their internal discipline with respect to revolving the capital sums was fairly weak.

Clinic staff involved in managing the RDF were trained using the Monitoring-Training Planning (MTP) approach, self-teaching technique based on written documents prepared centrally and sent to the NGOs after translation and field-testing. One representative from each NGO was trained separately to facilitate the MTP process in his/her clinic. The revolving drug funds were financed with capital from SMC program income and formally launched in December 1998. Drug prices were negotiated centrally by the NIPHP partners to ensure the most advantageous prices, generally 10-15% below market cost, giving UFHP customers an additional, cost competitive source of high quality drugs.

Zakat Fund:

While the RDF works for the majority of UFHP customers, there were nevertheless some

customers who could not afford to purchase needed medications even at the reduced RDF rates. As a result, UFHP clinics took collections from the community to establish Zakat funds. These funds are used by the clinics to finance the cost of drugs for those individuals too poor to buy the needed drugs themselves.

SUB RESULT 2: NGO TOTAL OPERATING COSTS CONTAINED

Major Activities Implemented:

- Regular budget and expenditure reviews
- Regular audits
- Cost efficiency Institutional Development Workshop
- Joint cost reduction exercises, June 2001

MAJOR ACHIEVEMENTS UNDER IRS ACCORDING TO CA INDICATORS:

Percent of UFHP operated clinic operating costs recovered from fees per year:

The UFHP network was able to achieve cost recovery rate of over 19% at the project end, up from 3% at the beginning of the program

Number of UFHP Clinics with revolving drug funds:

At EOP, all UFHP clinics had a functioning revolving drug fund. Initial seed capital for the fund totaled Tk 5,904,955. As of June 2002, the total value of the revolving drug fund was nearly double this amount, at Tk. 12,343,839.

Additional Achievements:

Cost sharing:

Over the course of the program, UFHP was able to achieve 145% of its cost sharing goals, as follows:

**John Snow Inc. (JSI)
Cost Sharing Statement**

For the period: August 1997 June 2002

●	JSI contribution	\$ 81,000
●	CCC sub-contract	\$ 257,800
●	NGO contribution:	
—	Cash	\$1,043,104
—	<u>Imputed</u>	<u>\$ 655,168</u>
	Total	\$2,037,072

Figure 24:

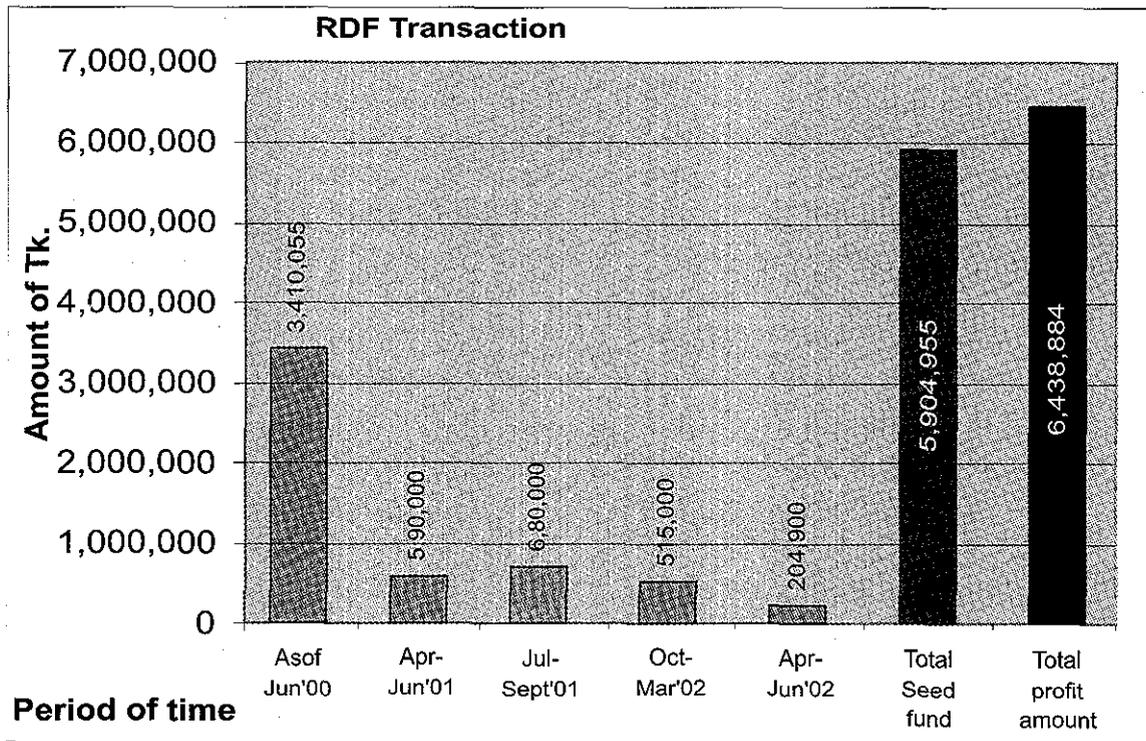
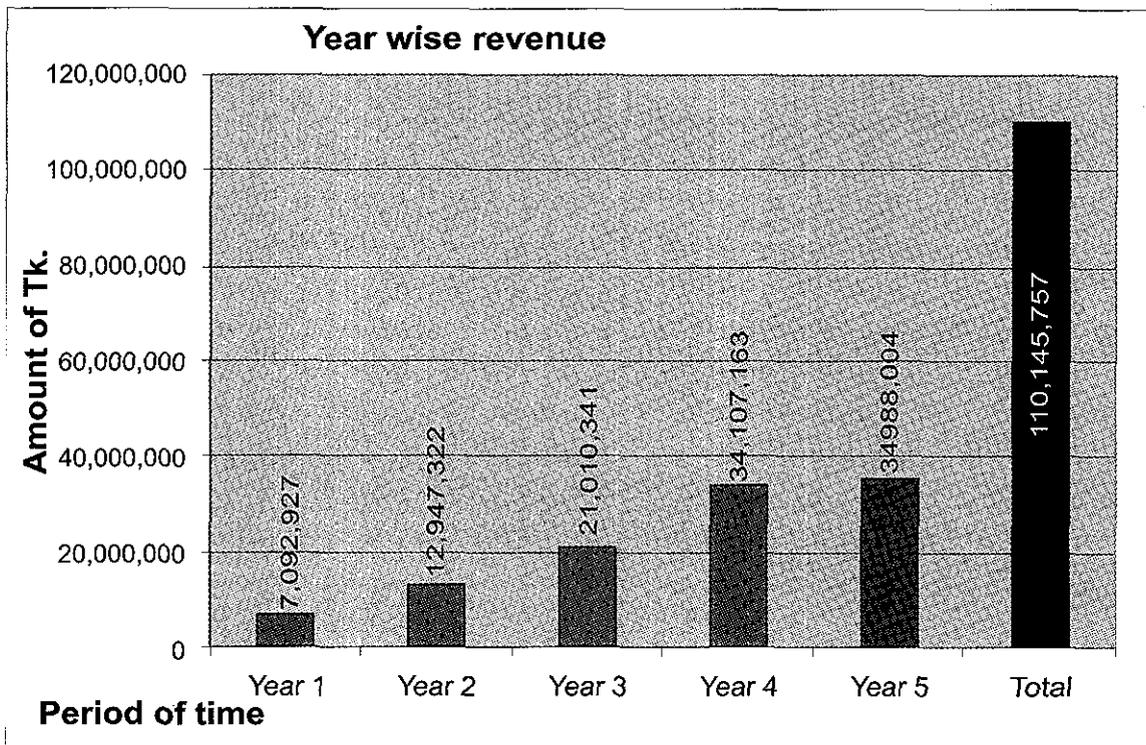


Figure 25:



NGO sustainability, leveraging, and collaboration:

Over the course of the implementation period, UFHP is proud to have fostered the sustainability of its management and service delivery partners through helping them to leverage funds and in kind contributions.

UFHP undertook a number of interventions to make its NGO partners sustainable both programmatically as well as institutionally. Emphasis was given for the NGOs to have their permanent clinic buildings. This intervention was strategized in the following three categories:

1. Use of revenues generated by the project activities for clinic/building construction;
2. Budgetary provision for major renovation of clinic buildings; and
3. Facilitation on funds from other donors to support NGO building construction.

Permission of USAID was obtained for construction of clinics and building for three NGOs namely Mamata, CWFD/Dhaka and Kanchan.

To ensure proper client flow and to facilitate strict adherence to quality assurance procedures, funds were made available in the budget of all UFHP partner NGOs to renovate their clinics. All UFHP Network NGOs undertook renovation works to upgrade their clinic buildings, which include SPADES - Adamgee and VFWA - Faridpur.

Kanchan and Banophul undertook renovation of the clinic buildings of Arabinda Shishu Hospital and Khulna Shishu Hospital respectively with whom they had local level partnership.

UFHP also leveraged substantial funds from JICA for construction of clinic buildings of PSTC - Dhaka, PSKP in ICDDR,B and Tilottama - Rajshahi.

UFHP/JSI
NGOs Program Income Statement
For the period August'97 - June'02

Table - 3

Name of the NGO/Project	Program Income			RDF Balance as of June 2002
	NGO Contribution to the Project (Aug'97 - June'02)	Balance with the NGOs as of 30 June'02	Total (Aug'97 - June'02)	
1	2	3	4	5
Mamata	4,136,190	2,063,233	6,199,423	521,204
Nishkriti	1,875,441	2,665,330	4,540,771	337,604
Image	1,320,930	3,381,850	4,702,780	392,924
Proshanti	1,040,517	887,237	1,927,754	165,515
CAMS	1,025,557	2,082,113	3,107,670	354,958
SSKS/Sylhet	1,415,061	2,411,716	3,826,777	290,815
CWFD/Dhaka	6,389,440	3,374,074	9,763,514	1,270,269
PSTC	4,100,388	4,831,406	8,931,794	899,462
UTPS	3,393,845	4,489,961	7,883,806	758,411
PSKP	3,825,057	5,466,481	9,291,538	967,802
BMS	2,500,000	3,372,106	5,872,106	329,080
CWFD/Mymensingh	1,034,822	1,150,943	2,185,765	315,899
Malancha	763,000	1,292,608	2,055,608	191,838
VFWA	1,655,360	1,135,883	2,791,243	549,783
FPAB/Khulna	2,543,412	2,246,338	4,789,750	394,056
PKS	700,023	1,870,799	2,570,822	488,558
Dipshikha	990,000	285,265	1,275,265	63,266
ASKS	1,275,000	1,538,744	2,813,744	136,830
UPGMS/Rangpur	930,000	1,308,105	2,238,105	474,419
Tilottama	1,520,047	1,464,377	2,984,424	353,760
Kanchan	3,053,565	552,517	3,606,082	947,363
FDSR	1,734,186	1,928,554	3,662,740	709,853
FPAB/Dhaka	263,351	1,560,770	1,824,121	293,036
SPADES	545,343	755,322	1,300,665	
KAJUS/Patuakhali	18,353	711,143	729,496	124,929
Banophul	4,624,126	2,188,612	6,812,738	841,231
SSKS/Moulvibazar	191,200	890,842	1,082,042	170,973
Sub-Total	52,864,214	55,906,329	108,770,543	12,343,838
Kajus/Barisal *	697,322	-	697,322	
PSSS/Narshindi *	800,000	-	800,000	
UPGMS/Bagra *	475,000	-	475,000	
Grand Total	54,836,536	55,906,329	110,742,865	

* Funding discontinued/Transferred to other NGOs

Use of program income for sustainability:

Figure 26

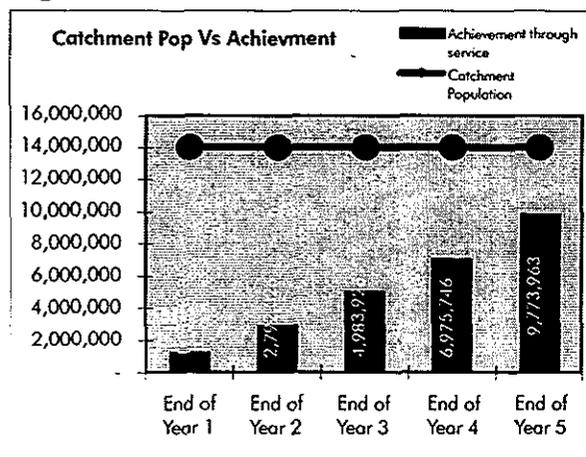
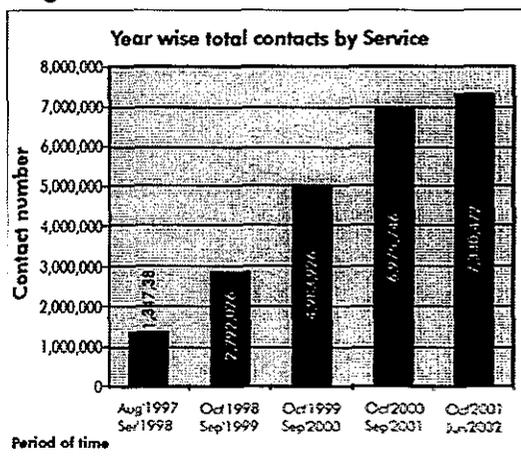


Figure 26i



UFHP Clinic Performance (August 1997 June 2002)

ESP	Aug. 1997 - Sep. 1998	Oct. 1998 - Sep. 1999	Oct. 1999 - Sep. 2000	Oct. 2000 - Sep. 2001	Oct. 2001 - Jun. 2002	Total	
Component	14 Months	12 Months	12 Months	12 Months	9 Months	59 Months	
CH	410,091	674,111	1,351,429	2,171,910	2,190,709	6,798,250	
RH	FP	396,879	819,330	1,283,264	1,685,930	1,517,938	5,703,341
	Non-FP	197,322	624,497	1,483,917	2,448,998	2,478,223	7,232,957
RH Total	594,201	1,443,827	2,767,181	4,134,928	3,996,161	12,936,298	
CDC	37,778	11,801	2,125	9,478	12,577	73,759	
LCC	305,311	662,287	863,191	659,430	1,131,025	3,621,244	
ESP Total	1,347,381	2,792,026	4,983,926	6,975,746	7,330,472	23,429,551	
NID	47,570	904,376	1,801,026	2,882,656	1,042,494	6,678,122	
Vitamin-A	127,206	463,364	1,165,815	1,388,592	800,000	3,944,977	
ESP Total with NID	1,522,157	4,159,766	7,950,767	11,246,994	9,172,966	34,052,650	

Table-4

**UFHP Final Expenditures Figures (as of 22 August 2002)
CA No. 388-A-00-96-90025-00 thru 09**

Cumulative Expenditure total to Date	US\$
Personnel	3,355,877
Travel	806,863
Equipment	294,044
Supplies	126,951
Contractual	21,651,609
Others	981,094
Total Direct Cost	27,216,438
Indirect Charges	1,055,357
USAID-funded Sub-total	28,271,794

Cumulative Expenditure Breakdown by Phase	
Design/Transition Phases (19 September 1996 30 June 1997)	489,023
UFHP Project Year 1 (1 July 1997 30 September 1998)	4,569,767
UFHP Project Year 2 (1 October 1998 30 September 1999)	5,217,004
UFHP Project Year 3 (1 October 1999 30 September 2000)	5,930,389
UFHP Project Year 4 (1 October 2000 30 September 2001)	7,257,510
UFHP Project Year 5 (1 October 2001 22 August 2002)	4,808,100
	28,271,794

Budget to Date by Phase	
Design/Transition Phases	561,364
UFHP Project Year 1 5 (July'97 June '02)	27,903,963
	28,465,327

Obligations Made to Date	
Original made 19 September 1996 (for period to 30 August 1997)	244,476
Modification 1 made 8 May 1997 (for period to 30 August 1997)	316,888
Modification 2 made 31 July 1997 (for period to 30 September 1998)	7,190,398
Modification 3 made 9 March 1998 (for period to 31 December 1998)	2,000,000
Modification 4 made 11 June 1998 (for period to 31 December 1999)	5,933,751
Modification 5 made 9 September 1998 (for period to 30 June 2000)	1,200,000
Modification 6 made 17 June 1999 (for period to 31 July 2000)	500,000
Modification 7 made 30 August 1999 (for period to 28 Feb 2001)	1,200,000
Modification 8 made 30 August 2000 (for the period to 30 June 2001)	3,063,748
Modification 9 made 13 June 2001 (for the period to 30 June 2002)	6,816,066
	28,465,327

**Funds Remaining at End of Project - 22 August 2002
(Obligations less expenditures) 193,532**

UFHP/JSI Expenditure Statement (US\$)

(From Inception to 22 August 2002))

Budget Line Item	Design	Year 1	Year 2	Year 3	Year 4	Year 5	Total Expenditure
	Sep'96- Jun'97	July'97- Sept'98	Oct'98 - Sept'99	Oct'99 - Sept'00	Oct 00 - Sept 01	Oct 01 - Aug 02	
a. Personnel	101,912	662,835	528,510	713,611	810,056	538,953	3,355,877
UFHP Local Hire Staff	2,120	164,255	224,599	305,892	369,113	349,114	1,415,093
UFHP International/Expat Staff	-	284,060	200,181	226,519	329,946	129,445	1,170,152
Offshore Staff (JSI/Boston)	98,689	139,275	85,548	129,376	87,684	53,988	594,560
Consultants (local + Int'l)	1,103	75,245	18,182	51,824	23,314	6,405	176,073
b. Benefits (included with Personnel)	-	-	-	-	-	-	0
c. Travel	72,846	126,825	161,441	171,102	172,220	102,429	806,863
International Travel	69,145	47,603	54,383	77,559	72,138	25,475	346,303
In-country Travel	3,701	63,217	83,515	64,373	86,308	67,507	368,621
Transport Operating Costs	0	16,005	23,543	29,170	13,774	9,446	91,939
d. Equipment	3,816	104,832	63,314	67,752	50,362	3,968	294,044
e. Supplies	0	30,380	24,737	30,505	27,202	14,126	126,951
f. Contractual	0	3,355,762	4,060,658	4,603,832	5,776,671	3,854,686	21,651,609
Service Delivery NGOs	0	2,563,615	3,037,804	3,570,137	4,841,938	3,240,229	17,256,724
BCCP	0	423,211	605,000	765,000	670,000	438,710	2,901,921
PSTC	0	205,295	169,519	128,289	156,794	116,965	776,862
CWFD	0	67,641	44,874	72,153	72,135	58,782	315,585
Contract-out Activities	0	96,000	203,461	68,253	32,803	0	400,517
g. Construction	-	-	-	-	-	-	0
h. Other Direct Costs	241,366	48,585	198,373	126,842	181,505	181,423	981,094
Office Rent/Utilities	207,058	-10,225	116,672	6,588	71,755	20,148	411,996
Communications	4,895	20,907	25,355	25,289	21,214	17,271	114,930
Repair/Maintenance	22,380	1,520	175	3,884	5,933	3,319	37,211
Other Programme Costs	6,650	31,222	30,253	36,777	74,609	81,696	261,207
Staff training	0	2,483	25,887	16,787	1,545	0	46,702
Training Offered (workshop)	0	2,220	31	34,782	9,449	38,447	84,930
Evaluation/Audit	383	458	0	2,735	0	20,541	24,117
i. Total Direct Costs	419,940	4,329,219	5,037,033	5,713,644	7,021,017	4,695,584	27,216,437
j. Indirect costs	69,083	240,548	179,971	216,745	233,493	112,517	1,055,357
k. SUB-TOTAL USAID AMOUNT	489,023	4,569,767	5,217,004	5,930,389	7,257,510	4,808,100	28,271,794
NGO Revenue (Cash Contribution)	0	76,750	123,633	514,001	151,252	177,468	1,043,104

Appendix 1: Bibliography of UFHP project documents

Contract / Consultancy Reports

Annual Work Plan/Revised/USAID (October 1997)
Annual Work Plan/Revised/USAID (October 1998)
Annual Work Plan/Revised/USAID (October 1999)
Annual Work Plan/Revised/USAID (October 2000)
Annual Work Plan/Revised/USAID (October 2001)
Annual Work Plan (November 1999)
Annual Work Plan (November 2000)
UFHP Semi-annual performance Report to USAID (May 1998)
UFHP Semi-annual Report to USAID, Dhaka (April 1999)
UFHP Semi-annual performance Report to USAID (May 2000)
UFHP Semi-annual performance Report to USAID (May 2001)
Unit Cost Analysis Consultancy Report (March 2000)
UFHP's HIV/AIDS Programme 2000-2001; A Consultancy Report on voluntary HIV Counseling and Testing (VCT) at UFHP Clinics (April 2000)
Assessing UFHP's Franchising Options (Final Report) (June 2000)
Pricing Strategy for Clinical Services; Study Findings and Action Proposals (July 2000)
Internal Mid-Term Review of the UFHP, Dhaka, 17-19 September 2000 (September 2000)
Review of Sterilization Services in Bangladesh, 14 October to 01 November 2000; an assessment report (Nov 2000)
A Health Insurance Consultancy report (Dec/Jan 2001)
Activities undertaken by GOB and other Partners in implementing Reproductive Rights and Reproductive Health Recommendations (Feb 2001)
A Report on Internal Evaluation of UFHP's HIV/AIDS Program (March 2001)
Monthly MIS report (Send to USAID in every month)
Quarterly Financial Report (Sent to USAID from August 1997 to June 2002)

Guidelines/ Training Curriculum

A facilitator's Guide to Strategic Planning for NGOs (August 1998)
UFHP's Current Non-financial Policy Guideline (June 1998)
Strategic Planning for NGOs (August 1998)
Rules and Procedures for Managing Revolving Drug Funds (September 1998)
NIPHP's MIS: A User Manual for UFHP NGOs/ Bangla (July 1998)
BCC and Marketing: Developing a Joint Plan / Bangla (July 1998)
RDF Manual- Rules and Procedures for Managing Drug Funds (September 1998)
Structured Communications (October 1998)
Exercise Booklet on Structured Communications (October 1998)
NIPHP: Quality Assurance (QA) Visit Guidelines & Checklist for UFHP Supported NGO Clinics; FY 1999-2000 (May 1998)
UFHP policies and Procurement Manual (May 1998)

UFHP Team Building and Motivation Workshop for NGO Staff: A Facilitators Guideline (June 1998)
Implementation of Revolving Drug Funds: Using Monitoring-Training- Planning (MTP) Techniques (September 1998)
Implementation of Revolving Drug Funds: Using Monitoring-Training- Planning (MTP) Techniques (Bangla) (September 1998)
IPC/Counseling Training Guide (December 1998)
Facilitation Skills (January 1999)
Team and Partnership Development for Project Directors, NGO Committee Colleagues and UFHP Staff (February 1999)
Guidelines for Performance Appraisal Systems (June 1998)
HIV/AIDS Communication Counseling (Bangla) (August 1999)
Standardized Guidelines for Preparation of Personnel Policies of UFHP funded NGOs (March 2001)
Adolescents' Reproductive Health Curriculum (March 2002)
BCC/M refresher Curriculum (2001)

Survey / Research / Study Documents

Catchments Areas for UFHP Clinic (February 1998)
Improving Coordination of Family Health Services in Urban Areas (May 1999)
Health Sector Study of the Urban Industrial Workers in Bangladesh (November 1999)
UFHP Baseline Survey (UFHP NGO Impact Assessment Survey 1998) (Nov 1999)
NIPHP Clinical Quality Definition/Achievement Study (Nov 1999)
Health Seeking Behavior, Willingness and Ability to Pay for Selected Health Services in Urban Family Health Partnership (UFHP) Areas of Bangladesh (February 2000)
A Study to Understand Current Popular Perceptions of IUD (August 2000)
A Study on Customer Satisfaction Monitoring at UFHP Clinics (September 2000)
Adolescent and Reproductive Health: A baseline study from selected urban areas of Bangladesh (Nov 2000)
Assessment of Met and Unmet Reproductive and Child-Health Needs of Clients of Urban Family Health Partnership (draft) (March 2001)

Other Documents

Adolescent Health Programme (Bangla)
An NGO Visit Checklist for NGO Liaison Officers of UFHP (September 1997)
Profile of Urban Family Health Partnership (September 1997)
A Standard Equipment List for UFHP Clinics (December 1997)
UFHP Personnel Policy (January 1998)
Achieving a Common UFHP Writing Style (November 1998)
Exercise Booklet-Writing Style Course; exercises to accompany writing style course (November 1998)

Adolescent Health Programme (Bangla) (May 1999)
BCC/Marketing Strategy 1999-2002; Framework for Action Planning (September 1999)
The UFHP Retreat, 3-6 December 1999; A Summary Results (January 2000)
Building Urban Slum Teams Towards Health Initiative (BUSTTI); (June 2000)
From Home to the Clinic: The Next Chapter in Bangladesh's Family Planning Success
Story Urban Sites; Empowerment of Women Research Program (June 2000)
A Catalogue of UFHP Training Programs 2000-2001; Booklet to Accompany UFHP
Annual Calendar (October 2000)
A Directory: UFHP Service Delivery Locations-2001 (Feb 2001)
The UFHP Retreat 24-26 February 2001; A summary of results (March 2001)
The UFHP Retreat 2002; A summary of results (April 2002)
UFHP Urban Star / 1st Issue (August 2001)
UFHP Urban Star / 2nd Issue (November 2001)
UFHP Urban Star / 3rd Issue (February 2001)
UFHP Urban Star / 4th Issue (May 2001)
UMIS- Record Keeping and Reporting (May 2001)
UFHP- NGO Executive Committee Retreats, Summary Report (August 2001)

Appendix 2: The Urban Family Health Partnership Project Team

Principal Collaborators of the Government of Bangladesh

- **Ministry of Health and Family Welfare**
- **Ministry of Local Government Rural Development and Cooperatives**
- **Directorate of Health Services**
- **Directorate of Family Planning**
- **National Institute of Population Research and Training (NIPORT)**
- **NGO Affairs Bureau**

Principal Collaborators of USAID Cooperating Agencies

- **PHN Team with other officials of USAID/Dhaka**

Dr Richard Brown Mission Director (until 1998)
Mr Gordon West, Mission Director (until 2001)
Mr Gene V George, Mission Director (from 2002)
Ms Lisa Chiles, Deputy Mission Director (until 1997)
Ms Ann Arness Deputy Mission Director (until 2000)
Ms Mary C Ott, Deputy Mission Director (from 2000)
Mr Davit Piet, Team Leader, PHN
Ms Margaret Neuse, Team Leader, PHN
Mr Richard Green, Dy. Team Leader, PHN
Mr Jay Anderson, Team Leader, PHN
Mr Charles Llewellyn, Deputy Team Leader
Ms Polly Gilbert, Cognizant Technical Officer
Ms Maureen A Shauket, Regional Agreement Officer
Ms Hermina Pangan, Controller, USAID
Mr Matthew S Friedman, Program Coordinator HIV/AIDS
Mr Aboul Quasem Bhuyan, Cognizant Technical Officer
Mr Moslehuddin Ahmed, Cognizant Technical Officer
Dr Sukumar Sarker, Project Management Specialist
Mr Shiril Sarcar, Activity Manager
Dr Kanta Jamil, Programme Coordinator
Mr Nasiruzzaman, Program Specialist
Dr Zerine Khair, Project Management Specialist
Mr Kishan Chakroborty, Cognizant Technical Officer
Mr Sk Belayet Hossain, Cognizant Technical Officer
Mr Rafiqul Islam, Acquisition Specialist
Mr Asif Ali Khan, Financial Specialist

- **Cooperating Agencies**

EngenderHealth/QIP: Dr Abu Jamil Faisal, Country Representative
PATHFINDER International/RSDP: Dr M Alauddin, Country Representative

Driver/JSI: Mr Nurul Hossain, Chief of Party
IOCH/MSH: Dr Pierre Claquin, Chief of Party
PRIME II: Dr Shalini Shah, Acting Chief of Party
ICDDR,B: Dr David Sack, Director
Population Council: Dr Ubaidur Rob, Resident Representative
Social Marketing Company: Mr A Z Khan, Managing Director
UPHCP: Dr Nurul Islam, Project Director
NIPHP: Mr Syed Shamim Ahsan, Senior Policy Advisor

● **UFHP Management Partners**

PSTC: Mr Abdur Rouf, Executive Director
CWFD: Ms Mufaweza Khan, Executive Director
BCCP: Mr Mohammad Shahjahan, Director

● **JSI Resident and Support Team**

Dr Ahmed Al-Kabir, Chief of Party (April 2000- June 2002, Deputy Chief of Party July 00 - March 02)
Ms Aleya Nayeem, Technical Support Coordinator (May 00-June 02)
Ms Amy Cullum, Head Documentation and Dissemination (April 00 - June 02)
Dr Anne Roy, Technical Support Coordinator (August 98- June 02)
Md Arif, Driver (September 97 - 31 March 02)
Mr Arun K Chowdhury, Finance Officer (August 97- June 02)
Dr Arzumand Akhter, Technical Support Coordinator (September 98 - June 02)
Mr Asad-uz-Zaman, Documentation & Information Officer (April 2000 June 2002)
Mr Ashfaque Iftekhar Khan, Systems Administrator (February 98 Mar'01), Consultant (Mar'02 June'02)
Mr Charles D Reberio, Messenger (August 97 - June 02)
Dr Hashina Begum, HIV/AIDS Program Coordinator/TSC (October 97 - June 02)
Dr Ikhtiar U Khandaker, Technical Support Coordinator (October 98 - June 02)
Dr Iqbal Anwar, Program Specialist NGO Sustainability, ID and Coordination (September 98- June 02)
Mr Isaac Serao, Driver (August 97 - June 02)
Dr Ishtiaq S Joarder, Technical Support Coordinator (October 97- June 02)
Md Kabil Uddin, Messenger (December 97- June 02)
Mr Kazi Rejaul Alam, Systems Associate (April 00 - June 02)
Mr Kishore Kumar Nag, Senior Secretary (August 97 - June 02)
Mr Kumar Prithwiraj Nath (Rajan), Documentation & Dissemination Officer (April 00 - June 02)
Md Lokman Bhuyan, Driver (August 97- June 02)
Ms Lousia Gomes, Training Coordinataor (August 97- January 00)
Ms Mahmuda Farzana Akhter, Outreach Program Coordinator (February 01 - April 02)
Mr Muhammad Zahid Hossain, BCC and Marketing Planner (September 97 - June 02)
Dr Nadira Sultana, Technical Support Coordinator (October 98 - June 02)
Mr Nikhil K Datta, Associate COP Finance and Contracts (August 97 - June 02)

Mr Nirmal Gomes, Driver (January 00 - June 02)
 Mr Omar Farooque, Manager Facilities and Equip Mgt (July 97 - June 02)
 Mr Peter J Connell, Chief of Party (July 97 April 00)
 Mr Quasem Bhuyan, Program Adviser (November 99 - June 02)
 Dr Rabeya Khatun, Technical Support Coordinator (June 00- June 02)
 Ms Radia Tashfique Pretty, Telephone Operator (September 01 - June 02)
 Mr Rezaul Karim, Grants Specialist (June 97 - June 02)
 Ms Rokhsana Reza, Technical Support Coordinator (November 99 - June 02)
 Ms Roxana Parveen, Training Officer (February 00 - June 02)
 Dr Rukhsana Haider, Associate COP, Technical (January 00 - June 02)
 Dr Sadia D Parveen, Technical Support Coordinator (February 98 - June 02)
 Dr Salim Ahmed , Technical Support Coordinator (April 00 - June 02)
 Mr Sekander Khan, Secretary (July 97 - June 02)
 Dr Setara Rahman, Reproductive Health Coordinator (November 99 - June 02)
 Mr Shah Md Salim, Driver (April 01 - June 02)
 Mr Shah Mohammed Yousuf, MIS Officer (March 01 - June 02)
 Ms Shamme Islam, Finance Associate (September 99 - June 02)
 Ms Shamsun Nahar Ahmed, Technical Support Coordinator (June 1997 - June 02)
 Dr Shams-uz-Zoha, Technical Adviser (August 01 - May 02)
 Mr Sharif Salauddin, Office Services Officer (July 97 - June 02)
 Mr Sheikh Mohd Abdul Amin, Systems Officer (January 98 - June 02)
 Mr Sukanta Dutta, IS Associate (January 01 - June 02)
 Ms Susan Friedrich, Deputy Chief of Party (August 00 August 01)
 Mr Syed Anwarul Islam, Program Advisor (November 01 - June 02)
 Ms Syeda Shahina B Bari, Secretary (August 97 - June 02)
 Dr Tariq Azim, Research Coordinator (December 00 - June 02)
 Mr Yousuf Bhuyan, Messenger (April 00 - June 02)
 Dr Zeenat Sultana, Technical Support Coordinator (September 00 - June 02)

● **JSI/Boston**

Dr Richard Moore, Senior Advisor (July 97-June 02)
 Mr Ken Olivola, Director, International Division (January 00-June 02)
 Mr Sharmarke Osman, Project Coordinator (June 0-June 02)
 Ms Alyssa Karp, Project Coordinator (January-August 01)
 Ms Sarah Littlefield, Finance Manager (May 01-June 02)
 Ms Lousia Gomes, Project Coordinator (May 00 - December 01)
 Ms Amy Deschaine, Project Coordinator (June 99-June 02)
 Dr Claudia Morrissey (February 99-December 01)
 Ms Amy Cullum, Project Coordinator (July 97-March 00)

References

Mitra and Associates, 2002. "2002 Urban Family Health Partnership (UFHP) Evaluation Survey, Preliminary Report" (draft). Mitra and Associates, Dhaka, Bangladesh, and MEASURE Evaluation, University of North Carolina, Chapel Hill, USA. May 2002.

"Bangladesh Maternal Mortality Survey (BMMS)". National Institute of Population Research and Training (NIPORT), Dhaka, Bangladesh. 2001.

"Bangladesh Demographic and Health Survey (BDHS) 1999 - 2000". National Institute of Population Research and Training (NIPORT) and Mitra and Associates, Dhaka, Bangladesh and ORC MACRO, Calverton, Maryland USA. May 2001.

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World Health Organization, 1997. "Post-abortion Family Planning: A practical guide for program managers". WHO, Division of Reproductive Health, (Technical Support). WHO, 1997.