

**Putting
Reengineering
into Practice:
A Guide to Designing
and Evaluating
USAID Population,
Health and Nutrition
Initiatives**

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**Population Technical
Assistance Project**

**Managed by BHM International
in association with
The Futures Group International
under USAID contract
No. CCP-C-00-93-00011**

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**P O P T E C H
T O O L S
S E R I E S**

**PUTTING REENGINEERING
INTO PRACTICE:
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OCTOBER, 1998

PRODUCED BY THE POPULATION TECHNICAL ASSISTANCE PROJECT (POPTECH)
POPTECH IS MANAGED BY BHM INTERNATIONAL IN COLLABORATION WITH
THE FUTURES GROUP INTERNATIONAL UNDER USAID CONTRACT No. CCP-C-00-93-00011





ABOUT THE POPTECH TOOL SERIES

POPTECH provides consulting support to USAID on design and evaluation of USAID-funded population and reproductive health projects. The POPTECH Tool Series comprises several analytic “tools” designed to support and enhance the expertise of POPTECH consultants, promote consistency and quality across reports, and provide assistance to the Global Bureau and Mission staff. These tools include checklists and papers that focus on issues central to the design and evaluation of family planning and reproductive health projects. *POPTECH Technical Assistance to USAID Missions on Results Frameworks: A POPTECH Reengineering Tool* is the third tool in the series.

ABOUT THE AUTHORS

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PREFACE

The audience for this manual is POPTECH consultants working with the United States Agency for International Development (USAID) to design population, health, and/or nutrition (PHN) Results Frameworks, Results Packages, or their components. Two case studies of POPTECH assistance to USAID PHN Teams, one in Benin and one in Bangladesh, serve as the basis for the manual. POPTECH believes these examples are useful because reengineering has changed the planning and design process; it is important for consultants to understand the new procedures, requirements, and language. Understanding USAID's four core values of teamwork and participation, customers and customer focus, results orientation, and empowerment is essential. However, while there is a great deal that is new in reengineering, experienced health professionals will recognize in the four core values practices that are standard in the field. PHN professionals have long been committed to teamwork, clients, results, and empowerment.

Throughout this manual, POPTECH has used, with permission, graphics and text prepared for the USAID/Center for Development Information and Evaluation (CDIE)/Division of Performance Measurement and Evaluation (PME) Summer Seminar in Strategic Planning & Performance Measurement Workshop, developed by Management Sciences International of Washington, D.C. We thank CDIE and Management Sciences International for their generous sharing of these materials.

We would also like to thank Mr. David Piet, Director of the PH Team in USAID/Bangladesh; USAID/Bangladesh; Ms. Susan Woolf, Family Health Team Leader in USAID/Benin; and USAID/Benin. This manual could not have been developed without their support, which included graciously allowing us to use their programs as case studies.



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ACRONYMS

ADS	Automated Directives System
AIDW	United States Agency for International Development/ Washington
CA	Cooperating Agency
CDE	Center for Development Information and Evaluation
DHS	Demographic and Health Surveys
R	Intermediate Result
MCH	maternal and child health
MSI	Management Sciences International
NGO	nongovernmental organization
PH	Population and Health
PHN	population, health, and nutrition
PME	Division of Performance Measurement and Evaluation
POPIECH	Population Technical Assistance Project
REDSOWCA	Regional Economic Development Support Office/ West and Central Africa
RA	Request for Applications
RP	Results Package
R4	Results Review and Resource Request
SO	Strategic Objective
SID	sexually transmitted disease
SII	sexually transmitted infection
SWOT	strengths, weaknesses, opportunities, and threats
USAID	United States Agency for International Development

REENGINEERING CORE VALUES

1. Teamwork and Participation

- 1 Empowered teams composed of:
 - q Missions
 - q Bureaus
 - q Partners
 - q Customers

2. Customers and Customer Focus

- 1 Customer participation in planning, achieving, and judging
- 1 Elimination of processes that do not add customer value
- 1 Flexible, rapid, and responsive development assistance

3. Results Orientation

- 1 Value more than cost
- 1 Managing for achievement
- 1 Resource allocation based on results
- 1 Commitment throughout the agency

4. Empowerment

- 1 Delegating authority
- 1 Accepting accountability

1. BACKGROUND

HISTORY

The Clinton Administration has been seeking to make federal agencies more innovative, successful, and responsive to customer needs through reengineering and reinvention initiatives. Central to these initiatives are new directions, presented in the Automated Directives System (ADS), for the way agencies plan, implement, and monitor programs. Previous practices are regarded as cumbersome, focused on inputs and involving too much paperwork. Reengineering builds on the concept of “best practices” and on information technology, with the intent of making procedures and processes more streamlined, more results-oriented, and more customer-focused. Reengineering is based on four core values: (1) teamwork and participation, (2) customers and customer focus, (3) results orientation, and (4) empowerment.

WHAT'S DIFFERENT

Professionals working for USAID in population, health, and nutrition (PHN)—whether in the Foreign Service or Civil Service, as direct hires or as contractors or consultants—have been successfully planning and monitoring, and achieving significant results, for many years. Their efforts and their concern for health status, client rights, and quality of care, combined with the efforts and the commitment of host-country colleagues and counterparts, other donors, communities, and countless individuals, have led to significant achievements. For example, USAID's Office of Population and Office of Health and Nutrition have contributed to the following results:

- u Between 1980 and 1995, child mortality in developing countries declined from 165/1,000 live births to 116/1,000, while infant mortality declined from 107/1,000 to 74/1,000.¹
- u An estimated 8.3 million children's deaths were averted globally from 1986 to 1993 as a result of the use of oral rehydration therapy.²
- u USAID increased the availability and utilization of reproductive health services up to 300 percent in selected areas in five African countries through the analysis of service system and human resource deficits, the performance-based training of service providers, and the introduction of new supervisory methods and standards.³ The agency has made a major contribution to the long-term decline in fertility and the long-term increase in contraceptive prevalence in the region.

¹ *Saving Lives Today and Tomorrow: A Decade Report on USAID's Child Survival Program*, USAID, December 1996.

² *Ibid.*

³ *Reproductive Health Programs Supported by USAID: A Progress Report on Implementing the Cairo Program of Action*, USAID, May 1996.

- u Ten of USAID's 24 HIV emphasis countries have adopted or implemented guidelines for syndromic management of sexually transmitted infections (STIs), up from one country in 1991.⁴

These examples emphasize the obvious: PHN professionals cared about customers, participation, results, and empowerment long before they became officially identified as core values. What is different now is:

- u Greater participation at every level and stage of the planning process.
- u Joint planning and programming.
- u More explicit linkage between achievement of results and budgeting.
- u Terminology and language for the management processes involved.
- u Easier access to information.
- u Fewer—only two—documents to USAID/Washington:
 - s Strategic Plan
 - s Results Review and Resource Request (R4)

This manual presents an overview of the reengineered process for designing USAID's PHN interventions. Since each USAID mission is empowered to undertake this process in its own way, the specific process followed varies greatly from country to country. Nonetheless, following a brief discussion of the Strategic Plan in Section 2, Sections 3 through 5 review, respectively, the common elements of three of the four core values: teamwork and participation, customers and customer focus, and results orientation. (Because this is a tool intended primarily for POPTECH design and evaluation consultants, the authors have not written about the core value of empowerment, which is more relevant to project implementation). Section 6 looks at the important issue of performance measurement, while Section 7 lists some key lessons learned about reengineering efforts. Appendices 1 and 2 present case studies of the design process in Benin and Bangladesh, respectively. Because the latter was a 6-month process to design a large (\$210 million) project, it is described at length in the belief that this richness of detail is the best way to convey the practical application of the concepts described in Sections 1 through 7.

⁴ *Ibid.*

2. THE STRATEGIC PLAN

USAID'S APPROACH TO STRATEGIC PLANNING AND PERFORMANCE MEASUREMENT

- 1 **Emphasize results.**
- 1 **Increase focus, and choose strategies and resources strategically.**
- 1 **Measure and report on results.**
- 1 **Analyze performance information to learn, replan, and improve performance.**
- 1 **Use performance information to tell USAID's story.**

Strategic planning is a disciplined effort to identify fundamental decisions and actions that shape what an organization (or other entity) is, what it does, and why. At its best, strategic planning requires “broad-scale information gathering, an exploration of alternatives, and an emphasis on the future implications of present decisions.”⁵

Typically, in strategic planning organizations ask:

- u Where are we going? (mission)
- u What is our vision of success? (vision)
- u How do we get there? (strategies)
- u What is our blueprint for action? (plans and budgets)
- u How do we know if we are on track? (monitoring system)

Strategic Plans are developed at the country, regional, and global levels. The Strategic Plans developed at the regional and global levels are designed to be supportive of plans at the country level. The country-level strategic planning process is illustrated in the graphic below.⁶ Most POPTECH consultants are involved with one particular component of a country Strategic Plan—the Results Framework. Results Frameworks are discussed in detail in Section 5.



⁵ J. M. Bryson, *Strategic Planning for Public and Nonprofit Organizations*. Jossey-Bass Publishers, 1989.

⁶ USAID defines the Strategic Plan as “the framework that an operating unit uses to articulate the organization’s priorities, to manage for desired results, and to tie the organization’s results to the customer”. (USAID CDIE/PME Summer Seminar in Strategic Planning and Performance Measurement Workshop, p.5). Management Systems International (MSI) has kindly allowed POPTECH to use many of its materials for this manual, including this graphic.



USAID/Washington (USAID/W) approval of a country Strategic Plan leads to a management contract, which includes the following elements:

- u Agreement on objectives
- u Confirmation of estimated resources over the strategy period
- u Provision of appropriate delegations of authority
- u Special management concerns requiring action

3. TEAMWORK AND PARTICIPATION

DEFINITIONS

As noted in Section 1, teamwork and participation is one of USAID's four core values. **Teams** may include USAID staff, partners, stakeholders, and customers. **Partners** work directly with USAID to affect the circumstances of customers. **Stakeholders** influence the circumstances of customers, but are not directly funded by USAID. **Customers** are the intended end users of U.S. assistance.

TEAMS AND PARTNERS IN DESIGN: CASE STUDY EXAMPLES

In the recent 3-week design of the Benin Family Health Results Framework, the USAID/Benin Family Health Team steered the Results Framework design process, with the team members, both expatriate and Beninois, being intimately involved from beginning to end. Representatives from USAID/W and from the Regional Economic Development Support Office/West and Central Africa (REDSO/WCA) were on the design team, which was complemented by a two-person POPTECH consultant team and a Francophone African facilitator. The Benin Ministry of Health was the key partner.

In the recent design of the large (\$210 million) Bangladesh National Integrated Population and Health Program (NIPHP), multiple teams and multiple partners were involved over the 6-month design process. Previously, USAID/Bangladesh had restructured its offices to form “empowered teams” including technical, program, contract, and budgeting staff. The Population and Health (PH) Team was composed of a “core team,” all from USAID/Bangladesh, and “virtual team members” including USAID/Bangladesh specialists, such as the legal advisor and USAID/W staff from the Office of Population, the Office of Health and Nutrition, and the Asia/Near East Bureau. The PH Team worked under a written PH Team Charter—“PH Design Team Principles and Common Agreements”—and held periodic meetings. A three-person consultant team, hired through contracts with the Southeast Asia Office of Arthur D. Little, Inc., and POPTECH, assisted the PH Team over the 6-month period.

As in Benin, the key USAID partner in this bilateral agreement was the Ministry of Health and Family Welfare. Other essential partners in the design process were seven Cooperating Agencies (CAs), three of which had internal partnerships. Thus a total of twelve organizations had to work in close collaboration with each other, USAID, and the Government of Bangladesh. From the time the design process began with the issuance of the Request for Applications (RFA), USAID informed all the parties involved that the NIPHP would be a partnership, with all of the CAs dependent upon each other to achieve their own objectives, as well as those of the program.

4. CUSTOMERS

DEFINITIONS

A customer is an individual or group that receives services or products from USAID, benefits from USAID programs, or is affected by USAID actions.

- u Ultimate Customer—USAID’s ultimate customers are those who are end users or beneficiaries of USAID programs.
- u Intermediate Customer—USAID’s intermediate customers are persons or organizations, internal or external to the agency, that use USAID services, products, or resources to serve the needs of their own intermediate or ultimate customers.

USAID/Bangladesh defined its ultimate customers as “socially and economically disadvantaged Bangladeshis.” In contrast, the International Center for Diarrheal Disease Research, Bangladesh, the CA chosen by USAID/Bangladesh for the operations research component of the NIPHP, defined its intermediate customers as the other six partners in the program, the Ministry of Health and Family Welfare, and the nongovernmental organizations (NGOs) that will be providing services directly.

CUSTOMER SERVICE PLAN

USAID reengineering guidance specifies that all operating units in USAID should develop a Customer Service Plan and should report annually on their effort to assess and meet customer needs.⁷

CUSTOMER SERVICE PLAN

The Customer Service Plan presents the operating unit’s vision for including customers and partners to achieve its objective. This plan is a management tool for the operating unit and does not require USAID/W approval. The plan:

- 1 Identifies the ultimate and intermediate customers for service delivery and segments customer groups for different programs, products, or services.
- 1 Describes appropriate means and provides a regular schedule for assessing service delivery, performance, and customer satisfaction.
- 1 Establishes service principles and specifies measurable service performance standards.
- 1 Indicates staff responsibilities for managing customer service activities—including assessments.
- 1 Specifies the resources required for customer service activities and assessments.

⁷ See *CDIE Performance and Monitoring TIPS*, “Conducting Customer Service Assessments,” Number 9, 1996, for excellent guidance on customer service plans. Much of the discussion in this section is based on that document.



SOURCES OF INFORMATION

There are many ways to collect information on and from customers. These include:

- u Formal customer surveys, such as the USAID-funded Demographic and Health Surveys (DHS).
- u Rapid appraisal methods, such as focus groups, town meetings, and interviews with key informants.⁸
- u Participatory appraisal techniques, in which customers plan, analyze, self-monitor, evaluate, and set priorities for activities.
- u Document reviews, including systematic use of social science research conducted by others.

CASE STUDY EXAMPLE

In its design for the NIPHP, USAID/Bangladesh was able to integrate and build upon information from a variety of sources and methods. Data from the 1993–1994 Bangladesh DHS provided information on key maternal and child health (MCH) indicators that enabled the program partners to identify underserved and low-performing geographic areas of the country. Preliminary data from the 1996–1997 DHS allowed the partners to establish baselines and refine targets. Rapid appraisal methods had produced extensive MCH information over the years and were particularly useful in identifying access, image, and quality issues. Participatory appraisal techniques were used in two USAID customer appraisals, the first in 1995 and a second, validation exercise in 1996. Information from these appraisals underscored that quality of care is an important problem, particularly in the public sector. The program partners also built upon the wealth of literature on MCH in Bangladesh, with which many of the partners had been involved.

⁸ Two useful tools, among many, are M. Debus, *Handbook for Excellence in Focus Group Research*, Academy for Educational Development, Washington D.C. (undated), and K. Hardee et al., *Quality of Care in Family Planning: A Catalog of Assessment and Improvement Tools*, Family Health International, Durham, North Carolina, 1993.

5. RESULTS ORIENTATION

DEFINITIONS

The product of a systematic results orientation is a Results Framework, built upon a solid problem analysis. The Results Framework presents a Development Hypothesis, Strategic Objectives, Intermediate Results, and Subresults. The framework also establishes an organizing basis for measuring, analyzing, and reporting results of the operating unit. It is typically presented in both narrative and graphical form.

- u The **Development Hypothesis** is a tentative explanation accounting for a set of facts that can be tested through further investigation. The Automated Directives System (ADS)⁹ uses the term “Development Hypothesis” interchangeably with “cause-and-effect linkages.”
- u The **Strategic Objective** is the most ambitious result (intended measurable change) that can be achieved by a USAID operating unit, along with its partners, and for which the unit is willing to be held responsible. The timeframe of a Strategic Objective is normally 5–8 years, but it may be shorter for programs operating under short-term transitional circumstances or conditions of uncertainty.
- u An **Intermediate Result** is a key result that must occur in order to achieve a Strategic Objective.
- u A **Subresult** is a building block toward attainment of an Intermediate Result, with a timeframe of 1–5 years.

RESULTS FRAMEWORK

The Results Framework serves many functions. Overall, its development, undertaken with partners, customers, and key stakeholders, builds consensus and commitment. As noted above, a Results Framework is usually in both narrative and graphical form.

As an example, see the graphical excerpt from the Results Framework for the USAID/Bangladesh National Integrated Population and Health Program in Appendix 2 (pages 44–45).

The Results Framework presents and illustrates the Development Hypothesis, and defines the Strategic Objective. It also identifies all major inputs required to achieve the Strategic Objective, including those provided by other development donors. In some cases, particularly those sectors and programs with large and broad donor support, it may be impossible to present the contributions of other donors on the graphic. This was the case in Bangladesh, where many bilateral donors and national and international NGOs are contributing to improved family health.

⁹ The ADS replaced the AID Handbooks as a reference for guidance in procedures for the design, implementation, and evaluation of foreign assistance projects



RESULTS FRAMEWORK—FUNCTIONS



- n Planning
- n Management
- n Communication
- n Building consensus and ownership
- n Reporting



The Results Framework should include, whether on the graphic, in the text, or in accompanying charts, performance indicators and targets, as well as baseline data. Both the USAID/Bangladesh and USAID/Benin Family Health Results Frameworks present such data on accompanying charts (see the case studies in Appendices 1 and 2).

Both USAID/Benin and USAID/Bangladesh have one Strategic Objective in the health sector. USAID/Benin will achieve its Strategic Objective through four Intermediate Results and USAID/Bangladesh through five.

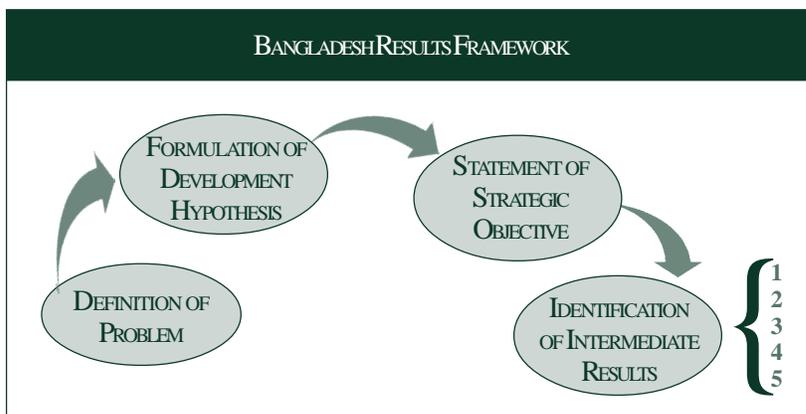
DEVELOPMENT HYPOTHESIS

The basis for the Development Hypothesis is a situational assessment based on sound technical analyses. Different Missions have developed technical analyses and performed problem analysis in different ways, depending on their resources and constraints. One tool frequently used is an analysis of the strengths, weaknesses, opportunities, and threats of a program or part of a program. USAID/Honduras, in the development of its private-sector population program, contracted four POPTECH consultants to conduct such analyses on key issues (clinical care, social marketing, and sustainability, for example). In the design of its Family Health Program, USAID/Benin used health-sector assessments conducted in Benin since 1994 on training, nutrition, family planning, HIV/AIDS, malaria, and safe motherhood practices, as well as surveys of the activities of NGOs and current donor investments in health. USAID/Bangladesh contracted for a compilation of national data and instructed each of the seven CAs that were to implement the USAID-funded program to assess its respective component.¹⁰ In the CA assessments, presented in detail at a design workshop, each CA had analyzed its role and activities, size and growth of services and operations, customers and competitors/collaborators, financial performance, and planning issues.

¹⁰ The seven are urban service delivery, rural service delivery, social marketing, quality improvement, urban immunization, operations research, and contraceptive logistics.

The results of such a situational assessment—including information about customers and assumptions about the future and the role of this USAID program in improving national population and health or nutrition status—are used to develop the Strategic Objectives, Intermediate Results, and Subresults. These elements are naturally interrelated. For example:

- u Problem—In certain rural regions of the country and in urban areas, health status was markedly worse according to standard MCH indicators.
- u Strategic Objective—“Fertility Reduced and Family Health Improved.”
- u Intermediate Result (one of five)—“Use of high-impact family health services in target population increased.”



RESULTS PACKAGE

A Results Package (RP) is the basic managerial concept through which USAID may organize and execute work to achieve results within a specified time and budget. At a minimum, a Results Package includes linkages between results and the activities necessary to achieve those results:

As an operating unit is developing a Results Framework for a Strategic Objective, it will be thinking about what activities will be necessary to achieve the Intermediate Results in the framework. During this process, thought also will be given to how to organize the management of the activities, and this would be the beginning of defining individual RPs. Decisions about RPs would be made once the objective is approved, but RPs can be revised at any time by the operating unit without outside approvals. (Note that some changes to individual activities may require specific approvals, e.g., changes to grants and contracts or to activities, which initially required Washington approval or concurrence.) The entire Results Framework for any one strategic objective may comprise one RP, or a framework may comprise two or more RPs.

RESULTS FRAMEWORK

- 1 Presents Strategic Objective and key Intermediate Results and the cause-and-effect linkages between them.
- 1 Identifies all Intermediate Results necessary to achieve the Strategic Objective, regardless of who is taking responsibility.
 - q Through USAID assistance
 - q Through other development partners
- 1 Includes performance indicators and targets, and baseline data.
- 1 As part of the Strategic Plan, presents the Mission’s Development Hypothesis.
- 1 Serves as a Mission management tool.

The number of RPs for any one framework depends on the complexity of the activities, the number of people involved in managing the work of the operating unit, and the management style of those involved in the work.¹¹

A USAID Mission might organize Results Packages in a number of ways, for example, on the basis of:

- u Personnel or technical competence.
 - s USAID team members or managers
 - s Partners and intermediaries
 - s Intermediate customers
 - s Other implementers
- u Funding mechanisms.
 - s Grants or contracts
 - s Special short-term or other donor sources.
- u Management Issues, such as institutional development

CASE STUDY EXAMPLE

The USAID/Bangladesh Results Framework, with one Strategic Objective and five Intermediate Results, includes seven Results Packages—one for each of the CAs contracted to achieve, as a team, the Strategic Objective and Intermediate Results.

RESULTS PACKAGE
TABLE OF CONTENTS FOR EACH CA PARTNER IN THE BANGLADESH NIPHP
1. CA Mission and Vision Statement
2. Subresults under one or more Intermediate Results
3. Strategies for contributing to achievement of the program's Intermediate Results
4. Action Plan for each Subresult, with Gantt Chart
5. Organigram, Staff Development Plan, and Localization Plan
6. Customer Service Plan
7. Budgets

¹¹ USAID CDIE/PME Summer Seminar in Strategic Planning and Performance Measurement Workshop (p.5)

6. PERFORMANCE MEASUREMENT¹²

USAID REQUIREMENTS

Program performance measurement systems are designed to provide limited performance information—using a few key performance indicators—for each Intermediate Result, as well as the Strategic Objective, set forth in the Results Framework (see Section 5). This information allows the managers to monitor what is being achieved over time so they can judge whether the Development Hypothesis is valid and whether the activities identified to achieve the Strategic Objective are accomplishing the desired results.

Missions are required to report to USAID/W annually on their Strategic Objectives and Intermediate Results, but not on lower-level activities, such as Subresults. The Results Review and Resource Request (R4) is used for this purpose.

The R4 may be a new document to many consultants. It is a most important document because it serves to inform interested USAID parties of program status and to justify future funding. Despite the fact that USAID PHN Teams report to Washington only on their Strategic Objectives and Intermediate Results, they will want to monitor carefully the validity of their Development Hypothesis. For this purpose, they will need performance information at lower levels. Such internal monitoring and evaluation of Intermediate Results and activities may lead the Mission to modify its tactics or even its broader Development Hypothesis.

PARTICIPATION

The strength of a performance measurement system is not in its ability to report on results, but in its ability to provide performance information that is used to *manage* for results. The users of this information include USAID, its partners, and agents who implement USAID programs. Therefore, an effective performance measurement system requires agreement among the members of the PHN Team, its partners, and agents regarding what is to be achieved. To this end, teams are encouraged to include their partners and agents actively in the formulation of performance indicators and in subsequent performance reviews conducted by Strategic Objective teams.

MONITORING

The USAID programs in the PHN sector are fortunate in comparison with newer fields supported by USAID, such as coastal resource management, in having had long and productive experience with monitoring and evaluation systems. Most readers of this manual will

¹² Much of this section is based closely on materials prepared for the *USAID CDIE/PME Summer Seminar in Strategic Planning and Performance Measurement Workshop*, p.5).

THE R4 MUST INCLUDE:

- 1 **Factors affecting program performance**
 - 1 **Progress toward achieving Strategic Objectives**
 - 1 **Status of management contract**
 - 1 **Resource requirements**
-

PARTICIPATION IN PERFORMANCE

- 1 **Performance reviews should include customers and partners when deemed appropriate by the operating unit.**
 - 1 **Customers and partners should be included in planning performance measurement.**
 - 1 **Customers and partners should be involved in collecting and interpreting performance information.**
-

**PERFORMANCE TARGET AND
BASELINE**

1 Performance Target

The specific intended results to be achieved within explicit time-frames, against which actual results will be compared and assessed

1 Performance Baseline

Value of an indicator at the beginning of (and/or prior to) a performance period; used for comparison to measure progress toward a result

have designed, used, or managed such systems. There are, moreover, excellent resources for those seeking additional guidance.¹³ This section is therefore brief.

STRATEGIC OBJECTIVES AND INTERMEDIATE RESULTS WILL:

- 1 Have at least one indicator with which to track performance.
- 1 For each indicator have a baseline and a target.

Several USAID Office of Population manuals produced by the Evaluation Project present and explain indicators useful in reproductive health. There are “strong performance indicators” for safe pregnancy, STDs/HIV, breastfeeding, women’s nutrition, and family planning (including service delivery operations applicable to services other than family planning).

STRONG PERFORMANCE INDICATORS

- 1 Direct
- 1 Objective
- 1 Unidimensional
- 1 Quantitative/qualitative
- 1 Disaggregated when useful (urban/rural; men/women)
- 1 Available
- 1 Practical

CASE STUDY EXAMPLE

The USAID/Bangladesh Strategic Objective is: Fertility reduced and family health improved.

¹³ See, for instance, J. Bertrand, R. Magnani, and N. Rutenberg, *Evaluating Family Planning Programs with Adaptations for Reproductive Health*, The Evaluation Project, USAID, 1996.

STRATEGIC OBJECTIVE:
FERTILITY REDUCED AND FAMILY HEALTH IMPROVED

INDICATOR	SOURCE	ANNUAL MEASURE	BASELINE	TARGET*	RESPONSIBILITY
Reduced total fertility rate	DHS	None	3.4 (DHS 1993-94)		USAID
Reduced infant mortality rate	DHS	None	87 (DHS 1993-94)		USAID
Reduced child mortality rate	DHS	None	50 (DHS 1993-94)		USAID
Increased proportion of pregnancies attended by trained provider (at least two antenatal care visits during pregnancy)	DHS	Number of ANC visits reported to Ministry of Health and Family Welfare management information system (MIS)	20% (DHS 1993-94)		USAID
Increased knowledge by men and women of risks and preventive measures for HIV/AIDS	DHS	None	TBD (DHS 1996-97)		USAID
Night blindness reported among children aged 24 to 59 months reduced	HKINSP**	HKINSP	0.7%		USAID

Notes:

* Targets were still being refined when this case study was developed. Data is required every 3–5 years for Strategic Objectives and every 1–2 years for key Intermediate Results.

** HKI= Helen Keller International. NSP= Nutrition Surveillance Program.

EVALUATION

Government regulations do not require evaluations as a matter of formality. If they will serve no management need (are not needed for management decisions), evaluations should not be conducted. PHN Teams, in consultation with their partners, customers, and senior managers, decide when evaluation is appropriate.

7. POPTECH LESSONS LEARNED

As noted in Section 1, it is important to recognize that each Mission's Results Framework design process is unique. While common principles apply under the basic structure of reengineering, situations in the field vary widely among countries. Whether in terms of national policies and strategies, the size of the program, the available talent pool, the maturity and experience of local NGOs, or the Mission's own priorities, there are myriad ways in which each situation is unique and requires flexible, individualized handling. Nevertheless, the basic elements of good planning and design have been affirmed in reengineering:

- u Fully involve all the relevant partners, stakeholders, and clients (customers), and learn from them; develop consensus, commitment, and ownership (participation). (See Sections 3 and 4.)
- u Understand a program's strengths, weaknesses, opportunities, and threats (situational analysis). (See Section 5.)
- u Specifically identify the problems being addressed, such as high infant mortality or poor quality of care. (See Section 5.)
- u Have a clear understanding of the desired future state and what the program should achieve (vision). (See Section 5.)
- u Develop objectives that represent a significant but realistic mitigation of the problem. (See Section 5.)
- u Identify a series of nesting results and activities that are necessary and sufficient to achieve the objectives. (See Section 5.)
- u Establish an efficient performance measurement system to provide timely, essential, valid data for decision making. (See Section 6.)

Mindful that the Results Framework belongs to the USAID/Mission, its partners, and its customers, a consultant should be sure to provide appropriate guidance so that the Results Framework follows the guidelines shown below.

PLANNING CHECKLIST	
1 Are Strategic Objective/Intermediate Results stated as results?	q
1 Are results unidimensional?	q
1 Are they objectively verifiable?	q
1 Are the relationships between results causal, not definitional/ categorical?	q
1 Are the how/why, if/then relationships direct, plausible, and clear?	q
1 Can the Strategic Objective results be materially affected by USAID programs and activities?	q
1 Are the assumptions reasonable?	q
1 Do the Intermediate Results include partner- as well as USAID- funded results?	q

APPENDIX 1: BENIN CASE STUDY

ACRONYMS



FP	family planning
HIT	Family Health Team
GOB	Government of Benin
IEC	information, education, and communication
MCH	maternal and child health
MIS	management information system
MOH	Ministry of Health
NGO	nongovernmental organization
ORS	oral rehydration salts
POPTech	Population Technical Assistance Project
PVO	private voluntary organization
REDSOWCA	Regional Economic Development Support Office/ West and Central Africa
RFA	Request for Applications
SO	Strategic Objective
SOAG	Strategic Objective Agreement Grant
SII	sexually transmitted infection
SID	sexually transmitted disease
USAID/W	United States Agency for International Development/ Washington



BACKGROUND AND COUNTRY CONTEXT

In March and April of 1997, the Family Health Team of the USAID Mission to Benin undertook the development of a Results Framework as the basis for a program to expand the availability, quality, and use of sustainable family health services in Benin. Since 1990, the Mission has supported selected family health initiatives, such as social marketing, in Benin. This program would be the Mission's first attempt to support a full range of family planning, HIV/AIDS, and child survival activities in one integrated package under its newly created Strategic Objective for Health.

From the outset, the Mission sought to make the Results Framework design process transparent, participatory, focused on results, and fully attuned to the priorities of its partners in the public and private sectors, especially the Benin Ministry of Health (MOH). Benin has made encouraging progress toward meeting the health care needs of its population, notably in raising immunization rates and beginning to achieve reductions in infant mortality. But in other areas of family and reproductive health, such as contraceptive use and maternal mortality reduction, progress has been slow.

The MOH and USAID wanted the proposed new program to focus on the most pressing needs as perceived and articulated by health service providers and clients, and analyzed in a series of health-sector assessments conducted since 1994, many with USAID support. At the same time, they wanted to be certain that any design would be consistent with national policies on the decentralization and integration of health services.



APPROACH AND TIMETABLE

The Mission requested that POPTECH provide consultant assistance in implementing a 3-week design process, centered on a two-day Results Framework presentation workshop attended by providers and decision makers from both public and private sectors. This event was preceded by development of a draft framework, along with detailed workshop planning, and followed by a period of synthesis and finalization of the framework and relevant indicators. The results of these efforts would later form the basis for a Strategic Objective Agreement Grant (SOAG) between USAID and the Government of Benin, and for a Request for Applications (RFA) from potential contractors who would initiate program activities in early 1998 (projected).

By holding to a relatively short timeframe for the design process, the Mission sought to keep the process intensive and focused. In its planning efforts, the Mission hoped to generate positive momentum for development of the family health program as a whole. It also hoped to avoid pitfalls encountered by other Missions when the strategy and Results Framework development process was too drawn out and diffuse.

KEY PARTICIPANTS AND THEIR ROLES

As noted in Section 3, **the USAID/Benin Mission's Family Health Team (FHT)** steered the Results Framework design process, with the team members, both expatriate and Beninois, being intimately involved from beginning to end. In preparation for the 3-week exercise, the FHT prepared a comprehensive set of briefing documents, gathering all health-sector assessments carried out under MOH, Mission, and other agency auspices. It set up and staffed a fully equipped office at a location apart from the Mission, so that the design process could proceed without interruption. Before the actual design process began, the FHT also scheduled and selected a venue for a Results Framework Workshop. In consultation with the MOH and other partners, it issued invitations to over 80 government, private-sector, NGO, and donor agency participants.

The Benin Ministry of Health was the key counterpart participant and partner. Its active involvement in the process was especially apparent during the workshop, in which policymakers and providers at both national and regional levels actively participated. When not directly involved, the MOH was kept regularly informed by the FHT on progress made toward designing the Results Framework and ensuring that it would coincide with the Ministry's own 5-year (1997–2001) National Health Strategy, which it was then in the process of releasing. The Ministries of Planning and of Education were also involved in the process, although to a lesser extent than the MOH.

The two-person core consultant team recruited by POPTECH combined skills in reproductive health and child survival programming, private-sector/NGO experience, substantial experience in West Africa, and French fluency. (The design exercise was conducted, for the most part, in French.) A third full-time position on the team was assumed by a representative of the USAID/W Global Bureau. This person brought to the effort important current perspectives on central USAID priorities, especially in the context of reengineering. A representative from the Regional Economic Development Support Office/West and Central Africa (REDSO/WCA) also sat in on the first phase of the design.

One other key external participant was **a Francophone African (Senegalese) facilitator** who served as a procedural and technical resource for the early stages of the design, coordinated the inputs of consultants and the FHT in planning for the presentation workshop, and facilitated the workshop itself. Having this person involved from the outset (rather than just for the 2-day workshop) was extremely important to the cohesion and efficiency of the process.

STEPS IN THE DESIGN PROCESS

As noted, the Results Framework design process had three distinct phases: preliminary drafting of the framework and workshop preparation, the design workshop itself, and finalization of the draft framework.

PHASE 1: PRELIMINARY DRAFTING/WORKSHOP PREPARATION

For purposes of the drafting exercise, the working Strategic Objective for USAID/Benin's Family Health Program was stated as "improvement of family health in Benin." In developing this Strategic Objective into a Results Framework, the following resources were consulted and discussed by the design group (FHT and consultants):

- u Health-sector assessments conducted in Benin since 1994 on training, nutrition, family planning, HIV/AIDS, malaria, and safe motherhood practices, as well as surveys of the activities of NGOs and current donor investments in health.
- u USAID/Benin Strategic Objectives for Basic Education and Democracy and Governance, for the purpose of identifying potential linkages with the new Strategic Objective for Health.
- u USAID/W program priorities for reproductive health and child survival.
- u The Government of Benin's National Health Plan, in particular its own recently developed strategic framework for a 5-year effort to improve the quality of and access to health services nationwide, and to expand community participation in health decision making.

Review of these resources enabled the group to make a preliminary assessment of the most pressing gaps in family health services and coverage in Benin, and begin selecting potential areas of emphasis along programmatic, technical, and geographic lines. Discussions addressed such issues as the relative importance, given limited resources, of different technical interventions (e.g., malaria prevention and treatment vs. family planning vs. HIV/AIDS prevention); convergence and/or conflict among Mission, REDSO, and USAID/W priorities; and the advisability of focusing all or most program interventions on a few, relatively underserved geographic areas.

Ultimately the group arrived at a framework specifying four Intermediate Results that, if achieved, would meet the Mission's family health Strategic Objective: (1) increasing the use of high-quality family planning services by men and women, (2) reducing the transmission of STIs and HIV, (3) reducing maternal and child mortality and morbidity, and (4) encouraging a positive sociopolitical environment for reproductive health. For political and strategic reasons, the issue of geographic focus was not addressed at this point.

The draft framework set forth the Intermediate Results, Subresults under each, possible activities for achieving the various results, and suggested indicators by which to measure progress. A preamble was drafted, setting the context for the framework in terms of both USAID/Benin's Strategic Objectives and the MOH's national strategy. Once assembled, the full draft became the principal handout for presentation and discussion at the workshop.

Senior officials of the MOH were invited to meet with the design group to receive the draft in advance of the workshop; to provide in turn the latest iteration of the MOH's strategy; and to discuss details of workshop goals, organization, and participation. The detailed discussion among key partners of all aspects of the design exercise was conducive to a spirit of teamwork and ensured that the workshop, the centerpiece of the design process, would go forward on a collaborative note.

PHASE 2: RESULTS FRAMEWORK WORKSHOP

The "Atelier de Presentation du Cadre Stratégique de Santé de l'USAID/Bénin," or Results Framework Workshop, took place April 2–3, 1997, at a hotel in Abomey, 2 hours north of the capital city of Cotonou. While the venue's distance limited participation to some extent, it enabled the 50 to 60 persons who did attend to focus on the agenda with minimal distraction.

In addition to approximately 20 MOH policymakers and providers from the central, regional, and district levels, participants included representatives of the Ministries of Planning and Education, national research institutions, national and regional health NGOs, the United Nations Development Programme, the United Nations Population Fund, other major donors active in Benin, and international private voluntary organizations (PVOs). The USAID FHT and consultants staffed the event, which opened with remarks from the MOH's Under Secretary for Health and the USAID Country Director. The workshop program had three distinct elements:

- u First was a presentation, by senior Beninois researchers and POPTECH consultants, of a health status report on Benin. This report drew on statistics from the recently completed Demographic and Health Survey and the findings of the Benin health-sector assessments and surveys, and set the scene for discussions of the country's health needs and priorities.
- u Next came the formal presentation by USAID of its draft Results Framework, as well as by the MOH of its health strategy, for review, analysis, and discussion by workshop participants.
- u The third, and by far the most substantial, portion of the program was a series of concurrent group discussions, each addressing one of the four Intermediate Results of the Results Framework. Groups (numbering 12 to 15 participants each) were asked to review the framework in general and their own Intermediate Results in particular from several perspectives. They were to:

- s Determine the interrelationships among the various intervention areas of the Results Framework.
- s Critique and prioritize the recommended activities and indicators proposed for that group's Intermediate Results.
- s Suggest one or two program areas that should be USAID/Benin's top priorities in formulating its health strategy, and recommend appropriate partners or collaborators.

The workshop concluded with presentations by each working group of its principal conclusions and recommendations. In addition, USAID and the MOH pledged to continue working closely together, and to keep participants informed of progress toward final program design and implementation.

Enhanced as it was by expert facilitation, the workshop was extremely interactive in every respect. Exchange of information and ideas, rather than one-way communication, quickly became the norm. Participants from the public and private sectors alike, expressing their appreciation for the openness of the process, gave freely of their ideas and recommendations, many of direct relevance to final drafting of the Results Framework. Some of the more significant are noted here. A detailed workshop report is available from the Benin Mission.

- u Close to 50 percent of workshop participants stressed family planning as their top priority program area, while 30 percent put child survival and maternal and child health (MCH) programs at the top of their lists. In terms of disease-specific interventions, the need to combat malaria was mentioned most frequently. The relatively low priority given HIV/AIDS initiatives was striking.
- u In terms of overarching program support, participants expressed strongly the need to improve and expand training capability in all programs and sectors. There was also significant advocacy of continued support for national-level policy dialogue, especially on complex issues such as integration and decentralization.
- u The community as a locus for program planning was emphasized throughout the workshop, whether in developing community-based distribution activities for family planning and AIDS prevention or strengthening community organizations to be more effective advocates for comprehensive health services. The observation was made that a community focus could effectively complement work under USAID/Benin's Strategic Objective for Democracy and Governance.
- u The development of effective collaboration between the public and private sectors was consistently emphasized.

PHASE 3: FINALIZATION OF DRAFT FRAMEWORK

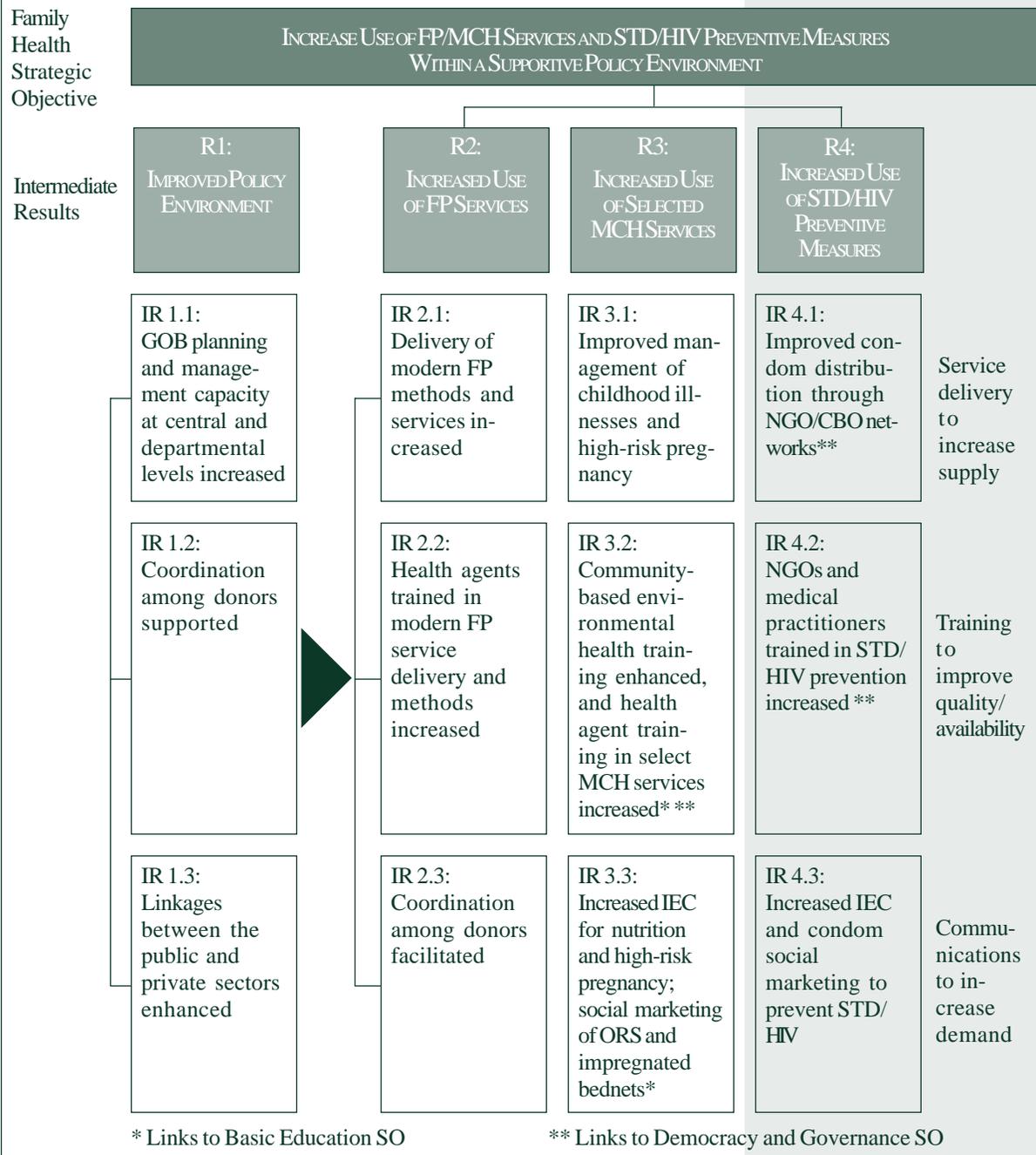
The third and final step in the Results Framework design exercise was to rework the draft framework, taking into account the recommendations and observations that emerged from the workshop. Even then the framework would remain a draft, since upon completion it would still need USAID/Mission and MOH approval, as well as clearance by USAID/W. But it would reflect the best thinking of the FHT, POPTECH consultants, and public- and private-sector partners as to the directions the USAID-funded Family Health Program should take in the coming years.

In many ways, this was the most difficult phase of the design process. The design team had to synthesize all inputs and recommendations with several, sometimes competing, realities in mind, such as:

- u The need to keep the framework as simple as possible, consistent with the needs of an integrated program.
- u The importance of remaining true to the reengineering precepts, consistently maintained during the design process, of participation, transparency, and a customer focus.
- u The need to maintain a results orientation, such that Intermediate Results and projected activities would be susceptible to the establishment of reasonable indicators.
- u The need to craft a program that, depending on decisions reached mutually with the MOH, could support fully integrated family health interventions in one or two regions while retaining some elements of national involvement, such as supporting policy dialogue or immunization campaigns.
- u The importance of identifying a niche in health programming that USAID/Benin can fill—one that is distinct from that of other donors, and perhaps linked to its other Strategic Objectives.
- u The need to take Washington’s priorities into account, such as by retaining an HIV/AIDS prevention component in the program despite its low national priority.

The following matrix is the result of this phase of the design process, and was presented to the Mission at the conclusion of the design exercise with detailed supporting documentation. The working Strategic Objective of “improvement of family health in Benin” evolved to “increase use of FP/MCH services and STD/HIV preventive measures within a supportive policy environment.” Four Intermediate Results were retained. Three of these (R2, R3, and R4 on the matrix) are clustered as results that could be applied in an integrated, regional program. The fourth—policy (R1 on the matrix)—had potential national application. Notable recommendations from the workshop, such as greater emphasis on training and a distinct community focus, figure prominently in the matrix, as do linkages with other USAID/Benin Strategic Objectives.

RESULTS FRAMEWORK FOR USAID/BENIN'S INTEGRATED FAMILY HEALTH PROGRAM¹⁴



¹⁴ Like all USAID Results Frameworks, this example is used for planning purposes. Results Frameworks are used throughout the life of a program and should be viewed as working documents. The frameworks provided here and in Appendix 2 are the frameworks for the Benin and Bangladesh programs, respectively, as of the date of drafting this POPTECH tool, and may have changed since that time.

APPENDIX 2: BANGLADESH CASE STUDY

ACRONYMS

ANC	antenatal care
ARI	acute respiratory infection
AVSC	AVSC International
BASICS	Basic Support for Institutionalizing Child Survival (USAID project)
BCCP	Bangladesh Center for Communications Programs
BRAC	Bangladesh Rural Advancement Committee
CA	Cooperating Agency
CDD	control of diarrheal disease
CMR	child mortality rate
CR	contraceptive prevalence rate
CWFP	Concerned Women for Family Planning
DHS	Demographic and Health Survey
EPI	Expanded Program on Immunization
ESP	Essential Service Package
FP	Family Planning
HLM	Family Planning Logistics Management Project
HSIC	Family Planning Services and Training Center
FWA	family welfare assistant
FWC	family welfare center
GOB	Government of Bangladesh
HA	health assistant
ICDDR/B	International Center for Diarrheal Disease Research, Bangladesh
IEC	information, education, and communication
IUD	intrauterine device
R	Intermediate Result
ISI	John Snow, Inc.
MCH	maternal and child health
MOH	Ministry of Health
MIS	management information system
NIT	neonatal tetanus toxoid
NGO	nongovernmental organization
NIPHP	National Integrated Population and Health Program
ORP	operations research partner
ORT	oral rehydration therapy
PSI	Population Services International
RA	Request for Applications
RP	Results Package
RTI	reproductive tract infection
SMC	Social Marketing Company
SID	sexually transmitted disease
SII	sexually transmitted infection
TBA	traditional birth attendant
THC	thana health complex
Tk	Taka (currency of Bangladesh)
TT	tetanus toxoid
TFR	total fertility rate
USAID/B	USAID/Bangladesh

BACKGROUND

In response to the challenges facing the Bangladesh National Population and Health Program, the Government of Bangladesh (GOB), USAID, the World Bank, and other development partners agreed in September 1995 to embrace the concept of an Essential Service Package to address the critical population and health needs of the country. Several months later, USAID and the GOB began planning for a follow-on project to the USAID-funded Family Planning and Health Services Project, a 10-year project that ended in August 1997. Based on an external evaluation of that project, a USAID-funded sector and strategic options assessment, and a 1995 USAID appraisal of family planning and health customers, USAID and the GOB decided that the new project, the National Integrated Population and Health Program (NIPHP), would comprise seven major components: urban service delivery, rural service delivery, social marketing, quality improvement, urban immunization, operations research, and contraceptive logistics.

USAID and the GOB agreed that the NIPHP should support those services of the Essential Service Package that would have the highest impact and whose provision was consistent with USAID's comparative advantage relative to other organizations. USAID would continue its national leadership role in the delivery of quality family planning services within a customer-focused, reproductive health approach. In addition to family planning information and services, USAID would support maternal and child health (MCH), prevention of reproductive tract infections (RTIs)/sexually transmitted infections (STIs) and HIV/AIDS, and response to and referrals for other family health needs as feasible and appropriate. Nongovernmental organizations (NGOs) were already providing many of these services, although the coverage and quality needed to be improved; it was agreed the NGOs would introduce new or improved services in a carefully phased manner. USAID would maintain the linkage between rigorous operations research and replication of new or improved service delivery approaches and services.

The 7-year NIPHP had a \$210 million budget, and would begin in 1997 and continue until 2004. In early 1996, USAID began selecting the Cooperating Agencies (CAs) that would serve as project partners and would, according to new USAID procurement regulations, both design and implement the NIPHP. At that time, USAID/Bangladesh (USAID/B) and the GOB decided that there existed experienced and competent organizations that were singularly suited to implement four of the NIPHP components: (1) the International Center for Diarrheal Disease Research, Bangladesh (ICDDR/B) for operations research, (2) the Family Planning Logistics Management Project (FPLM) for contraceptive logistics, (3) the Social Marketing Company (SMC) for social marketing, and (4) the Basic Support for



Institutionalizing Child Survival (BASICS) project for child survival and urban immunization. Requests for Applications (RFAs) for the remaining three components were issued during January–September 1996. In September 1996, USAID made awards to Pathfinder International, with the Bangladesh Rural Advancement Committee (BRAC) and Bangladesh Center for Communications Programs (BCCP), for rural service delivery; to John Snow Inc. (JSI), with the Family Planning Services and Training Center (FPSTC), for urban service delivery; and to AVSC, with World Vision and Concerned Women for Family Planning (CWFP), for quality improvement.

THE DESIGN PROCESS

The USAID Mission chose a consultant from Arthur D. Little, Inc., to conduct strategic planning using a business-oriented approach. USAID and the GOB agreed that the design process would involve three main steps:

- u Design of a Strategic Framework, Strategic Objectives, and five Intermediate Results, to be collaboratively developed by USAID, the seven CA partners, and the GOB.
- u Conduct of a qualitative survey of poor and disadvantaged Bangladeshi families who would be the primary customers of the NIPHP.
- u Design of a Results Package by each of the CA partners, in collaboration with other CAs, USAID, and the GOB. The CAs, USAID, and the GOB would be partners in design, implementation, and evaluation.

There was agreement that the design would “reflect the Agency’s core values of customer focus, teamwork, managing for results, and empowerment and accountability.” This design process would merge the new design principles and procedures outlined in USAID’s Automated Directives System with a rigorous strategic planning exercise. As interpreted by USAID/B, strategic planning comprised the following basic procedures: “the vision, the strategy and actions required to achieve the vision, and financial projections/analysis.”¹⁵ The following table shows the critical steps in the design process.

¹⁵ Scope of Work for POPTECH Technical Assistance, *USAID/Bangladesh Coordination of Design of New Initiatives in Population and Health Program*.

CRITICAL STEPS IN THE DESIGN PROCESS

DATE	EVENT
June 1995	First USAID Customer Appraisal was conducted.
November 1995	USAID and GOB began planning for new project—based on USAID’s historical and organizational capabilities and mandate.
Jan. – Sept. 1996	1 RFAs were issued for three components. 1 “Sole sourcing” was used for four components, based on unique capabilities.
September 1996	Process of selecting seven CA partners was completed. Seven CA partners began work on their Situation Analysis for presentation at the Design Workshop.
October 1996	Ten-day Design Workshop held in Bangladesh, attended by CA partners, MOH, donors, and other local stakeholders, produced the Strategic Framework: 1 Strategic Objective 1 Five interlinked Intermediate Results 1 Elements of Essential Service Package 1 Corporate steering mechanism comprising nine NIPHP partners (USAID, GOB, seven CA partners)
November 1996	Customer Validation Exercise of Strategic Framework was carried out, and partners began work on Subresults.
December 1996	Subresults, strategies, and performance indicators were drafted by each of the seven CA partners and presented for partner review and revision at an NIPHP plenary.
January 1997	At partners’ plenary, USAID gave guidance on action plans, budgets, and organizational and staff development plans.
March 1997	Partners submitted Results Packages, including action plans, budgets, and organizational and staff development plans, and first drafts of customer service plans. Arthur D. Little, Inc. and POPTECH facilitation of the process concluded at this point.
April 1997	Partners continued to revise their Results Packages, particularly budgets.
May 1997	USAID signed Strategic Objective Agreement with GOB.
July–Aug. 1997	USAID signed Cooperative Agreements with CAs.
September 1997	NIPHP began.

CUSTOMERS

CUSTOMER IDENTIFICATION AND NEEDS

USAID/B had defined its “ultimate customers” as socially and economically disadvantaged Bangladeshis, about whom there were extensive data on health status and knowledge, attitudes, and practices in terms of fertility, family planning, and some aspects of MCH. The sources of these data included Bangladesh Demographic and Health Surveys (DHS), as well as qualitative and quantitative research carried out by Bangladeshi organizations, USAID contractors, and other donors. The 1993–1994 DHS provided data on knowledge, attitudes, and practices and on access to services, assisting the NIPHP partners to identify, from the onset of the design, underserved and low-performing regions of the country.

USAID’s ultimate customers include about 45 percent of the 123 million people in the country, in low-performing and underserved thanas and urban areas and in selected underserved pockets in high-performing areas. Geographically, this means a focus on Chittagong and Sylet divisions and slums in urban areas. In total, over 4 million families are targeted for direct service delivery under the NIPHP.

Many organizations and persons, both providers and customers, have identified the quality of family planning and health care services, particularly in the public sector, as a major problem. ICDDR/B and the Population Council, among others, have researched and published extensively on reproductive health from the customer’s perspective.¹⁶ To provide still further detail on the customer’s point of view, USAID/B conducted a nationwide “rapid appraisal” in June 1995 to assess the perceptions, needs, and choices of its customers on a number of questions, including the following:¹⁷

- u What family planning and selected health care commodities and services are used by socially and economically disadvantaged Bangladeshis?
- u How do these customers perceive the characteristics and assess the quality of these commodities and services?
- u What sources of family planning, MCH, and other health care information are available to the customers, and what are the gaps in this information?
- u What are the customers’ opinions about integrated family planning, MCH, and adult health care services?

¹⁶ See, for example, E. Goodburn et al., “Beliefs and Practices Regarding Delivery and Postpartum Maternal Morbidity in Rural Bangladesh,” *Studies in Family Planning*, Vol. 26, Number 1, Jan/Feb 1995, and R. Simmons, “Women’s Lives in Transition: A Qualitative Analysis of the Fertility Decline in Bangladesh,” *Studies in Family Planning*, Vol. 27, Number 5, Sept/Oct 1996.

¹⁷ *RFA – USAID/Bangladesh – 96-P-001*, Attachment A, “Synopsis, Population and Health Customer Appraisal,” June 1995.

- u To what extent do customers currently pay and to what extent are they willing to pay for family planning and health care commodities and services?
- u Do customers know about the existence and treatment of RTIs and STDs?
- u What differences do marital status, gender, and geographic residence introduce into answers to the above questions?

To address these questions, USAID/B staff spent 3 weeks in field interviews with approximately 400 socially and economically disadvantaged Bangladeshis throughout the country. There were findings in six areas: (1) customers' ideas/beliefs/attitudes/knowledge, (2) the family decision-making process, (3) curative health/family planning/MCH needs, (4) access/availability/cost, (5) social mobilization, and (6) reproductive health. The results of this appraisal, together with data from various other sources and sound public health principles, were used by USAID/B staff to guide the preliminary conceptualization of the components of the new family planning and health services program. A synopsis was included in the USAID RFAs to provide guidance to CAs and was among the materials provided to participants in the October design workshop.

In November 1996, USAID/B undertook a rapid-appraisal validation of the proposed NIPHP program with both customers and service providers. The validation confirmed earlier findings, most importantly that "customers are willing to pay for accessible, high-quality and integrated family planning and primary health care services." The NIPHP has been designed around this principle. Therefore, the program will monitor the perceptions of its ultimate customers regarding improved quality, access, and integration of health and family planning services.

Providers of health and family planning services in targeted areas were identified as the intermediate customers of the NIPHP. The program will benefit these providers by improving their management and clinical skills, thereby enabling them to offer better information and services to the program's ultimate customers. The NIPHP will therefore monitor the service providers' perceptions of improvements in training, commodity logistics and quality, management support, communications, coordination among providers, and research, thereby tracking the improvements made in services to the ultimate customers.

PLAN FOR ONGOING APPRAISAL OF CUSTOMER SATISFACTION

The NIPHP will conduct a qualitative rapid appraisal in all project areas every 2 years, beginning in late 1999. See the section on the customer service plan later in this appendix.

PARTICIPATION AND TEAMWORK

USAID: MISSION, BUREAUS, AND GLOBAL

USAID/B had embraced the concept of reengineering prior to the beginning of the design process and had restructured USAID offices to form “empowered teams” that include technical, program, contract, and budgeting staff. The Population and Health (PH) Team, composed of a “core team” and “virtual team” members, guided this design process, led by the PH Director and Deputy Director. Core team members were all from USAID/B, while virtual team members included USAID/B specialists, such as the legal advisor. The PH Team worked on the basis of a written PH Team Charter, written PH Design Team Principles and Common Agreements, and periodic meetings.

The Bangladesh design experience was unique in its involvement of virtual team members from USAID/Washington (USAID/W) in the Office of Population, the Office of Health and Nutrition, and the Asia/Near East Bureau. These USAID/W staff participated in reviewing documents, giving feedback, brainstorming, and providing other technical inputs through e-mail and telephone communications. In the early stages, they were involved in the creation of the RFAs and in partner selection. Once the partners had been selected, they traveled to Bangladesh to participate in the planning workshop that defined the work scopes of the selected CAs, host-country counterparts, and the Ministry of Health (MOH).

THE GOB AND OTHER DONORS: PARTNERS WITH USAID

The NIPHP was developed within the broader context of the GOB’s National Population and Health Program; the key GOB partner was the Ministry of Health and Family Welfare. By embracing the GOB’s Health and Population Sector Strategy and its concept of an Essential Service Package, USAID aimed to complement the work of other donors and support the GOB’s goals and objectives for the sector. Other donors with which USAID would work in concert included the World Bank’s consortium of donors, the United Nations Fund for Population Activities (UNFPA), UNICEF, the Japanese, and the European Union.

THE SEVEN CA PARTNERS

As noted in Section 3, three of the seven CA partners had internal partnerships, so that a total of twelve organizations had to work in close collaboration with each other, USAID, and the GOB. Many of the partners involved in this process had projects that were ongoing during the planning for the new project design. Detailed project planning prevented disruption of those continuing projects.

DESIGN RESOURCES: ARTHUR D. LITTLE, INC., AND POPTECH

Given the magnitude of the design process, the reengineered focus on results, and the commitment to use a “business-oriented strategic



planning approach in the design of the NIPHP,” USAID/B decided to contract for technical assistance in the 6-month design process:

- u One contract was with the Southeast Asia office of Arthur D. Little, Inc., for the services of a strategic planner with a business-oriented approach who would assist USAID in designing and leading the strategic planning process. This support would include facilitating a 10-day design workshop to begin the formal design process. This strategic planner outlined the process, developed and provided written guidelines and formats for various steps of the process, and periodically spent time in Dhaka to provide technical assistance to USAID and the partners and facilitate NIPHP meetings and processes.
- u A second contract was with POPTECH for logistics support to the design workshop and the customer validation survey, and for the services of a full-time PH design specialist. The design specialist, operating out of a USAID/B office, worked on a daily basis with the seven CA partners over the 6 months to assist them in developing, in a collaborative and integrated fashion, the various components of the Results Framework and the Results Packages.
- u A third human resource development specialist was provided by POPTECH to conduct a human resources review and analyze staffing patterns. As a result of this individual’s recommendations, project functions were consolidated and redundancies eliminated, resulting in staff reductions and cost savings.

DESIGN WORKSHOP

At the design workshop, representatives of the NIPHP partners and collaborating donor agencies met for 10 days of strategic planning. The workshop participants planned the NIPHP as one segment, among many, of the National Health and Population Program. To assist participants in establishing the larger health and population context, the Additional Secretary of the Ministry of Health and Family Welfare presented progress on the design of the Bangladesh Health and Population Services Strategy, which had been in development since May 1996 with the assistance of the World Bank, other donors, and nongovernmental partners. The draft strategy document included a summary of systemic issues, a draft of an essential package of basic health and family planning services, and guiding principles for the sector. Additionally, an overall sectoral assessment (based upon an assessment of national demographic and health data) and situation analyses were presented by each of the seven CA partners on their respective components.¹⁸ Each CA had analyzed its role and activities, size and growth of services and operations, customers and competitors/collaborators, financial performance, and planning issues.

¹⁸ POPTECH has a copy of the guidelines provided to the CAs by Arthur D. Little, Inc. Those interested in this level of detail should ask for a copy of “Peter Connell/Arthur D. Little Memorandum: Cooperating Agencies’ Presentations to NIPHP Workshop.”



Over the course of the 10-day workshop, the strategic planner from Arthur D. Little, Inc. led the approximately 45 full-time and 40 part-time participants in a series of plenary and small-group exercises that led to the following outputs:

- u NIPHP Mission and Vision Statement
- u NIPHP Results Framework, incorporating:
 - s An NIPHP Strategic Objective
 - s Five interlinked Intermediate Results
 - s Performance indicators
 - s Agreement on priority services from the GOB draft of an essential package of basic health and family planning services to be funded by the NIPHP
 - s CA Visions (preliminary drafts)
 - s Results Package Guidelines
 - s Ideas on fostering team work
 - s Suggested topics for the USAID customer appraisal

The planning process was conducted by and for Bangladeshis in Bangladesh. Very few non-Bangladeshis were involved in the process. Therefore, it was an extremely participatory process that was wholly owned by the partners and the MOH.



RESULTS FRAMEWORK

MISSION AND VISION

This section presents key outputs of the design workshop as drafted during the workshop, later revised for form, and still later approved by the partners.

NIPHP MISSION STATEMENT

The NIPHP is a partnership among USAID, the CA partners, and the GOB. The partners operate within Bangladesh's National Health and Population Program to contribute to the nation's immediate health and demographic objectives, as well as its longer-term development objective of self-reliance. Our primary purpose is to enhance the quality of life of poor and underprivileged members of society by helping to reduce fertility and improve family health. We shall do this by:

- u Delivering an Essential Service Package of high-quality, high-impact family planning and health services to the areas of greatest need.
- u Promoting awareness and use of those services through a variety of information, education, and communication (IEC) methods.
- u Enhancing the ability of individuals, families, and communities to protect and to provide for their own health.
- u Building a strong NIPHP organization and supporting systems to maximize integration of services to customers and coordination among the partners.
- u Promoting sustainability throughout the delivery chain, from commodity procurement to a provider/customer interface that is client centered.
- u Encouraging the GOB to develop and implement a policy framework that facilitates and mobilizes GOB and nongovernmental resources in support of NIPHP to the community level.

The NIPHP aims to build a base of customers who are empowered to influence our service package and delivery approaches and who become proactive in seeking quality information, services, and products. We will interact with other donors on the basis of our clearly articulated plans and seek to integrate our program with theirs, leveraging each other as much as possible. We will use appropriately qualified service providers at the local level and will train and support them, to the extent possible, to enhance their delivery capability.

NIPHP VISION STATEMENT

NIPHP's purpose is to improve the quality of life in Bangladesh by directly supporting the GOB's National Population and Health Program—and the country's longer-term development objective of self-reliance. Specifically, we shall focus on reducing fertility and improving family health. In doing this, we shall work closely with the GOB on contraceptive



logistics and urban immunization, national operations research, and IEC programs, and support selected Ministry of Health and Family Welfare/thana/union-level service delivery programs.

Our planning timeframe is 7 years, which is a critical demographic period for Bangladesh, providing maybe the last opportunity for the country to stabilize its population growth at sustainable levels. By the year 2004, the NIPHP partnership (USAID, the CA partners, and the GOB) will support an Essential Service Package that fosters active participation from all family members (i.e., men, women, and children). The package will cover family planning, priority MCH, STIs/HIV/AIDS, and response to and referrals for other family health needs as feasible and appropriate. We shall look for opportunities to integrate youth as a new customer segment, to the extent that synergy with the Essential Service Package and budget allows.

Our main priority will be serving areas of low health performance in Bangladesh, characterized by high proportions of unmet need and resistance to and/or unavailability of both family planning and basic health services. High priority will also be given to underserved pockets and specialized services in higher-performing areas. Demographically, we shall concentrate on discontinuers in family planning and the Expanded Program on Immunization (EPI), nonusers of the entire range of services within our Essential Service Package, and special groups such as newlyweds and postpartum women. Throughout, we shall maintain our overriding concern with the poor and socially disadvantaged segments of the population and shall aim to respond to customer needs as expressed in customer appraisals and identified in demographic and health surveys (such as the DHS) and other quantitative and qualitative customer research.

The total NIPHP budget to 2004 is approximately US\$210 million, roughly the same as for the Family Planning and Health Services Project on a per annum basis. To achieve an expansion of service scope, focused on low-performing areas and with ambitious performance expectations, we shall be pursuing programmatic, organizational, and financial sustainability with renewed vigor. We start the plan period with nine partners under the NIPHP umbrella, facilitating greater interpartner cooperation and management efficiency through teamwork than we have achieved in the past. We expect to evolve an organizational structure for the NIPHP that reinforces these themes and strengthens coordination of support services (e.g., logistics and management information) among partners for the national program. Furthermore, we shall have progressively transferred service delivery to more cost-effective static centers, making best use of existing facilities of the GOB and NGOs and of the private sector. We shall be providing more customers with one-stop access to an integrated range of basic health services.

By the end of the plan period, we expect to have phased out our technical assistance to both urban immunization and contraceptive logistics management. We also expect to be delivering services



through fewer, larger, and more organizationally robust NGOs that are firmly rooted in their local communities and that strongly collaborate with government programs. Social marketing, which will be more than fully recovering its operating costs on the basis of assured commodity supplies, will have assumed a greater share of the burden, in terms of both offering more services and taking on a greater share of the contraceptive market from the GOB and NGOs. We will also have made every effort to involve the for-profit sector more actively in our service package. All partners will have acted aggressively over the 7 years to contain their costs.

The following text, written by members of the PH Team, is excerpted from the NIPHP Results Framework and presents the problem analysis, major causal relationships, program hypotheses, and key assumptions behind the Strategic Objective and Intermediate Results.

DEVELOPMENT RATIONALE

PROBLEM ANALYSIS

With a population of 123 million, Bangladesh is one of the world's most densely populated countries. The per capita GNP of \$240 is among the lowest in the world, and approximately 45 percent of the population live below the poverty level. Reductions in fertility and improved human health are important indicators of poverty alleviation, the Mission's overall development goal.

Such reductions also increase labor productivity and the quality of life. In addition, access to high priority health services (especially preventive) significantly reduces the vulnerability of poor households to illness-induced income erosion and expenditure crises.

Controlling population growth and reducing mortality have been identified by Bangladesh as among its most critical development problems. Without further intervention, Bangladesh's current population of 123 million is expected to double to almost 250 million in 35 years, given the present 2 percent growth rate. Almost 10 percent of infants die before reaching their first birthday. Maternal mortality is among the highest in the world at approximately 4.5 per thousand live births. While fertility and mortality rates have declined considerably over the last two decades, they remain higher than desirable and further improvements represent priority objectives for the GOB and USAID.

The GOB, donors, and the private sector have recognized that past approaches in the country's delivery of family planning services will have to be revised to achieve the coverage levels needed to complete and sustain its demographic transition. Bangladesh's National Population and Health Program faces new demographic and programmatic realities. To reach the GOB's goal of replacement-level fertility by 2005, the total number of contraceptive users will have to more than double to 21 million. To achieve this, high-quality family planning services and information need to be delivered as part of a customer-centered, reproductive health approach. In addition, high

levels of infant and child mortality need to be reduced to ensure that a decision to bear a child can be made with a reasonable expectation that the child will survive to adulthood.

It is projected that total available financial resources will be insufficient to keep pace with the health and family planning needs of the rapidly growing Bangladesh population. Thus, to achieve its demographic goals, the National Population and Health Program must become significantly more cost-effective, which means delivering a package of quality essential health and family planning services in an integrated manner. This reflects the GOB's official policy as articulated in the recently approved Health and Population Sector Strategy, the policy statements of donors, as well as the stated desires of Bangladeshi customers.

Over the past 20 years, Bangladesh has achieved substantial success in lowering fertility from over 7 births per woman in 1974 to approximately 3.4 in 1994. This decline is largely due to the steady rise in contraceptive use from 3 percent in 1971 to 45 percent in 1994. The national program's emphasis on the provision of services supported by information, education, and communication (IEC), an effective FP/MCH logistics system, vibrant networks of NGOs providing services, rigorous operations research, and effective social marketing has been successful. Today, the two-child norm is now widely accepted, and the vast majority of couples favor family planning.

Impressive gains have also been made in reducing mortality. (In the late 1980s, infant mortality began to drop from a level of over 100 per 1,000 to just under 90 by 1994.) Similarly, under-five mortality has decreased by 20 percent during this period to 133 deaths per 1,000 live births. This coincides with the expanded program on immunization launched by the GOB and its partners. By 1996, approximately 60 percent of children were fully immunized by 12 months of age compared to a rate of less than 5 percent in 1986.

Bangladesh continues to face a number of significant challenges including a large unmet need for family planning, an unbalanced contraceptive method mix, high discontinuation rates for family planning and immunization, large regional variation in contraceptive prevalence, poor quality of family planning and other basic health services, and large underserved populations (e.g., newlyweds, urban slum dwellers, adolescents).

Although the declining mortality rate is encouraging, much remains to be done. Immunization rates need to be further increased to at least 80 percent and polio eradication needs to be completed. Pneumonia and other acute respiratory infections and dehydration due to diarrhea are major causes of infant and child mortality. The availability and quality of reproductive and maternal and child health services are limited, leading to many preventable maternal and child deaths. For example, only about 25 percent of children with acute respiratory infections (ARI) are taken to a health care provider for treatment. Although the majority of women live within one mile of a health care facility, almost 75 percent of pregnancies

still do not receive antenatal care and the vast majority of deliveries take place at home without the assistance of medically trained persons.

While the number of detected HIV infections and AIDS cases is presently low, Bangladesh is at risk of a major HIV/AIDS problem due to epidemics in neighboring countries, high rates of sexually transmitted infections (STIs) and reproductive tract infections (RTIs), and other factors. Its impact, however, will be determined largely by how successful the health system is in controlling STIs and promoting awareness and prevention of HIV. While there is little systematic reporting or accurate data on the prevalence of STIs and RTIs in Bangladesh, their incidence appears to exceed 10 percent of Bangladeshis of reproductive age.

Customer survey and other research information confirms that Bangladeshis have a strong desire for integrated family planning, reproductive health, and other essential health services that are both accessible and of high quality. It is also clear that traditional assumptions about women not being willing and able to leave their homes for health services need to be revised. Given the increasing number of people to be served, the Bangladesh National Population and Health Program will have to become far more cost-efficient if demographic objectives are to be achieved.

MAJOR CAUSAL RELATIONSHIPS AND PROGRAM HYPOTHESES

- u For Bangladesh to move from medium to high coverage rates for family planning and key child survival services, it has been hypothesized and evidence (from recent operations research conducted in Bangladesh and elsewhere) strongly indicates that essential, customer-centered services need to be provided in an accessible, integrated manner. The maintenance of separate, parallel family planning and health systems is extremely expensive. Integrated delivery of an essential service package of high-impact family health services is cost effective, maximizes all contacts with health providers, and addresses the stated desire of Bangladeshi customers for “one-stop shopping.” Reduction in fertility and infant/child/maternal mortality are intertwined in that people’s decisions to bear children are contingent on their expectations that their children will survive and be healthy.*
- u To achieve replacement-level fertility, family planning information and services need to be expanded and there needs to be greater use of more effective, clinical contraceptive methods. Experience in Bangladesh and throughout the world has shown that increased access to voluntary and safe contraceptive services is the most cost-effective manner by which to lower fertility.*
- u To reduce high infant and child mortality, immunization, ARI, and CDD (control of diarrheal disease) services need to be expanded. The large majority of infant and child deaths worldwide (and in Bangladesh) are due to a limited number of causes, principally pneumonia, dehydration due to diarrhea, and vaccine preventable diseases. Experience has shown ARI, CDD, and immunization programs are very cost-effective.*

- u *To reduce high maternal mortality rates and improve maternal health, it is generally accepted that high-quality and accessible family planning information and services need to be delivered within a customer-centered, reproductive health approach. Reducing unwanted pregnancies will decrease maternal deaths. Furthermore, it has been hypothesized that basic antenatal care (including tetanus toxoid immunization), the prevention and treatment of STIs/RTIs, postpartum contraceptive services, and added focus on men and adolescents are among the most effective reproductive/maternal health interventions.*
- u *The quality of clinical family planning and health services needs to be improved to increase customer use and effectiveness of these services. High contraceptive and vaccination discontinuation rates, low acceptance of clinical contraception, and low use of critical reproductive services are due, in large part, to the poor quality of services and counseling.*
- u *To achieve family planning and health objectives, individuals, families, and communities need to be motivated and have information and skills to protect and provide for their own health. Only when individuals take the initiative to assure their own health can lasting progress be made in achieving national health goals. Strong and sustained IEC efforts need to be promulgated both at the national and local levels.*
- u *Critical management and support systems for the public and private sectors and NGOs need to be strengthened to permit services to be delivered in a cost-effective, sustainable manner, and to ensure that essential family health services are readily available and accessible. In addition, sound operations research is needed to ensure that modifications/enhancements are empirically grounded.*
- u *Achievements in fertility and mortality reductions cannot be maintained in the future without ensuring that health care systems become increasingly self-supporting and self-sustaining, financially, programmatically, and organizationally.*

KEY ASSUMPTIONS

- u *The GOB, under the Health and Population Sector Strategy, will continue its move toward integrated delivery of family planning and health services.*
- u *USAID/W will provide an adequate and an appropriate mix of Population and Child Survival/Health funding in a timely manner.*
- u *Other donors will continue to provide complementary inputs (e.g., public sector training).*
- u *Other donors will continue to provide an adequate supply of commodities, particularly contraceptives, in a timely manner.*
- u *The GOB will continue to support an expanded role for NGOs and the commercial sector in health care.*

- u *The GOB will allow NGOs and the Social Marketing Company to set appropriate prices for contraceptives and will not intervene in other NGO pricing policies.*
- u *Consumers will continue to pay for quality services and products that have been carefully priced in recognition of costs and consumers' willingness and ability to pay.*

STRATEGIC OBJECTIVE

The PHN Strategic Plan is linked with the other Strategic Objectives of the USAID/B Mission, such as food security and democracy. Its Strategic Objectives and Intermediate Results will contribute to the Mission's overall, long-term goal of poverty alleviation.

During the October workshop, USAID, the GOB, the seven CA partners, and representatives from other donor agencies established a single Strategic Objective: *Fertility reduced and family health improved.* The rationale for that objective was later refined as follows:

Poverty reduction, USAID's strategic goal, requires smaller and healthier families. Fertility reduction and improvement in family health, in turn, require:

- s *Access to a broad range of high-impact services, delivered and communicated in an integrated manner.*
- s *Attention to quality in the design and delivery of information and services.*
- s *Better-informed customers who are proactive in improving and protecting their health.*
- s *Communities mobilized to promote and support the service-delivery system.*

While gains have been made in fertility reduction and child health, large variations persist, with continuing poor performance in selected geographic areas and demographic segments.

USAID has had success in promoting family planning and child survival through support to NGOs, the Ministry of Health and Family Welfare, and the SMC both nationally and in the targeted areas, which has contributed to significant reductions in fertility and infant and child mortality. These organizations have supported delivery of information and services and operations research, and have strengthened management and support services. The NIPHP will build on this positive experience, focusing coverage on low-performing and underserved groups. The program will support and facilitate NGOs, the GOB, and social marketing, and will initiate support to the commercial sector on a national basis. At the same time, it will work to increase these service providers' programmatic, organizational, and financial sustainability.

FIVE INTERMEDIATE RESULTS

During the October workshop, the NIPHP partners developed five Intermediate Results to achieve the above Strategic Objective and

elaborated the rationale behind their decisions. The following text is a refined version of their work over the week.

IR1: USE OF HIGH-IMPACT FAMILY HEALTH SERVICES IN TARGET POPULATION INCREASED.

Rationale: In order to reduce fertility and improve family health, the NIPHP needs to increase the use of high-impact services selected from the 1996 draft GOB Essential Service Package.¹⁹ We will focus on increasing access to and coverage of high-impact family health services to low and underserved thanas and urban areas by working closely with all service providers, especially at the union level and below. We will focus on specific customer populations (e.g., adolescents and low-parity couples) and ensure that high-quality information and services address their specific needs. This systems approach will work toward the rational provision of services within these areas. We will respond to the customers' preference for accessibility and quality by making as many high-quality services as possible available at a nearby facility, thereby bringing "one-stop shopping" to more customers. This increased convenience will be further enhanced by the development of an effective and easy-to-use system of referrals as appropriate. Special attention will be given to assisting customers to receive full information and advice about the availability and use of these services.

IR2: CAPABILITIES OF INDIVIDUALS, FAMILIES, AND COMMUNITIES TO PROTECT AND PROVIDE FOR THEIR OWN HEALTH INCREASED.

Rationale: Individuals and families need to be empowered through IEC to make better health decisions that are cost-effective and respond to their needs. Mothers, who are the primary caregivers, need to make decisions about antenatal care, childbirth, immunizations, oral rehydration therapy, ARI, nutrition, and first aid. Caregivers need to develop their diagnostic skills and recognize key symptoms in order to know when to deal with health situations/problems on their own and when to seek assistance from appropriate health providers. Fathers need similar understanding so that they are supportive of their wives' decisions. All sexually active persons (youth, men, and women) should know the risks, means of transmission, and prevention of STIs/HIV/AIDS.

The NIPHP will promote such empowerment at two levels: at the national level through IEC programs and campaigns planned and implemented with other donors, and at the community level through fieldworkers and other service providers, as we move toward more clinic-based service delivery. A national IEC campaign will address key elements of the Essential Service Package. A particular national IEC emphasis will be on STIs/HIV/AIDS; such a focus is essential in light of the rapid spread of HIV/AIDS in neighboring countries. Community-

¹⁹ These services were selected by a working group during the October workshop based upon an assessment of customers' perceived demand, public health need, probable impact, the feasibility of USAID support, existence of other donor funding, and the opportunity costs of investing in a specific service.



level health education (e.g., hygiene, STIs, ARI danger signs), provided by fieldworkers and paramedics, will both complement and expand on information and education provided through the mass media and print media at the national level. IEC at both levels will encourage families to make better, safer, and more cost-effective health choices, thereby maximizing the family's health status and limited resources.

IR3: QUALITY OF INFORMATION, SERVICES, AND PRODUCTS IMPROVED, AND CUSTOMER SATISFACTION IMPROVED.

Rationale: Improved quality is essential to increasing both the use and the sustainability of the national program. Improved quality of information, services, and products leads to a reduction in complications, enhanced customer satisfaction, higher utilization of services, and ultimately better health outcomes. Improved quality of services also should contribute to a long-term reduction in unit costs.

In the 1995 USAID customer appraisal, customers reported dissatisfaction with the quality of family planning and primary health services. They identified a number of areas in which they expect improvements. This Intermediate Result will address the major quality issues related to the delivery of the NIPHP Essential Service Package. Interventions will be made to improve the technical competence of service providers; establish and apply service standards and protocols; improve customer/provider interaction, including counseling; and help provide an expanded and more integrated range of high-quality services, as desired by the customers surveyed by USAID in 1995.

IR4: LOCAL SERVICE-DELIVERY ORGANIZATIONS STRENGTHENED, AND SUPPORT SYSTEMS FOR HIGH-IMPACT FAMILY HEALTH SERVICES IMPROVED.

Rationale: To facilitate the delivery of high-impact family health information, services, and products, a number of support systems are required. These include logistics, operations research, IEC, human resources management, quality improvement, management information/health information systems, and management. Such support systems are necessary to strengthen the National Health and Family Planning Program over the long term and to assist the CA partners in effectively meeting their individual and collective responsibilities over the shorter term.

This Intermediate Result will strengthen the support systems required for the Essential Service Package at the national program level. It will also result in improved teamwork and increased collaboration among the nine partners implementing the NIPHP, more efficient use of NIPHP resources, more focused information and service-delivery interventions, and better coordination with external partners and other stakeholders in the national program.

To assist the NIPHP and its nine partners in planning and coordinating its activities and support systems, a program coordination mechanism (e.g., coordinating board) is needed over the life of the project and will be established.

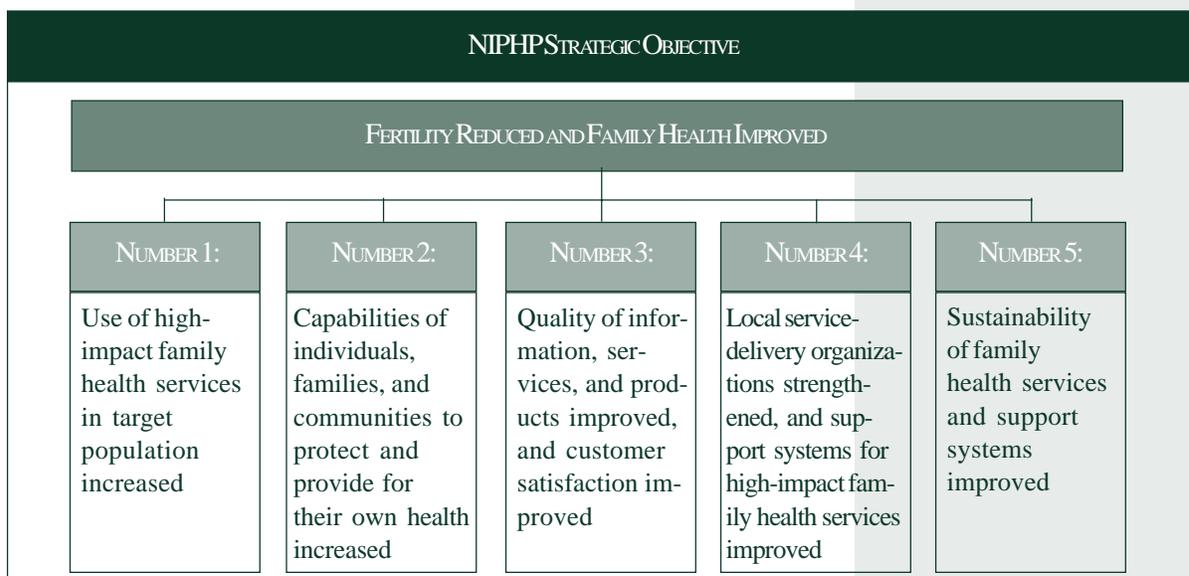
IR5: SUSTAINABILITY OF FAMILY HEALTH SERVICES AND SUPPORT SYSTEMS IMPROVED.

Rationale: To maintain the achievements of the NIPHP on a sustainable basis, service-delivery systems, including support systems, need to be increasingly self-supporting on at least three levels. First, programmatically, the health system needs to be more technically capable of providing quality services and to be less reliant on external expertise and supply systems. Second, organizationally, the GOB and NGOs need to have strong management, leading to more efficient service-delivery (and support) systems capable of providing an Essential Service Package valued by customers. Third, financially, the program will have to reduce its reliance on external sources of funding. This reduction will be accomplished through a number of key changes, such as (1) increasing the private sector’s (and social marketing’s) market share of health services and products; (2) increasing efficiency through measures that reduce costs (e.g., shifting away from doorstep service delivery, reducing overhead, shifting to long-term family planning methods, and reducing duplication of services); and (3) increasing cost recovery.

STRATEGIES

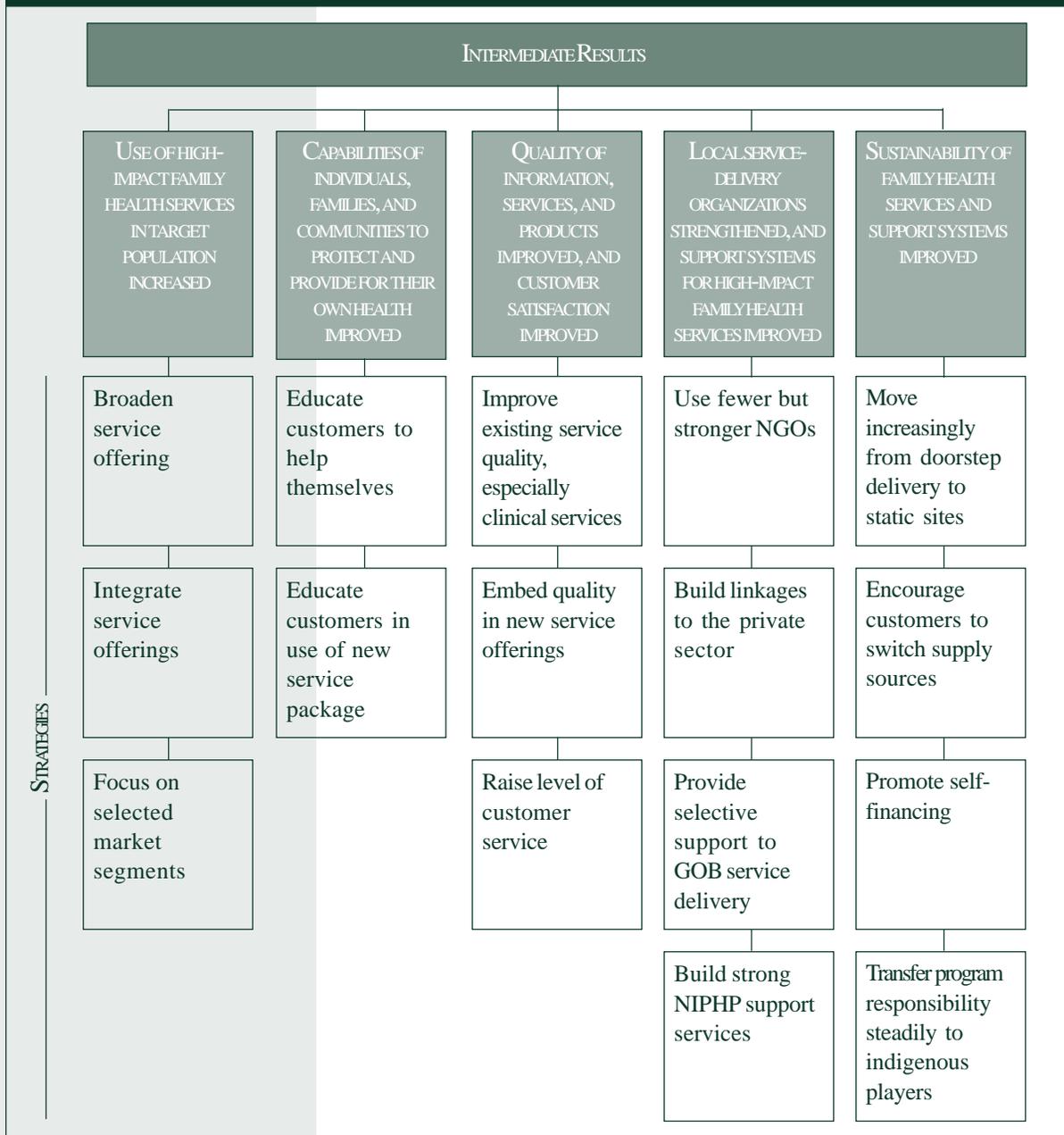
Following the October workshop, the seven CA partners began the detailed work of developing the second planning level under Intermediate Results, or Subresults. As the preliminary work on Subresults was examined, it became apparent that the design process was not capturing in writing the strategies through which the Intermediate Results would be achieved, although these strategies had been verbalized and were supported by all. Accordingly, 16 strategies were identified as the means through which the NIPHP would achieve its Intermediate Results. The Subresults of each CA are means to carry out these strategies. The following two tables present the Strategic Objective, Intermediate Results, and strategies. See the section on the customer service plan for a description of the structure designed to support and coordinate the NIPHP.

STRATEGIC OBJECTIVE AND FIVE INTERMEDIATE RESULTS



NIPHP INTERMEDIATE RESULTS AND STRATEGIES

16 STRATEGIES IDENTIFIED THAT WILL BE PURSUED TO ACHIEVE THE NIPHP INTERMEDIATE RESULTS



CA RESULTS PACKAGES

The seven CA partners, working with the GOB and USAID, are interdependent with respect to achieving the NIPHP Intermediate Results. To plan its respective contribution, each partner developed a Results Package designed to contribute toward specific strategies of one or more of the Intermediate Results; together, the partners will achieve all five. Each Results Package, developed with guidance from USAID, Arthur D. Little, Inc., and POPTECH, has seven components (see

the following table). At various NIPHP plenary sessions, the CA partners presented the first four components to each other, USAID, and the GOB for collaborative review and revision. The intent was to build NIPHP teamwork and to ensure that partner activities would be sufficient to achieve the NIPHP Strategic Objective. This was an iterative process to ensure completeness and collaboration, and to eliminate duplication and inefficiency.

COMPONENT	COMMENTS
1. Mission and Vision Statement	Drafted during design workshop (October 1996) and finalized thereafter. Describes the Mission and Vision of the partnership (for example, the quality improvement partnership) as a whole.
2. Strategies	Describe how the NIPHP Intermediate Results will be achieved (November).
3. Subresults	Contribute to a specific strategy for a specific Intermediate Result: specify what will be achieved, key collaborators, performance indicators (baseline target), means of verification, and start and completion dates. Developed and revised over 2 months (November–December).
4. Action Plans	Outline plans to achieve Subresults, including tasks, responsibilities, collaborating partners, and benchmarks. Developed over 2 months (January–March).
a) Organigram, Staff Development Plan, and Localization Plan	Designed by CAs prior to final USAID review (March) and revised with POPTECH technical assistance following that review.
b) Customer Service Plan	Developed and finalized by each CA by May 1997; complements and contributes to the NIPHP customer service plan.
c) Budgets	<p>Drafted for March USAID review, and revised and negotiated during March–August 1997. Included:</p> <ul style="list-style-type: none"> n Financial projections <ul style="list-style-type: none"> o For the main contractor in each partnership o For any and all subcontractors in the partnership o For any NGOs contracted by a main contractor or a subcontractor to deliver services n Two documents prepared <ul style="list-style-type: none"> o A detailed budget for the first 15 months o Indicative projections for the following 6 years



EXPECTED IMPACT

By the end of the 7-year life of the NIPHP, USAID expects to achieve significant reductions in fertility and mortality. Specifically, USAID anticipates reductions in the total fertility rate (from 3.3 live births per woman in 1996–1997 to a projected 2.8 in 2004), the infant mortality rate (from 82 infant deaths per 1,000 live births in 1996–1997 to a projected 70 in 2004), and the child mortality rate (from 37 child deaths per 1,000 live births in 1996–1997 to a projected 30 in 2004). USAID also expects maternal mortality to decline, but since there is no accurate measurement for this indicator in Bangladesh, an estimate of the expected reduction cannot be given.

Through the implementation of the NIPHP, USAID NGOs will serve areas with approximately 20,000,000 people. These NGOs will also provide targeted support to public-sector programs, which are expected to benefit another 15,000,000 persons. In total, both direct and indirect support for service delivery will benefit approximately one-quarter of the population. In addition, mass media IEC programs for HIV/AIDS are expected to reach approximately 40 percent of the population. Finally, the following assistance will be provided nationally: the social marketing of key reproductive and child health products through SMC; support for the national family planning/MCH logistics system through the FPLM project; assistance to the national immunization program (focused on urban areas), including polio eradication and disease surveillance through the BASICS Project; and support for quality assurance through the quality improvement partnership.

PERFORMANCE MONITORING AND EVALUATION

Preliminary data from the DHS of 1996–1997 were available at the end of the design phase. These data were used to establish baselines and assisted the partners in formulating targets. The following tables present the basis for performance monitoring and evaluation plans for the NIPHP.

PERFORMANCE MONITORING AND EVALUATION AT THE RESULTS FRAMEWORK LEVEL

STRATEGIC OBJECTIVE: FERTILITY REDUCED AND FAMILY HEALTH IMPROVED					
INDICATOR	SOURCE	ANNUAL MEASURE	BASELINE	PROJECTED 2004 ²⁰	RESPONSIBILITY
Reduced total fertility rate	DHS	None	3.3 (DHS 1996–97)	2.8	USAID
Reduced infant mortality rate	DHS	None	87/1000 (DHS 1996–97)	70/1000	USAID
Reduced child mortality rate	DHS	None	36/1000 (DHS 1996–97)	30/1000	USAID
Increased proportion of pregnancies attended by trained provider (at least two antenatal care [ANC] visits during pregnancy)	DHS	Number of ANC visits reported to Ministry of Health and Family Welfare management information system (MIS)	26% (DHS 1996–97)	40%	USAID
Percent of aggregate operating costs of USAID-supported NGOs covered by program-generated revenues	CA reports	Same	0%	25%	USAID

²⁰ These projections are based on the preliminary results of the 1996–1997 Bangladesh DHS. They may be revised when the official results are available.

INTERMEDIATE RESULT ONE:
USE OF HIGH-IMPACT FAMILY HEALTH SERVICES IN TARGET POPULATION INCREASED

INDICATOR	SOURCE	ANNUAL MEASURE	BASELINE	RESPONSIBILITY ²¹
Increase in contraceptive prevalence rate (CPR)—all methods	DHS	Number of IUDs, sterilizations, and injectables	49% (DHS 1993–94)	USAID
Increase in CPR — modern methods	DHS	Same as above	41.5% (DHS 1993–94)	USAID
Improved contraceptive method mix in favor of clinical methods (CPR for injectables, IUDs, sterilization, NORPLANT®)	DHS	Same as above	16.7% (DHS 1996–97)	USAID
Proportion of fully immunized children by age 1 year nationwide	National EPI survey	EPI service statistics	51% (EPI survey 1997)	BASICS
Tetanus toxoid 2 coverage rate for women giving birth in last year	National EPI survey	EPI service statistics	72% (EPI survey 1997)	BASICS
Vitamin A capsule coverage for children under age 3 in prior 6 months	DHS	UNICEF service statistics	48.8% (DHS 1993–94)	BASICS
Proportion of diarrheal cases in prior 2 weeks among children under age 3 treated with ORT	DHS	Number of oral rehydration salts packets sold by SMC and market share	62.6% (DHS 1997)	SMC
Proportion of ARI cases in prior 2 weeks among children under age 3 treated by trained provider	DHS	Number of pneumonia cases treated by CAs according to standards	36% (DHS 1996–97)	Urban and rural CAs
Proportion of USAID-funded NGO clinics that offer at least four high-impact services according to standards (clinical FP, nonclinical FP, EPI/vit. A, ARI, CDD, ANC, STD/RTI)	CA service statistics	Same	0.00	Urban and rural CAs

²¹ In addition to the organizations designated in this column, the GOB is included as a responsible party for all Strategic Objective and Intermediate Results indicators.



INTERMEDIATE RESULT TWO: CAPABILITIES OF INDIVIDUALS, FAMILIES, AND COMMUNITIES TO PROTECT AND PROVIDE FOR THEIR OWN HEALTH IMPROVED				
INDICATOR	SOURCE	ANNUAL MEASURE	BASELINE	RESPONSIBILITY
National FP/health IEC strategy revised, implemented, and evaluated	BCCP reports	Same	Plan needs revision	BCCP
Increased knowledge by men and women of risks and preventive measures for HIV/AIDS	DHS	None	TBD from DHS 1996-97	USAID
Number of condoms sold in proximity to targeted high-risk populations	SMC and CA service statistics	Same	21,000/month (SMC 1996)	SMC and urban and rural CAs

INTERMEDIATE RESULT THREE: QUALITY OF INFORMATION, SERVICES, AND PRODUCTS IMPROVED, AND CUSTOMER SATISFACTION IMPROVED				
INDICATOR	SOURCE	ANNUAL MEASURE	BASELINE	RESPONSIBILITY
Percent of service providers in USAID-supported areas complying with standards/protocols (for at least five priority services)	CA service statistics	Same	0	Urban and rural CAs
Percent of service sites in USAID areas having appropriate personnel, equipment, supplies, and facilities for basic package of services	CA service statistics	Same	0	Urban and rural CAs
Percent of EPI dropouts	National EPI survey	EPI service statistics	37% (Nat. EPI survey 1997)	BASICS
IUD discontinuation rate (12 months)	DHS	None	38% (DHS 1993-94)	USAID
Oral contraceptive pill discontinuation rate (12 months)	DHS	None	37% (DHS 1993-94)	USAID
Injectable contraceptive discontinuation rate (12 month)	DHS	None	57% (DHS 1993-94)	USAID
More customers who receive information, services, products they want (qualitative trend information)	CA customer surveys	Same	TBD in 1996 by Pathfinder International and BCCP	Urban and rural CAs

INTERMEDIATE RESULT FOUR:

LOCAL SERVICE-DELIVERY ORGANIZATIONS STRENGTHENED, AND ASSOCIATED SUPPORT SYSTEMS FOR HIGH-IMPACT FAMILY HEALTH SERVICES IMPROVED

INDICATOR	SOURCE	ANNUAL MEASURE	BASELINE	RESPONSIBILITY
Stockout rate of FP commodities maintained at low level	FPLM stock survey	Same	4%	FPLM
Stockout rate of ESP commodities for USAID NGOs at field level	FPLM stock survey	Same	No system	FPLM
Percent of FP logistics activities performed by GOB without external technical assistance	CA service statistics	Same	TBD in late 1996 by FPLM	FPLM
Number of OR findings/results replicated by other CAs	ICDDR/B MIS	Same	0.00	ICDDR/B
Number of OR activities conducted to operationalize the ESP	ICDDR/B MIS	Same	0	ICDDR/B
Completeness of polio and neonatal tetanus toxoid national surveillance reporting	Nat. EPI MIS	Same	Polio 10%, NTT 2%	BASICS

INTERMEDIATE RESULT FIVE:

SUSTAINABILITY OF FAMILY HEALTH SERVICES AND SUPPORT SYSTEMS IMPROVED

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

MONITORING AT THE “ACHIEVING” LEVEL

Each CA partner developed performance monitoring plans in its Subresults and in its action plans, which they shared with all other partners. There were two reasons for such detail: (1) good planning for the CA partner itself; and (2) to enable the cross-partner collaboration upon which the NIPHP depends. The first example below, an excerpt from the Urban Service Delivery Partnership, is at the Subresults level. The second example, at the action plan level, is from the Rural Service Delivery Partnership.

CANAME: URBAN SERVICE DELIVERY PARTNERSHIP		COLLABORATORS: BASICS, QUALITY IMPROVEMENT PARTNERSHIP AND NGOS		IR1: USE OF HIGH-IMPACT FAMILY HEALTH SERVICES IN TARGET POPULATION INCREASED		
STRATEGIES	SUBRESULTS	PERFORMANCE INDICATORS				
		INDICATOR	BASELINE 1996	BENCHMARK (MID-2000)	TARGET 2004	MEANS OF VERIFICATION
Broaden service offerings	1.1 In approximately 44 low-performing municipalities, priority ESP services offered cost-effectively according to standards	Number of municipalities having ESP services that meet standards	0	44	44	NGO reports, site visits
		% of population covered in the target areas	TBD	40%	50%	NGO reports
	1.2 Service-delivery infrastructure for more clinical and long-lasting methods expanded	No. of clinics and clinical networks offering full range of clinical contraceptive services	None	150	250	Service reports
		% of referrals that received services	TBD	80%	100%	NGO reports
Integrate service offerings	1.3 Priority ESP services offered in an integrated manner to meet customer expectation of one-stop shopping	No. of NGO clinics offering at least four high-impact services	None	150	250	NGO reports, site visits
		% of NGO clinics offering services to all members of the family	0	80%	100%	
Focus on selected market segments	1.4 Appropriate services provided to low-parity couples, newlyweds, adolescents, and pregnant women	% of low-parity couples using contraceptive services	21%	35%	60%	NGO reports, DHS
		% of pregnant women receiving iron folate tablets	None	25%	50%	
		% of women receiving TT	49%	70%	95%	

Intermediate Result 1: Use of high-impact family health services in target population increased

Subresult 1.1: In approximately 150 low-performing and/or underserved thanas (a geographic unit), high-priority services from ESP offered cost-effectively and according to standards

Action Plan Title 1.1.2: Introduce high-priority services in targeted thanas based on customer needs

Key Collaborators: Operations research partner

ACTION PLAN DESCRIPTION (TASKS)	RESPONSIBILITY	COMPLETION OF TASK	COMPLETION OF PLAN
1.1.2.1 Contribute to the development of <i>Guidelines for Needs Assessments</i> to identify high-priority services within ESP	ORP, Pathfinder, BRAC	December 1997	December 1998
1.1.2.2 Conduct needs assessment among customers in the targeted thanas for identification of high-priority services within ESP	Pathfinder, BRAC, NGOs	June 1998	
1.1.2.3 Design and introduce ESP services in phases according to the findings of the needs assessment in the targeted thanas	Pathfinder, BRAC, NGOs	December 1998	

CORPORATE SUPPORT AND COORDINATION

NIPHP COORDINATION MECHANISM

The NIPHP will be coordinated through the following mechanisms:

- u Annual performance reviews, chaired by the Secretary of Health and Family Welfare (or his designee) will be held among USAID, the GOB, and the seven CA partners and their partner organizations.
- u Annual workplans for each of the components of the NIPHP (urban service delivery, rural service delivery, social marketing, quality improvement, child survival, urban immunization, operations research, and contraceptive logistics) will be reviewed and approved by designated working groups, or a similar mechanism, as mutually agreed. The working groups will be chaired by GOB senior officials.
- u USAID/B will furnish to the GOB an annual performance narrative report and quarterly financial reports, by Strategic Objective budget line item, in a mutually agreed-upon format.
- u Regular coordination meetings and field visits, as well as periodic external assessments, will be conducted by USAID and the GOB for the purpose of program assessment and monitoring, planning and problem solving, as mutually agreed.

NIPHP CORPORATE SUBRESULTS

The corporate body has established six subresults:

- u Contributions will be made toward establishing a national policy framework for the delivery of integrated population and health services.
- u Essential family planning/MCH/health commodities will be made available to the USAID-supported NGO clinics and service-delivery organizations.
- u The NIPHP Strategic Plan will be reviewed and updated on a regular basis.
- u Coordination will be achieved among the nine NIPHP partners and between the NIPHP program and other donor and GOB population and health programs.
- u There will be rational planning and allocation of USAID funds across partners.
- u Emphasis will be placed on effective communication and dissemination of NIPHP implementation status, problems, issues, lessons learned, and accomplishments.

CUSTOMER SERVICE PLAN

The purpose of the customer service plan is to provide a mechanism for checking on whether NIPHP activities and the work of the CA partners are continuing to meet customer needs. The seven CA partners and their partner organizations developed customer service plans in May 1997. The following text is taken from the final Results Package presented to USAID/W.

DATA COLLECTION

The NIPHP will use both quantitative and qualitative methods to gather and analyze customer data. Quantitative (and qualitative, if/as appropriate) data will be collected from both end users and service providers and analyzed at least annually by each of the partners for their individual programs. Data collection and analysis will be completed prior to the annual workplan review process. This data will also be used annually by the corporate body to determine customer satisfaction at the program level (with particular attention to the links between the service providers and the ultimate customers).

In addition, the corporate body will manage a qualitative rapid appraisal in all project areas every two years beginning in late 1999 (for a total of three appraisals—in 1999, 2001 and 2003). Every partner will participate in the data gathering and analysis stages of the appraisal. The rapid appraisal will seek information about, but not necessarily limited to, the following,

FROM THE ULTIMATE CUSTOMERS:

- u *Change in variety and delivery of information, services, and commodities*
- u *Change in satisfaction with information, services, and commodities*
- u *Change in quality of information, services, and commodities*
- u *Change in cost of services and commodities*
- u *Change in personal practices and awareness of the customers*
- u *Change in reasons for visits (demand for service)*

FROM THE SERVICE PROVIDERS:

- u *Change in their understanding of how to manage services*
- u *Change in delivery systems*
- u *Change in their ability to deliver services*
- u *Available commodities*
- u *Available equipment*
- u *Technical knowledge and skills*
- u *Change in policies, protocols, and procedures that improved their ability to provide services and commodities*

- u *Change in administrative support*
- u *Change in coordination/cooperation among service providers (public, private, NGOs)*
- u *Change in fee structure and cost coverage*
- u *Change in customer demand for (types of) services*
- u *Change in referral practices for unavailable services*

DATA ANALYSIS AND USE

Each CA partner and its partner organizations will analyze the data collected in the annual surveys (both quantitative and qualitative, as appropriate) and will revise/adjust its annual workplans accordingly, based on the schedule set by the corporate body for annual workplan review and approval.

Each CA and its partner organizations will also incorporate the results/lessons learned from the qualitative rapid appraisals into its workplans in 1999, 2001, and 2003.

The corporate body will also be responsible for reviewing the findings of the qualitative and quantitative surveys in light of the Results Framework and the action plans of the partners to ensure that the individual CAs and their partner organizations or groups of CAs appropriately modify their workplans if/as necessary. The corporate body is responsible as well for ensuring that the overall framework remains responsive to the stated needs of the customers, based on the customer information gathered.

ROLES AND RESPONSIBILITIES

Each CA and its partner organizations is responsible for gathering and analyzing customer data on its activities and using that information to prepare annual workplans and execute its activities. The corporate body will oversee this process.

The USAID partnership will take responsibility for coordinating, organizing, and facilitating the rapid appraisal of ultimate customers every 2 years. Each CA and its partner organizations will contribute to the development of the questionnaire and provide interviewers so that all may learn the impact of the program's collective and individual activities on both intermediate and ultimate customers.

SYNOPSIS OF THE POPULATION/HEALTH CUSTOMER VALIDATION: NOVEMBER 1996

SERVICE AVAILABILITY

The majority of socially and economically disadvantaged Bangladeshis reported that family planning, MCH, and adult health services (most often from traditional healers) were available in their urban wards and rural unions. Rural customers received their nonclinical contraceptives primarily from fieldworkers, and urban customers received their nonclinical contraceptives primarily from fieldworkers and pharmacies. Rural children generally received immunizations from EPI spots and urban children from EPI spots and clinics. Many people reported the availability of contraceptive methods, such as pills, condoms, and injectables, in satellite clinics, family welfare centers (FWCs), thana health complexes (THCs), and NGO clinics, and the availability of all these contraceptives plus IUDs in the FWCs, THCs, and NGO clinics. They also reported the availability of MCH services, such as immunization, antenatal care, and Vitamin A distribution, in these facilities. (Generally, they defined antenatal care as receiving tetanus toxoid vaccinations, rather than making pregnancy-related visits.)

A minority of respondents, particularly those living in low-performing areas, had little knowledge of or access to any family planning or MCH services. Some female slum dwellers who had recently migrated to Dhaka reported that they did not know where to go for services.

Many respondents also reported that FWCs and NGO clinics offered treatment of common diseases, although the vast majority of men and women in both urban and rural areas used local private practitioners (often traditional healers) for curative care. Women typically gave birth at home, attended by a dai, (TBA) or family member. Reasons cited for home delivery included comfort in using a traditional, community service source (and sometimes fear of using an outside source), privacy, convenience, lack of cost, and lack of knowledge about delivery services in other locales.

Many women in low-performing areas said they did not use contraception, despite having some knowledge of modern methods. Some stated they and their families still desired to have additional children. People in Teknaf said high infant mortality, especially from malaria, was a major reason for desiring large families. Some women said they were reluctant to adopt or continue with family planning because of side effects and health problems. Newlyweds in particular stated that there were familial and social norms for them to have at least one or two children before using contraceptive methods; as a result, they were generally disinclined to use contraceptives until these children had been born.

The majority of respondents strongly urged the continuation of a community-based supply and information distribution system. They



viewed community delivery as offering more convenience and privacy and costing less than other delivery modes. In particular, they liked the possibility of two-way communication with fieldworkers, because it afforded them the opportunity to receive detailed information and to ask questions. (In some instances, they were dissatisfied with their current interpersonal communication with community service providers).

Respondents generally supported the idea that community-based services could be provided through cluster or community group meetings, rather than through doorstep delivery. (Some respondents preferred the convenience of doorstep delivery, even though they said they would use cluster services; others thought that an advantage of a cluster approach would be delivery of expanded services and information.) Respondents also said separate group meetings should be held for males and females, particularly for family-life education and RTI/STI information dissemination. The respondents advocated doorstep delivery, as opposed to cluster or group delivery only, to provide contraceptives and family planning information to newlyweds.

The vast majority of customers, including those recommending community-based services through doorstep or cluster or group delivery, advocated accessible, integrated service delivery from fixed sites. Their reasons included time savings from not having to visit multiple service-delivery centers for various services and the opportunity to receive higher-quality, better-managed services at these centers. They often identified desirable specific days and times in addition to those offered under the current system (particularly afternoon and evening hours) for the provision of these integrated services. Various respondents mentioned that the following types of services or supplies could be provided at the integrated facilities: family planning (including clinical contraception); MCH (antenatal care, postnatal care, safe delivery, Vitamin A, immunizations); primary health care (treatment of RTIs and STIs); counseling; and health education. They generally defined accessibility as being within 1–2 kilometers of their home communities.

Most customers supported the idea of all family members receiving services from the same site. However, customers deemed privacy, especially for family planning, very important, and it was seen as lacking in many facilities under the current system. In general, customers were willing to accept common waiting rooms. Some said that men and women presently sit together in the same waiting room at private clinics. However, they advocated separate counseling and examination rooms and preferred service providers of the same sex (especially for family planning and treatment of RTIs/STIs).

Respondents, particularly those from rural areas, said they often visited private traditional practitioners, usually local uncredentialed providers (palli chikitshak, kobiraj, quacks, and homeopaths) when they or their children are ill. Cited advantages of traditional healers included easy access, availability, and lower cost, and the fact that



some traditional healers provided services on credit. Generally, disadvantaged Bangladeshis said they were satisfied with the services received from the traditional doctors. Some claimed that homeopathic medicine is safe because it causes fewer side effects than allopathic medicine, although a few respondents complained that homeopathic medicine took time to work.

If local practitioners could not cure an ailment, those disadvantaged Bangladeshis with disposable income reported that they would go to credentialed practitioners. Those with little or no disposable income or those with serious, acute illnesses said they would go to public-sector providers first. If they were not cured by public-sector providers and if their illness were serious enough, they would be compelled to go to private practitioners, even if it meant borrowing money or selling assets. Urban residents said they often used the services of physicians attached to pharmacies.

Women said they were able to use local public-sector family planning and MCH services because they were visited by FWAs or were able to use satellite clinics or FWCs. Many women, however, said they used local private practitioners when public-sector services were not available or when they questioned the quality of these services. (No public-sector facilities exist in some remote areas.) Men stated that they almost exclusively used private practitioners because local public-sector facilities were geared toward family planning and MCH; because they viewed private practitioners as reliable, attentive, and experienced; and because private practitioners were accessible. The closest public health facilities officially open to men were the THCs and union-level rural dispensary in some areas. FWC-based medical assistants usually also maintained private chambers where men could receive treatment.

Many disadvantaged respondents reported that they failed to receive follow-up services because service providers were not available or did not counsel them to do so. Some customers, on the other hand, said they deliberately did not return for follow-up services because they could not afford a full course of treatment or because they saw no need to do so once they felt better. In general, customers were more likely to receive family planning than curative health follow-up services. NGOs, as compared with government facilities and service providers, were also more likely to recommend family planning follow-up services.

Many socially and economically disadvantaged Bangladeshis reported that they and their family members suffered from respiratory infections, diarrhea, scabies, and parasites. A few respondents noted the presence of malaria and tuberculosis in their areas. Customers in Cox's Bazar claimed that malaria was pervasive in their community, contending the disease had become prevalent during the previous 3 years when the government stopped its mosquito eradication program.

PAYMENT FOR SERVICES

In most instances, customers said they received free pills, injectables, and IUDs and paid a very nominal fee for condoms. However, some respondents in rural Sylhet, Cox's Bazar, and Patiya said that they paid for pills or injectables from public-sector providers. Customers usually bought ORS from the market, although they said they could receive it for free from government service providers. They almost always received free Vitamin A and immunizations. NGOs commonly charged a registration fee and fees for various kinds of services and commodities, including family planning commodities. Urban residents typically paid Tk. 2–3 for a cycle of pills, Tk. 1–2 for two dozen condoms, Tk. 5 for injectables, and Tk. 2–3 for a sachet of ORS. A few women reported that they paid for commercial pills because they experienced side effects from the free brands.

Many customers reported that they paid for services at public-sector hospitals, THCs, and FWCs, despite an official policy that these facilities provide free services. Public hospitals (medical colleges and sadar hospitals) generally charged a registration fee. Besides fees that could be considered standard, disadvantaged Bangladeshis reported paying “unofficial” fees. Men in Rajshahi claimed they paid these fees (in essence bribes) varying between Tk. 5 and Tk. 50, to physicians to render services and even to gatekeepers and peons to allow them to enter hospital grounds. Many people reported paying bribes of Tk. 15–20 to THC personnel to receive adequate services. Several respondents mentioned that parents and children died because they could not pay for public-sector services. Other respondents said that under no conditions would they pay for public-sector services because they should not have to do so.

Services at THCs were usually reported to be free, although clients often paid high transportation fares to get there. Typically, customers paid commercial prices in the market for drugs prescribed by THC physicians. They considered drugs received for free in the THCs to be ineffective. Customers resented this situation because they desired to receive effective medicine free of cost at the THCs. Respondents said they would consider delivery of babies at the THC typically only for high-risk or emergency cases.

Reports of payment at FWCs varied. Some respondents said that commodities and services were free; others reported paying charges for routine FWC service delivery. FWCs typically did not offer child delivery services. Socially and economically disadvantaged Bangladeshis generally consider that dais and TBAs provide a community service when they deliver babies, but they commonly pay these service providers either very small amounts of cash or in kind for their efforts.

Services from credentialed private-sector physicians were reported to be relatively expensive, typically ranging between Tk. 50 and Tk. 100, although they could cost as much as several hundred taka. In addition to paying this service fee, customers said they paid commercial prices for medicines prescribed by these physicians.



Clients visiting palli chikitsak and other traditional healers typically said they did not pay for the service, but they did pay between Tk. 10 and Tk. 50 for medicine recommended by these providers. Both urban and rural disadvantaged Bangladeshis generally said they were willing to pay a nominal amount to ensure adequate quality and availability of staff. Some people said they would be willing to pay if facilities introduced a formal fee structure and gave receipts, improved the quality of care (including management of staff), and offered subsidized medicine. Nonetheless, many residents said they could not afford to pay anything for medical services and therefore tolerated poor quality of care at public-sector facilities. Many respondents, especially women, also were not able to quantify how much they could pay for medical services.

Socially and economically disadvantaged Bangladeshis were emphatic in indicating that they had to pay for medical care in life-threatening situations for themselves or their families. Several respondents reported that they took out loans or sold property or assets to cover those costs. However, because of the importance of maintaining health, Bangladeshis are willing to pay high costs or go into debt as long as treatments are effective. A rickshaw driver, from Rajshahi City Corporation said that, on recommendation from medical college physicians, he paid Tk. 500 for medicine for his pregnant wife. Another rickshaw driver, from Rangpur Division, said he borrowed Tk. 10,000 for surgery, and a tempo driver said he spent Tk. 17,000 to treat tuberculosis. A woman in Khulna Division said her husband spent Tk. 18,500 to treat her complicated pregnancy. However, customers reported they were often unwilling to treat minor ailments with anything other than herbal medicines because of the cost.

REFERRALS

Customers have had varied experiences with referrals. Most disadvantaged Bangladeshis said service providers usually did not refer them or their families to other family planning or health service providers or facilities. Many respondents said they asked family members or neighbors for names of appropriate providers or facilities. In this case, men typically chose the service providers for curative care and women those for family planning and MCH. Some felt that doctors, often traditional doctors or dais, delayed referring them to other practitioners in order to keep the business for themselves. This situation was experienced particularly in cases of chronic, rather than acute, diseases. Some respondents said that service providers referred them to other service providers, but did not specify whom or where. Some customers reported that providers working in public-sector facilities would advise clients to visit them later in their private chambers.

Some socially and economically disadvantaged Bangladeshis, however, reported successful referrals. Several women from Sylhet said service providers from their FWC had referred their children or other relatives to the THC or private practitioners, and the treatment had been successful. Several women and men in high-performing

areas said private practitioners or paramedics had satisfactorily referred them to other providers or facilities. In general, the family planning referral system functions better than the curative health referral system. The family planning referral system works relatively well for clinical method follow-up, but less well for management of nonclinical side effects.

SATISFACTION WITH SERVICES

The majority of both women and men criticized public-sector service delivery. They typically complained of a lack of medicine or inadequate medicine for common diseases such as ARI, diarrhea, scabies, and fever. Because medicine was not readily available at public facilities, disadvantaged Bangladeshis said they were compelled to purchase medicine at commercial prices in the market. Indeed, many respondents wanted to receive services and drugs at one integrated facility, and in fact some thought the FWC should be that kind of facility. There was also a widespread belief that service providers and staff sold free public-sector medicines in the commercial market. In addition, respondents questioned the efficacy of medicines given to them in public-sector facilities. Most people mentioned that they received the same kind of medicine (white tablets) for all ailments. Some underscored their preference for multiple medicines that public-sector doctors did not provide.

Respondents also complained about long waiting times, lack of privacy, lack of counseling, and inattentive or discourteous behavior by staff. For example, one woman in Rajshahi City Corporation complained that clinic paramedics wasted their clients' time by incessant gossiping. One man in Rajshahi City Corporation said that hospitals were a good place to rest, not to receive treatment. Women, especially those under purdah restrictions, complained about lack of privacy. The dissatisfaction was aimed more at treatment of common diseases than either family planning or MCH services.

Both men and women leveled particular criticism at service provision at the THCs, payment for ostensibly free medicine, lack of privacy, discourteous behavior or lack of attention from staff, absent staff, long waiting periods, and lack of or inappropriate medicine.

Perceptions about FWCs varied. As a rule, satisfaction with FWC services was low, particularly among women. A majority of customers complained that desired staff, medicines (not including contraceptives), and counseling were often not available at their FWCs. By contrast, others claimed that FWAs in the FWCs provided needed services and commodities and maintained privacy.

Many customers in both low- and high-performing areas reported FWAs visited them infrequently or not at all. They noted that fieldworker visitation was particularly infrequent for newlyweds, contraceptive nonacceptors, and pregnant women. Nonvisitation appeared to be a particularly troublesome problem in remote areas. Some women observed that FWAs only distributed pills and condoms;



did not provide counseling about side effects, motivation, or MCH information; or spent inadequate time with them. An imam (religious leader) in Rangpur Division said his wife had become pregnant as a result of not receiving family planning services from a fieldworker and had ended up terminating her pregnancy with menstrual regulation. By contrast, some respondents reported having good experiences with FWAs. One woman from Rajshahi City Corporation described an FWA who accompanied her to a clinic to treat her child for scabies. She said she would remember this FWA's kindness for the rest of her life. Men did not report contact with family planning fieldworkers and did not express a need to be visited by them.

Customers generally claimed that health assistant visits were either rare or nonexistent. Experiences with satellite clinics varied. Most respondents said satellite clinics were held in their communities. On the other hand, rural Chittagong residents said satellite clinics were not held regularly in their areas, while customers in Rangpur noted the clinics were held, but did not offer MCH services.

Of all service delivery, socially and economically disadvantaged Bangladeshis were most satisfied with the provision of EPI services because of their easy access, their lack of cost, and the perceived efficacy of vaccines. Customers also expressed satisfaction with private practitioners (both traditional and professional) and pharmacies. They generally considered traditional doctors to be known and trusted members of their communities, to be accessible, and to offer reasonably priced services. They also considered pharmacists to be accessible and to offer a wide range of medicines, and appreciated those pharmacies with an adjoining room for a Bachelor of Medicine in Surgery (MBBS). They generally considered credentialed private-sector physicians to have technical capabilities, to be courteous, and to provide effective treatment.

Customers who received NGO services were generally satisfied because of the perceived quality of the services. However, some respondents in Rajshahi noted that their NGO fieldworkers did not visit regularly and charged for their services, and residents in Sunamganj complained that their NGO only offered motivational services and did not provide counseling or treatment.

INFORMATION AVAILABILITY

Socially and economically disadvantaged Bangladeshis said they had learned about family planning and MCH from a variety of sources: fieldworkers, radio, television, billboards, posters, pharmacists, associations (such as Grameen Bank and BRAC), and word of mouth from neighbors and family members. Even newly married women often had basic information about family planning and MCH that they had obtained from FWA visits to their mothers or sisters-in-law. Generally, women seemed to know more about family planning and MCH and men more about curative care. Overall, people appeared best informed about family planning, immunization, and preparation of ORS. In general, newlyweds were less well informed about family planning and health issues than those married for several years.



Many customers had access to radio, and a few had access to television, and they were able to learn elementary MCH, sanitation, and nutrition information from these sources. Both rural and urban residents suggested that population and health information be conveyed through the mass media. Most customers preferred face-to-face communication, especially those with little or no access to the mass media. People observed that even though the mass media could transmit basic messages, interpersonal communication was far more effective in providing detailed information and answering questions.

Many customers felt the need to be better informed about family planning and health issues. Some explicitly mentioned their need to know more basic information about contraceptives (e.g., frequency of use, suitability), contraceptive side effects, MCH, and RTIs/STIs. They said that by being better informed, they could make better decisions about their own and their family's health.

Some respondents, particularly those who were most destitute, were misinformed or lacked basic information about family planning and health service provision. One mother in Rangpur had heard a rumor that immunizations could cripple or kill her child and for that reason had not taken her last child to be immunized, although her older children had been. Women in Teknaf had not taken their children to be immunized because no information had been made available to them about the timing of the EPI sessions.

Virtually all respondents believed that men should be better informed about family planning, MCH, and primary health care. Women thought this would be beneficial because men formally made family planning decisions and needed to have better information in order to make better decisions. Some men wanted more information because they felt it was their responsibility to take care of their family's family planning and health needs. Men said they needed information because they often were the ones to take their sick children to private practitioners. One group of women in Sylhet Division observed that women would no longer need to use contraceptives secretly once men know more about the benefits of family planning. Women stated that greater male knowledge would translate into more active male involvement with family planning. For example, one woman in Rajshahi cited the example of her husband, who nightly reminded her to take her pill.

Respondents often said that men received their family planning and MCH information from their wives. In general, wives were more knowledgeable than their husbands about family planning and MCH, although some husbands, particularly those in urban areas, knew basic facts about family planning methods, immunization, and nutrition. Some men observed that family planning and health information was geared mainly toward women and children. In general, communication between husbands and wives appeared limited.



PERSONAL OR COMMUNITY INVOLVEMENT

Socially and economically disadvantaged Bangladeshis generally said their communities were not much involved in the provision of family planning and health services. (In some areas, community involvement was precluded by a lack of services or facilities.) However, some customers mentioned that their communities provided space and logistics for satellite clinics and EPI camps. Some respondents also said their communities had depot holders. Many people did not know whether elected local governments were providing support for population and health activities. Attitudes toward local government involvement were mixed. Some respondents felt that their ward commissioners or union parishad chairmen or members were already knowledgeable or that they would benefit from their leaders being involved; others felt that their elected local government officials were untrustworthy, were interested primarily in their own self-promotion, or would simply lack the interest to be involved in population and health activities. Many respondents did not even know about the existence of union family planning committees. Some felt that traditional leaders, such as matbars, schoolteachers, traditional doctors, educated women, and elderly women, would take an interest in family planning and health and would be willing to work on a voluntary basis to promote them. Many customers stated that they did not know who in their communities would be suitable for involvement.

Many people said they would be willing to volunteer to provide family planning and health services, although they generally did not have a clear idea about what this kind of involvement would entail in terms of effort or time. Many women and men said they were also willing to provide these services without monetary compensation. For example, a woman in Khulna district said that even though she needed to abide by purdah restrictions, she would still like to distribute pills and ORS and provide information about hygiene from her house. However, several respondents stated that they had no time to be involved in activities on a nonpaying, voluntary basis. A distinct minority felt that community members providing these family planning and health services should be paid, particularly if doing so took a large amount of time. Some respondents said that associations and NGOs could most effectively organize them because they would not be able to take any initiatives on their own.

The great majority of men and women supported the idea that adolescents should receive family-life education, defined as instruction provided about personal hygiene, physical development (especially puberty), nutrition, and sanitation. Women in particular believed this kind of education is important for adolescent or unmarried girls. A group of women in Teknaf emphasized the importance and urgency of providing family-life education. They noted that premarital and extramarital sexual activities were increasing in frequency because marriages were being postponed for reasons of dowry and education.



People said they commonly referred to fieldworkers or, less often, an association, to provide family-life education through community or group discussion, although some women in both high- and low-performing areas desired that individual instruction be given to their daughters. Some also felt that community members could be trained to impart this information. Others felt that public schools could provide family-life education, although several respondents noted that school dropouts would also need to be covered. Finally, some respondents suggested that the mass media could convey family-life messages. All customers believed boys and girls should be taught separately.

INFORMATION ABOUT RTIs/STIs/AIDS

Both men and women had little technical knowledge about RTIs/STIs, although a large minority expressed a desire to know more about them. Many women in both high- and low-performing areas reported symptoms, such as white discharge, itching, burning, genital sores, and lower abdominal pain. The pervasive reports of these symptoms suggest that RTIs are common among people living in slums and villages. People in all areas mentioned symptoms that indicated the presence of STIs. For example, a woman in Khulna District said that her brother-in-law suffered from extreme genital distress as a result of “gonorag” (gonorrhoea) contracted from prostitutes. Women in Sylhet said that STIs were a concern because men visited commercial sex workers as a result of delayed marriage, and also because some men engaged in homosexual practices there. STIs were also a concern in Chittagong and Sylhet because many men there had temporarily migrated outside Bangladesh.

Some respondents considered these diseases to be part of everyday life and not specific targets for treatment. Others, such as women in Teknaf, explicitly requested treatment of these diseases.

Many Bangladeshis, particularly women, had no idea who should treat these diseases or where. Many people either did not treat these diseases or did so using herbal remedies. If the disease persisted, they would visit a kobiraj, and if treatment by the kobiraj was ineffective, they would sometimes visit a professional private practitioner. However, allopathic doctors were considered expensive. Many Bangladeshis said RTIs/STIs were treated by the local kobiraj or other local private practitioners because they were more convenient and less expensive than allopathic doctors. Some men reported using a kobiraj outside their community for fear of recognition. Virtually all respondents who mentioned that they had received treatment said their service provider had neither counseled them nor requested that their spouse be examined and receive treatment. Both women and men complained about a lack of qualified physicians to treat these diseases.

Some respondents suggested that female family planning and health fieldworkers should inform women about these diseases



through group discussions; others felt that credentialed physicians should provide the instruction. A large minority of customers preferred that men and women receive separate instruction about these diseases.

Men appeared to be better informed than women about the names and symptoms of STIs such as syphilis and gonorrhea. Few disadvantaged Bangladeshis were aware of AIDS, although some men in Chittagong were aware of the disease because of their residence abroad.

GENERAL SUGGESTIONS FOR IMPROVEMENT

Both men and women preferred that a local site be available to handle their family planning and health needs; that essential drugs and professional staff, such as MBBSs, be made available at this site; that waiting time be reduced; that privacy be maintained; and that proper counseling and examinations be given. They also recommended that this facility offer subsidized services and commodities. Many people supported the idea of integrated facilities that would provide higher-quality services and said they would be willing to pay a nominal fee for these services. They also supported the idea that cluster or community groups would provide motivational activities, in-depth IEC, and counseling through interpersonal communication. They were in favor of these groups informing them about RTIs and STIs. Finally, they urged that men participate in these groups, but separately from women.

GLOSSARY OF TERMS

Activity: An action undertaken either to help achieve a program result or set of results, or to support the functioning of USAID or one of its operating units. (a) In a program context, i.e., in the context of Results Frameworks and Strategic Objectives, an activity may include any action used to advance the achievement of a given result or objective, whether financial resources are used or not. For example, an activity could be defined around the work of a USAID staff member directly negotiating policy change with a host-country government, or it could involve the use of one or more grants or contracts to provide technical assistance and commodities in a particular area. Also within this context, for the purposes of the new management systems, “activity” includes the Strategic Objective itself as an initial budgeting and accounting element to be used before any specific actions requiring obligations are defined. (b) In an operating expense context, an activity may include any action undertaken to meet the operating requirements of any organizational unit of USAID.

Activity Manager: The member of the Strategic Objective/Results Package team designated by that team to manage a given activity or set of activities contributing to the results to be achieved under the Results Package.

Agency Goal: A long-term development result in a specific area to which USAID programs contribute and which has been identified as a specific goal by the Agency. (See also **Operating Unit Goal.**)

Agency Mission: The ultimate purpose of USAID’s programs; it is the unique contribution of USAID to our national interest. There is one Agency mission.

Agency Objective: A significant development result that USAID contributes to, and which contributes to the achievement of an Agency goal. Several Agency objectives contribute to each Agency goal. Changes in Agency objectives are typically observable only every few years.

Agency Program Approach: A program or tactic identified by the Agency as commonly used to achieve a particular objective. Several program approaches are associated with each Agency objective.

Critical Assumption: In the context of developing a Results Framework, critical assumptions refer to general conditions under which a development hypothesis will hold true, or conditions that are outside of the control or influence of USAID and are likely to affect the achievement of results in the Results Framework. Examples are the ability to avert a crisis caused by drought, the outcome of a national election, and birth rates continuing to decline as they relate to an education program. A critical assumption differs from an Intermediate Result in the Results Framework in that the Intermediate Result represents a focused and discrete outcome that specifically contributes to the achievement of the Strategic Objective.



Customer: Those host-country individuals, especially the socially and economically disadvantaged, who are beneficiaries of USAID assistance and whose participation is essential to achieving sustainable development results. An individual or organization that receives USAID services or products, benefits from USAID programs, or is affected by USAID actions is a customer.

Customer Representative: Any individual or organization that represents the interests of those individuals, communities, groups, or organizations targeted for USAID assistance.

Customer Service Plan: A document that presents the operating unit's vision for including customers and partners to achieve its objectives. This document also articulates the actions necessary to engage participation of customers and partners in planning, implementation, and evaluation of USAID programs and objectives. It acts as a management tool for the individual operating unit and must be developed in the context of existing Agency parameters.

Customer Surveys: Surveys (or other strategies) designed to elicit information about the needs, preferences, or reactions of customers regarding an existing or planned activity, result, or Strategic Objective.

Implementation Letters: Formal correspondence, numbered sequentially, between USAID and other parties pursuant to a duly signed agreement that addresses, inter alia, interpretations of agreements, satisfaction of conditions precedent to disbursement, funding commitments, and mutually agreed-upon modifications to program descriptions.

Input: The provision of technical assistance, commodities, capital, or training in addressing development or humanitarian needs.

Interim Performance Target: A target value that applies to a time period less than the overall time period related to the respective performance indicator and performance target.

Intermediate Customer: A person or organization, internal or external to USAID, that uses USAID services, products, or resources to serve indirectly or directly the needs of ultimate customers.

Intermediate Result: A key result that must occur in order to achieve a Strategic Objective.

Joint Planning: A process by which an operating unit actively engages and consults with other relevant and interested USAID offices in an open and transparent manner. This may occur through participation on teams or through other forms of consultation.

Lesson Learned: The conclusions drawn by participants, managers, customers, or evaluators based on review of a development program or activity, with implications for effectively addressing similar issues/problems in another setting.

Limited Scope Grant Agreement: The Limited Scope Grant Agreement (LSGA) is similar to the Strategic Objective Agreement, but is shorter in length. It is used for obligating funds for a small activity or

intervention, e.g., participant training or PD&S. Model agreements, including the LSGA, can be found in the Series 300 directives.

Operating Unit Goal: A higher-level development result to which an operating unit contributes, but which lies beyond the unit's level of responsibility. An operating unit goal is a longer-term development result that represents the reason for achieving one or more objectives in an operating unit strategic plan. An operating unit goal may be identical to an Agency goal, but is normally distinguished from it in several key ways. An Agency goal is a long-term general development objective in a specific strategic sector that USAID works toward, and represents the contribution of Agency programs working in that sector. An operating unit goal is optional and represents a long-term result in a specific country or program to which an operating unit's programs contribute, and it may cross sector boundaries.

Output: The product of a specific action, e.g., number of people trained, number of vaccinations administered.

Parameter: A given framework or condition within which decision-making takes place (e.g., Agency goals, earmarks, legislation).

Participation: The active engagement of partners and customers in sharing ideas, committing time and resources, making decisions, and taking action to bring about a desired development objective.

Partner: An organization or customer representative with which/whom USAID works cooperatively to achieve mutually agreed-upon objectives and Intermediate Results, and to secure customer participation. Partners include private voluntary organizations, indigenous and other; international nongovernmental organizations; universities; other U.S. government agencies; the United Nations and other multilateral organizations; professional and business associations; private businesses (as, for example, under the U.S.-Asia Environmental Partnership); and host-country governments at all levels.

Partner Representative: An individual who represents an organization with which USAID works cooperatively to achieve mutually agreed-upon objectives.

Partnership: An association among USAID, its partners, and customers based upon mutual respect, complementary strengths, and shared commitment to achieve mutually agreed-upon objectives.

Performance Monitoring Plan: A detailed plan for managing the collection of data in order to monitor performance. It identifies the indicators to be tracked; specifies the source, method of collection, and schedule of collection for each data item required; and assigns responsibility for collection to a specific office, team, or individual. (a) At the Agency level, it is the plan for gathering data on Agency goals and objectives. (b) At the operating unit level, it contains information for gathering data on the Strategic Objectives, Intermediate Results, and Critical Assumptions included in an operating unit's Results Framework.



Performance Monitoring System: An organized approach or process for systematically monitoring the performance of a program, process, or activity toward its objectives over time. Performance monitoring systems at USAID consist of, inter alia, performance indicators, performance baselines, and performance targets for all Strategic Objectives, Strategic Support Objectives, Special Objectives, and Intermediate Results presented in a Results Framework; means for tracking critical assumptions; performance monitoring plans to assist in managing the data collection process; and the regular collection of actual results data.

Performance Target: The specific and intended result to be achieved within an explicit timeframe and against which actual results are compared and assessed. A performance target is to be defined for each performance indicator. In addition to final targets, interim targets may also be defined.

Portfolio: The sum of USAID-funded programs being managed by a single operating unit.

Rapid, Low-Cost Evaluations: Analytic or problem-solving efforts that emphasize the gathering of empirical data in ways that are low-cost, timely, and practical for management decision making. Methodological approaches include mini-surveys, rapid appraisals, focus groups, key informant interviews, observation, and purposive sampling.

Results Package: The formal analysis of a potential assistance activity conducted by USAID that addresses the anticipated benefits, resources required, and collateral effects of the activity. A Results Package (RP) consists of people, funding, authorities, activities, and associated documentation required to achieve a specified result(s) within an established timeframe. An RP is managed by a Strategic Objective Team (or a Results Package Team, if established) that coordinates the development, negotiation, management, monitoring, and evaluation of activities designed consistent with (1) the principles for developing and managing activities, and (2) achievement of one or more results identified in the approved Results Framework. The purpose of a Results Package is to deliver a given result or set of results contributing to the achievement of the Strategic Objective. The Strategic Objective Team defines one or more RPs to support specific results from the Results Framework. It may elect to manage the package or packages itself, or may create one or more subteams for the purpose. In addition, Strategic Objective Teams create, modify, and terminate Results Packages as required to meet changing circumstances pursuant to the achievement of the Strategic Objective. Thus, typically a results package will be of shorter duration than its associated Strategic Objective.

Results Package Database: Consists of data related to the actions, decisions, events, and performance of activities under a Results Package.



Results Review and Resource Request (R4): A document that is reviewed internally and submitted to USAID/W by the operating unit on an annual basis. The R4 contains two components: (1) the Results Review and (2) the Resource Request. Judgment of progress is based on a combination of data and analysis and is used to inform budget decision making.

Strategic Objective Team: A group of people committed to achieving a specific Strategic Objective and willing to be held accountable for the results necessary to achieve that objective. Teams can include USAID employees exclusively or USAID, partner, stakeholder, and customer representatives.

Strategic Plan: The framework an operating unit uses to articulate the organization's priorities, to manage for results, and to tie the organization's results to the customer/beneficiary. The Strategic Plan is a comprehensive plan that includes the delineation of a Strategic Objective and a description of how the operating unit plans to deploy resources to accomplish that objective. A Strategic Plan is prepared for each portfolio, whether it is managed at the country level, regionally, or centrally.

Strategic Support Objective: Intended to capture and measure regional or global development objectives whose achievement is dependent on the results of other USAID operating units, but to which a global or regional program makes an important contribution. Therefore, the key difference from a Strategic Objective, as defined above, is that achievement of the objective is accomplished and measured, in part, through activities and results at the field mission level.

Subgoal: A higher-level objective that is beyond the operating unit's responsibility, but provides a link between the Strategic Objective and the operating unit goal. Inclusion in operating unit plans is optional.

Target: See **Performance Target**.

U.S. National Interest: A political/strategic interest of the United States that guides the identification of recipients of foreign assistance and the fundamental characteristics of development assistance.

Ultimate Customer: Host-country people who are end-users or beneficiaries of USAID assistance and whose participation is essential to achieving sustainable development results.