

PD-ABN-680

**DEVELOPMENT OF USAID, BANGLADESH  
HEALTH AND FAMILY  
PLANNING PROJECT**

October 1-24, 1996  
November 11-14, 1996

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BASICS Technical Directive No. 007-BD-01-067  
USAID Contract Number: HRN-6006-Q-07-3031-00

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## ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
CDD	Control of Diarrheal Diseases
GOB	Government of Bangladesh
ICDDR/B	International Center for Diarrheal Disease Research
MCH	Maternal and Child Health
MOH	Ministry of Health
NIPHP	National Integrated Population and Health Project
USAID	United States Agency for International Development

## **I. EXECUTIVE SUMMARY**

Consultation was provided to the BASICS project and USAID/Dhaka during the period October 1-November 5, 1996, in the design of health components of the new National Integrated Population and Health Project (NIPHP). NIPHP represents USAID support to a proposed coordinated donor effort to maintain gains made in fertility while strengthening child health and antenatal care. The content and organization of the proposed effort are similar to those described in the 1993 World Development Report.

The majority of consultant effort was spent in preparation for and participation in the early project design and team development activities. Those activities are proceeding on schedule. It is to be expected that by September 1997 all planning will be completed for a large integrated health and family planning effort. Major reliance for project implementation will be lodged with non-governmental organizations (NGOs).

The shift in USAID, other donor, and national priorities implies a substantial shift in priorities and related organizations, e.g., de-emphasis of family planning organization and uni-purpose staff. While all major donors advocate such change, the Government of Bangladesh has not yet committed itself.

It is reasonably clear that special effort will be required to effect policy change and assure technical quality of interventions. BASICS can usefully provide needed technical expertise in a number of areas.

## **II. PURPOSE OF VISIT**

Assist USAID/Bangladesh in planning a new seven-year health and population program. Specifically, to provide advice on child survival components of the proposed project, largely through participation in a two-week project design workshop.

## **III. BACKGROUND**

BASICS has been selected as one of the seven cooperating agencies to engage the new health and population program. BASICS was chosen to address urban immunization activities. The choice of BASICS for this area derives from current activities supported by BASICS in urban areas under the Urban Immunization Project.

The other six collaborating agencies are—

- John Snow Inc., Urban Health
- Pathfinder International, Rural Health

- Association for Voluntary Surgical Contraception, Quality Improvement
- International Center for Diarrheal Disease Research, Operations Research
- Family Planning Logistics Management, Contractive Logistics
- Population Services International, Social Marketing

The National Integrated Populations and Health Project (NIPHP) represents a substantial departure from previous USAID funding in Bangladesh in the extent of its health funding (40 percent). Previously USAID/Bangladesh funding to health has been less than 5 percent of its level of funding of population activities. The choice of seven collaborating agencies also represents a sharp reduction from current levels of approximately 24.

#### **IV. TRIP ACTIVITIES**

##### **BASICS/Headquarters Briefing**

On October 1, 2, and 4, I met with BASICS/Headquarters staff. Background information was obtained on current USAID-supported activities. I also met with Dr. Hashem, one of the principals of the John Snow Inc. Urban Health Project team, and with Phil Gowers, the World Bank official primarily responsible for the development of a proposed new health and population loan to the Government of Bangladesh.

##### **Meeting with BASICS/Bangladesh Staff**

After travel during October 5 through 7, 1996, I met with BASICS/Bangladesh staff. I also met with a few of their colleagues, including David Piet and Richard Green, USAID; Abdullah Baqui, ICDDR/B; Nasim Uddin, National CDD Program Manager; Mohammed Ashraf, Chief Health Officer, Dhaka City Cooperation; and some of the officials in the Health Directorate of the Ministry of Health.

Findings from these meetings and review of materials included—

- Substantial progress has been made in Bangladesh in family planning and some disease prevention programs. Specifically, fertility rates have decreased substantially and immunization rates have increased.
- Some health indicators have shown little improvement, e.g., maternal mortality. There are substantial differences among regions of the country and socio-economic groups in all indicators of health and population. Of particular note are consistently better health and fertility indicators in urban areas and lagging performance in the two Eastern divisions, Chittagong and Sylhet.

- The areas of progress and lack of progress can be almost entirely explained by organizational and programmatic choices made by the GOB and its donor consortium. For example, there is a great preponderance of utilization of non-clinical contraceptives, which is directly attributable to program choices emphasizing household delivery of contraceptives, de-emphasizing facility based contraception. The home visitors program has been very effective in providing consistent coverage to the majority of households in rural areas.
- Malnutrition, particularly stunting, continues to be an enormous problem largely due to poverty and inappropriate supplementary feeding practices despite almost universal breastfeeding.
- There is widespread agreement that the currently divided population and health services in the MCH division of the Ministry of Health hinders further progress in improving MCH services.
- The World Bank and the Asian Development Bank intend substantial loans to the GOB in the areas of health and population. Proposed loans will support packages of prevention and medical interventions similar to those described in the 1993 World Development Report.
- The infrastructure for urban MCH programs support is not as developed as that for rural MCH programs. The MOH does not have the same range of responsibility in urban as in rural areas.

#### Regandrapur Project Planning Retreat

October 13-24, 1996 was spent at the Regandrapur Conference Center completing initial planning for the NIPHP. The meeting met its targets of establishing the vision, objectives, and intermediate results for the project. Although the meeting was successful in meeting its targets, it represented an investment of time and manpower which was probably in excess of that necessary to achieve the outputs.

#### Findings associated with the Regandrapur Conference—

- USAID appears to be entirely committed to both a broader scope of its health and population support to Bangladesh and a more participatory relationship with its cooperating agencies.
- USAID is also committed to thorough collaborative planning for the NIPHP.
- USAID is carefully planning its new project within the framework of the recent World Bank sector reports.

- The strategic planning framework utilized would have been more readily understood and useful had it been modified to make it more applicable to issues involved in planning public health programs.
- The seven collaborating agencies and USAID went a long way toward forming effective partnerships. GOB has not yet fully dealt with the changed scope of USAID support nor the lack of USAID budgetary support for the MOH under the NIPH project.
- USAID is unwilling to require needed organizational changes in the MOH as conditions precedent for the NIPH project. The MOH demonstrates little interest in reintegrating its family planning and child health activities.
- USAID and the seven cooperating agencies were of the opinion that current home visitor family planning services should be reduced and more emphasis placed on community-based interventions. The GOB was reluctant to commit to such a change.

#### Follow-up On BASICS/Headquarters Consultation

November 11-14, 1996 was spent at BASICS/Headquarters in debriefing, meeting with John Snow Inc., The Urban Health Services Cooperating Agency, and in completing the BASICS/Bangladesh vision and sub-results package. Outcomes of these meetings included the agreement that BASICS should assume the responsibility for advisory assistance to the strengthening of child health services, as well as immunization in urban areas.

## V. RESULTS AND CONCLUSIONS

Work to date has resulted in an agreement between the seven collaborating agencies that BASICS should engage in several areas of activity under NIPHP.

They are—

- To continue efforts in urban immunization from 1997 to 2002, with special emphasis in poliomyelitis eradication.
- To work toward a strengthened disease surveillance system, with initial emphasis on immunizeable diseases.
- To work at the national level in advocacy for policy definition and development of plans, standards, and training for integrated case management for childhood illness (IMCI).

- To assure primary responsibility for technical advice to all child health interventions and to antenatal services in urban areas. (It is likely that a role will evolve for BASICS in the rural partnership.)

Although still somewhat early in the planning process, it is possible to identify some strengths and weaknesses of the approach to the NIPHP and its probable content and implementation.

- USAID/Bangladesh is breaking out of its traditional program scope and management procedures in ways which represent clear improvement.
- It may be that the seven collaborating agencies, USAID, and the GOB do not yet have sufficient capacity to achieve desired improvements in maternal and child health. Their capacity in family planning is much more extensive than in other aspects of MCH. Current USAID technical assistance patterns minimizing expatriate and permanent consultant staff may not be as appropriate for the relatively new health portfolio as for the more mature population program which required relatively large technical assistance inputs in its early stages.
- The unwillingness of the GOB to commit to establishing a more supportive organizational arrangement for integrated health and family planning activities tends to substantially reduce the likelihood of achieving NIPHP objectives.

## **VI. RECOMMENDATIONS**

1. BASICS should seek to maximize its efforts to support the NIPHP given the comparative thinness of technical capacity among the other cooperating agencies in the areas of maternal and child health. BASICS should consistently represent the level of technical assistance required to most effectively and efficiently achieve maternal and child health objectives.
2. BASICS should make a strong commitment to partnership with the other collaborating agencies, USAID, and the GOB in order to best support the intentions of USAID. This commitment may need to take the form of encouraging USAID to empower the partnership and, once acceptable general principles are established, avoid excessive managerial intrusion during project implementation.
3. Reconsideration should be given to project feasibility if the MOH is unwilling to establish an organizational entity which is supportive of integrated health and population services. A sizeable effort is warranted to try and get the organization right. If the organizational structure is not supportive, an enormous amount of effort will be required to work around organizational obstacles. A consistent commitment should be maintained to the organization principles contained in the World Bank aide-memoire.

## **VII. FOLLOW-UP ACTION REQUIRED**

- (1) Provide adequate health expertise for the remaining steps of NIPHP planning.
- (2) Consider pre-implementation steps which can be taken, such as training current urban EPI officers to assume broader roles during the last months of the current project.
- (3) Support working groups and other fora established to better conceptualize project design and implementation issues and their resolution. BASICS will have a particularly important role to play in the maternal and child health issues.

**APPENDIXES**

**APPENDIX A  
CONTACT LIST**

## CONTACT LIST

### BASICS/Headquarters

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### Government of Bangladesh

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Mohammed Ali	Secretary MOHFP
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Shahadat Hossain	Health Services
A.K. Shamsuddin Siddiquez	Health Services
Azizur Rahmar	Logistics and Supply
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Khairuzzamen Chowdhury	DG Family Planning

## USAID

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## NIPHP Partners

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Ratu Gopal Saha	World Vision

Frank White	FPLM
Rich Owens	FPLM
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Davis Olson	PSI
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## Other

Nancy Gerein	CIDA
Peter Connell	ADL
Laurel Cobb	Poptech
Henry Mosley	JHV
David Sniadek	WHO
Phil Gowers	World Bank

**APPENDIX B**  
**MATERIALS REVIEWED**

## Material Reviewed

Fifth Population and Health Project

BASIC Health Services Package, World Bank, May 1996

Plan of Action for Improving Surveillance for AFP and Other EPI Diseases WHO, October 1996

Guiding Principles and Implications for Service Delivery, World Bank, September 1996

Information for Action - Using Data to Improve EPI Impact, BASICS, February, 1996

Dhaka Urban Integrated Child Survival Project (DUICSP), Mid-term Evaluation, World Vision, August, 1996

Urban Poor Strategy Bangladesh, BASICS, 1995

Draft Technical Assistance Project Proposal on Urban Primary Health Care Pilot Project, WHO, 1994

GOB - UNICEF Programme of Cooperation 1996-2000 Safe Motherhood, UNICEF, 1994

Control of Major Childhood Disease, UNICEF, 1994

Bangladesh Evaluation of National Immunization Days, 1995

Interministerial Urban PHC Task Force Report, GOBD, 1994

The Urban MCH-FP Initiative, USAID, 1995

Urban Poor Strategy, Bangladesh, BASICS, 1995

Meeting Report Government of Bangladesh and Donor Consultation for the Future Populations and Health Program, 1995

Bangladesh Demographic and Health Survey, 1993-94, MACRO International Inc., 1995

**APPENDIX C**  
**DRAFT NIPHP VISION DOCUMENT**

## Draft NIPHP Vision Statement

NIPHP's purpose is to improve the quality of life in Bangladesh by directly supporting the GOB's national Health and Population programme - 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 GOB on contraceptive logistics and urban immunisation, national operations research and IEC programmes, and support of selected MOHFW thana/union-level service delivery programmes.

Our planning timeframe is seven years, which overlaps significantly with Bangladesh's remaining 10-year window of opportunity for resolving its fertility crisis. By the year 2004, the NIPHP partnership (USAID, its 7 cooperating agencies and GOB) will support a basic package of services that fosters active participation from all family members (ie men, women and children). The package covers family planning, maternal and child health, RTI/STDs/HIV/AIDS and referrals for other family health needs as feasible - and the accompanying communication support in these areas. We shall look for opportunities to integrate youth as a new customer segment, to the extent that synergy with the basic package of services and budget allow.

Our main priority will be on serving areas of low health performance in Bangladesh, characterised by high proportions of unmet need and resistance to both family planning and basic health services. Geographically, this means a focus on Chittagong and Sylhet divisions and slums in urban areas; high priority will also be given to under-served pockets and specialised services in higher performing areas. Demographically, we shall concentrate on discontinuers in family planning/EPI, non-users of the entire range of services within our basic package and special groups like newly-weds and post-partum women. Throughout, we shall maintain our overriding concern with the poor and socially disadvantaged segments of the population and shall aim to respond to clearly expressed customer needs.

Within this scope, our performance objectives are ambitious. By 2004, we want to contribute to:

- Raising contraceptive prevalence from around XX % today to YY%.
- Increasing the rate of immunisation against EPI diseases from 64% to XX% for children and from 84% to YY% for women
- Increasing pregnancies supervised by trained staff from XX% to YY%.
- Raising provision of Vitamin A supplements from XX% of under-5s today to YY%.
- Achieving the national targets for improving child survival and maternal health:
  - reducing the total fertility rate from 3.4 to XX;
  - reducing infant and child mortality from XX/1000 today to YY/1000.
- Increasing knowledge of youths, men and women about the risks and prevention of STDs/AIDS.

The total NIPHP budget to 2004 is approximately US\$210 million, roughly the same as for the FPHSP on a per annum basis. To achieve an expansion of service scope, focussed on low performing areas and with ambitious performance expectations, we shall be pursuing programmatic, organisational and financial sustainability with renewed vigour. We start the plan period with just nine partners under the NIPHP umbrella, facilitating greater inter-partner cooperation and management efficiency through teamwork than we have achieved in the past. We expect to evolve an organisational structure for NIPHP which reinforces these themes and strengthens coordination of support services among partners. Furthermore, we shall have progressively transferred service delivery to more cost-effective static centres - making best use of existing GOB and NGO facilities and providing more customers with one-stop access to an integrated range of our services.

By the end of the plan period, we expect to have phased out our TA to both urban immunisation and contraceptive logistics management. We also expect to be delivering services through fewer, larger and more organisationally robust NGOs which are firmly rooted in their local communities. 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 - both in terms of offering more services and taking on a greater share of the contraceptives market from both 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 seven years to contain their costs

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**Draft NIPHP Mission Statement**  
*(Long Version)*

NIPHP is a partnership between USAID, its seven cooperating agencies and GOB. The partners operate within Bangladesh's national health and population programme to contribute to the nation's immediate health and demographic objectives - and its longer term development objective of self-reliance.

Our primary purpose is to enhance the quality of life of poor and under-privileged members of society by helping to reduce fertility and improving family health. We shall do this by:

- Delivering a basic package of high quality, high impact family planning and health services to the areas of greatest need;
- Promoting awareness and use of those services through a variety of information, education and communication methods;
- Building a strong organisation and supporting systems to maximise integration and coordination among the partners;
- Promoting sustainability throughout the delivery chain, from commodity procurement to customer interface;
- Encouraging GOB to develop and implement a policy framework that facilitates our work and mobilises its resources in support of NIPHP right down to community level.

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 and services. We will interact with other donors on the basis of our clearly articulated plans and seek to integrate our programme 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 capacity.

**Draft NIPHP Mission Statement**  
*(Short Version)*

Our primary purpose is to enhance the quality of life of poor and under-privileged members of society by helping to reduce fertility and improving family health. We shall focus on delivering a basic package of high quality and high impact services, backed up by sophisticated communications, strong organisation and support services, a favourable GOB policy framework and close attention to building sustainability throughout. We are driven by our customers' needs. Our programme is supported by other donors' efforts which we can leverage and a strong cadre of service providers at the local level.

We have selected a single Strategic Objective for the NIPHP.

**Strategic Objective 1:**  
Fertility reduced and family health improved.

**Rationale:** USAID's goal of poverty reduction requires smaller and healthier families. Fertility reduction and improvement in family health require:

- Access to a broader range of services, delivered and communicated in an integrated manner;
- Attention to quality in service design and delivery;
- Better informed customers;
- Communities mobilised 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 and demographic segments.

USAID has had positive experience in supporting: NGOs to deliver selected services in targeted areas; operations research; strengthened support services and service delivery through TA. Therefore, NIPHP will support GOB, NGOs, social marketing and the commercial sector to focus coverage on low-performing areas and under-served groups - while working to increase these service deliverers' programmatic, organisational and financial sustainability.

**Indicators:** (1) Reduced TFR; (2) Reduced infant mortality; (3) Reduced child mortality; (4) Increased proportion of pregnancies attended by trained staff; (5) Increased knowledge by youth, men and women of risks and preventive measures for STDs/AIDS.  
*[Baseline, benchmarks, targets and means of verification - see separate page]*

**Key assumptions:** (1) GOB will move towards integrated health care delivery; (2) Other donors will liaise with NIPHP on complementary inputs (eg commodities); (3) GOB will support an expanded role for NGOs/commercial sector in health care; (4) USAID will support NIPHP for seven years.

**We have selected five Intermediate Results for the NIPHP.**

<p><b>Intermediate Result 1:</b> Use of high impact family health services in target population increased</p>	<p><b>Rationale:</b> In order to reduce fertility and improve family health the program needs to increase the use of high impact services selected from the GOB Basic Package of Services We will focus on increasing access and coverage of high impact family health services to low and underserved thanas and urban areas by working closely with all major service providers. This systems approach will work toward the rational provision of services within these areas. By focusing on specific customer populations (e g adolescents &amp; low parity couples) and by assuring the quality of services, we will better understand and take their needs into consideration. We will respond to the customer's preference for convenience by making as many services as possible available at a nearby facility, thereby bringing "one-stop shopping" to customers This convenience will be further enhanced by the development of an effective and easy to use system of referrals when needed. Special attention will be given to assisting customers to receive full information and advice about the availability and use of these services.</p> <p><b>Indicators:</b> (1) CPR - total and method mix; (2) % of fully immunised children by age 1 year; (3) TT2 coverage rate for women giving birth in last year; (4) Coverage rate for ANC (ie 2 visits by qualified provider); (5) Vitamin A coverage rate for under-3s; (6) % of low parity couples (2 or less children) using contraception; (7) %of under-3s suffering diarrhea and treated with ORT last 2 weeks; (8) %ARI cases among under-3s last 2 weeks treated by trained provider; (9) %USAID-funded NGOs offering 4+ high impact services from BSP; (10) # condoms sold in proximity to targeted high risk populations. <i>[Baseline, benchmarks, targets and means of verification - see separate page]</i></p> <p><b>Key assumptions:</b> (1) Commodities remain available; (2) GOB leadership supportive of NIPHP; (3) Human resources remain available to provide services in target areas.</p>
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**Intermediate Result 1: Use of high impact family health services in target populations increased.**

**# Performance Indicators: 10**

Indicators	Source of Data	Annual measure	Baseline
CPR (Total, Modern & method mix).	DHS	#1	Total 44.6, Modern 36.2
Proportion of fully immunized children by 1 year.	DHS, EPI coverage survey, UNICEF	service statistics	54% (EPI cov. Surv., 95)
TT2 coverage rate for women given birth in last year.	DHS, EPI coverage survey, UNICEF	Service Statistics	85% (EPI cov. surv., 95)
Coverage rate for ANC (2 visits by qualified provider).	DHS	MIS	2plus visit 19.5%
Vit. A coverage for under 3 year olds.	DHS	Service statistics by UNICEF	48.8% (DHS 93-94)
Proportion of low parity couples (2 or less children) using contraception.	DHS	trend from CA Service statistics	36% (PF)
Proportion of diarrhea cases < 3 years in last 2 weeks treated with ORT.	DHS(1999)	#2	58.3% DMTS,95
Proportion of ARI cases < 3 years in last 2 weeks treated by a trained provider	DHS	#3	28%(seen in facility, provider)
Proportion of USAID funded NGO clinics that offer at least 4 high impact services according to the standards	Services Statistics by Cas	Service.stat. by Cas	0
# of condoms sold in proximity to targeted high risk populations	SMC, NGO's MIS	SMC, NGOs	16000/M

Annual Indicators: (Proxy measures for indicators which can't be measured annually)

- 1 Number of IUD insertions, male & female sterilization, injections.
- 2 # of ORS sales and share by SMC
- 3 # of pneumonia cases treated according to the standard guidelines

**We have selected five Intermediate Results for the NIPHP (cont'd).**

<p><b>Intermediate Result 2:</b> Capabilities of individuals, families and communities to protect and provide for their own health increased.</p>	<p><b>Rationale:</b> Families need to be empowered through health education to make better health care decisions for themselves that are cost effective and responsive to their particular situation. Mothers, who are the primary care givers, need to make decisions about ante-natal care, childbirth, immunizations, ORT, ARI, nutrition and first aid. Mothers also need to develop their diagnostic skills and recognize key symptoms to either deal with certain situations themselves or to know when to seek assistance from appropriate health providers. Fathers need a similar understanding so that they are supportive of their wives' decisions.</p> <p>FWAs and HAs are in the best position to provide the health education required for this intervention. The intervention would lead to families making better family health choices that are cost-effective for the family, maximizing the family's limited resources. This empowerment of families complements the BSP by providing community mobilization and support outside but complementary to the BSP. [Something on effective use of resources (FWA and HE)?]</p> <p><b>Indicators:</b> (1) %of individuals and families making informed decisions on their own health (eg % mothers/children who see a qualified provider for ANC, ARI or child birth care) [Baseline, benchmarks, targets and means of verification - see separate page]</p> <p><b>Key assumptions:</b> (1) GOB will re-orient FWAs and HAs in the medium term.</p>
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**Intermediate Result 2: Capabilities of individuals , families and communities to protect and provide for their own health increased.**

**# Performance Indicators: 1**

**Indicator:**

Proportion of individuals and families making informed decisions on their own health, eg proportion of mothers/children who see a qualified provider for:

- ante natal care
- ARI
- child birth care

**Sub Indicators:**

- 1 Attendance a community meetings
- 2 Contact with information provider
- 3 Customers have discussed the messages
4. Customers support and disseminate messages
5. Husband and wife communication about:
  - ante natal care
  - child birth care
  - immunization
  - nutrition
  - breast feeding
  - danger signs of pregnancy
6. Knowledge of the Green Umbrella campaign messages

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We have selected five Intermediate Results for the NIPHP (cont'd).

**Intermediate Result 3:**  
Quality of information, services and products assured and customer satisfaction improved.

**Rationale:** Quality of service is an important element in the NIPHP project. Improved quality of information, services, and products leads to enhanced customer satisfaction, better utilization of services, and ultimately better health outcomes. Improved quality of services will reduce complications, improve utilization of services and should contribute to long term reduction in unit costs. The USAID customer survey found that the customers expressed dissatisfaction with the quality of family planning and primary health services. They have identified a number of areas where they expect improvements. This intermediate result will address the major quality issues. 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 provide an appropriate range of information and services to meet the customer expectations and needs. This will lead to informed and proactive families and individuals to seek and use appropriate and effective family planning and primary health information, services, and products.

**Indicators:** (1) %of service delivery providers complyig with standards/protocols; (2) %of service sites having appropriate personnel, equipment, supplies and facilities; (3) Increased continuation rates for FP, EPI and ANC; (4) % of completed referrals completed ?; (5) Compliance with advice ?; (6) Medical barriers removed (geographical abd parity)  
*[Baseline, benchmarks, targets and means of verification - see separate page]*

**Key assumptions:** (1) GOB will change policies which restrict access to services.

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**Intermediate Result 3: Quality of information, services and products assured and customer satisfaction improved.**

**# Performance Indicators: 7**

Indicators:	Sources of Information
<p><b>Direct (To be worked by QI component)</b></p> <p>1. Percent of service delivery providers complying with standards/protocols</p> <p>2. % of service sites having appropriate personnel, equipment, supplies, and facilities</p> <p><b>Through Basic Service Package</b></p> <p>1. Increased continuation rates  <b>FP</b> ( drop outs due to side effects, other reasons)  <b>EPI</b> (drop outs, BCG scar rate)</p> <p><b>ANC</b> (Coverage and number of visits)</p> <p>2. % of customers who receive the information, services and products they want</p> <p><b>To be discussed with other groups</b></p> <p>1. % of completed referrals increased (measurable?)</p> <p>2. Compliance with advice ???</p> <p>3. Medical barriers removed (geographical and parity)</p> <p><b>Sub-Results</b></p> <p>1. Reward system for providers established to recognize higher quality and efficiency</p> <p>2. Percent of clients whose side effects are managed</p>	<p>Checklist, Survey research/observations</p> <p>Checklist, survey research/observations</p> <p>(i) DHS, (ii) Matlab, (iii) SRS</p> <p>(i) Prevalence studies, (ii) DHS, (iii) EPI surveys, (iv) Surveillance</p> <p>(i) Matlab, (ii) ICDDR,B card system</p> <p>Customer appraisals, Customer service plans, COPE</p>
<p><b>Assumptions:</b></p>	

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We have selected five Intermediate Results for the NIPHP (cont'd).

**Intermediate Result 4:**  
Robust organisation and associated support systems for the high impact family health services designed, operationalised and maintained.

**Rationale:** NIPHP partners must work together effectively to achieve the Strategic Objective. To facilitate the delivery of high impact family health services, information and products (as articulated under the GOB's Health and Population Sector Strategy) a number of support systems are required; these include logistics, operations research, information, education and communication, human resource management, quality improvement, management information systems/health information systems, management. These support systems are necessary to sustain both the NIPHP organization and management structure [e.g. a coordinating board] and to assist the CA partners to most effectively carry out their individual and collective responsibilities. For example, at the organization and management level there is the need to address policy issues, prioritization of interventions, partnership coordination, strategic/annual planning, human resource management, allocation of resources among partners, and coordination of overall NIPHP activities with other stakeholders. These support systems could be assigned to an existing partner (e.g operations research, logistics), a combination of the partners working collectively, or by subcontracting for specialized activities/tasks. This IR will result in increased teamwork and collaboration among the partners, more efficient use of NIPHP resources, more focused information and service delivery interventions, and better coordination with external partners and other stakeholders in the Population and Health sector. In addition, these support systems, especially logistics, OR, IEC and quality improvement, are critical to the performance of the National Population and Health Program.

**Indicators:** (1) Stock-out rate of essential FP commodities reduced to \_\_\_ at the field level; (2) Stock-out rate of essential BPS commodities for the USAID funded NGOs reduced to \_\_\_ at the field level; (3) % of FP logistics activities performed by GOB without external TA; (4) Number of OR findings/results implemented by other CA; (5) Number of OR activities conducted to operationalize the different components of the BPS; (6) Increased demand for quality services by target groups; (7) Modify/test/implement/evaluate a National IEC strategy to include all elements of BPS in a timely manner; (8) Completeness of reporting for selected diseases by the national surveillance team; (9) Design, test and implement national quality standards for high impact family health services.  
*[Baseline, benchmarks, targets and means of verification - see separate page]*

**Key Assumptions:** (1) An adequate supply of commodities needed to implement the BPS is ensured; (2) Adequate funding of NIPHP is available in a timely manner; (3) Political stability is ensured; (4) Integration of FP and H ensured at the field level; (5) GOB policy for BPS is adequate and implemented.

**Intermediate Result 4: Robust organisation and associated support systems for the high impact family health services designed, operationalised and maintained.**

**# Performance Indicators: 8**

- Stock-out rate of essential FP commodities reduced to \_\_\_\_\_ at the field level; OR Percentage of field level units with appropriate minimum stock level.
- Stock-out rate of essential BPS commodities for the USAID funded NGO reduced to \_\_\_\_\_ at the field level; OR Percentage of field level units with appropriate minimum stock level.
- Percentage of FP logistics activities performed by GOB without external TA [Sustainability indicator]
- Number of OR findings/results implemented by other CA
- Number of OR activities conducted to operationalize the different components of the BPS.
- Increased demand for quality services by target groups.
- Modify/test/implement/evaluate a National IEC strategy to include all elements of the BPS in a timely manner.
- Completeness of reporting for selected diseases by the national surveillance system.
- Design, test, and implement national quality standards for high impact family health services

We have selected five Intermediate Results for the NIPHP (cont'd).

**Intermediate Result 5:**  
Sustainability of family health services and support systems improved.

**Rationale:** In order to realize the NIPHP Strategic Objective, health service delivery systems, including support systems, will need to be increasingly self-supporting on at least three levels: (1) Programmatically, the health system needs to be more technically capable of providing quality services and less reliant on external expertise and supply systems. (2) Organizationally, the GOB and the NGOs need to have stronger management leading to more efficient service delivery and support systems capable of providing a basic package of services valued by customers. (3) Financially, the program will have to reduce its reliance on external sources of funding. This will be accomplished through a number of key changes such as: a) increasing the private sector's (and social marketing's) market share of health services; b) increasing efficiency through measures which reduce costs (e.g., shifting away from doorstep service delivery, reduced overhead, shift to long-term family planning methods, reduced duplication of services); and c) increased cost recovery.

**Indicators:** (1) Utilization rates of static sites (e.g., clusters, satellite clinics, fixed facilities) increased. (2) Proportion of services delivered through mechanisms more cost-effective than doorstep service increased. (3) Prevalence of long-term contraceptive methods among women and men increased. (4) Appropriate organizational vision (specifying activities, performance targets, core competencies, and strategic positioning) developed by each NIPHP partner, and reviewed/revised as necessary. (5) Share of products and services provided through either social marketing or the commercial sector increased. (6) Share of revenues from cost recovery (client fee and other) increased. (7) Cost per client served reduced.  
*[Baseline, benchmarks, targets and means of verification - see separate page]*

**Key assumptions:** (1) GOB allows NGO's to set appropriate prices for services and products. (2) Adequate supplies of essential commodities for Basic Health Service Package will be available. (3) Consumers will be willing to pay more for health services as their incomes increase. (4) Civil unrest and fluctuations in exchange rate will not disrupt service delivery. (5) The GOB will move toward an integrated approach to health care service delivery.

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**Intermediate Result 5: Sustainability of family health services and support systems improved.**

**# Performance Indicators: 7**

Performance Indicator	Data Sources	Baseline Data		Expected and Actual Results						
		Year	Value	1998	1999	2000	2001	2002	2003	2004
(1) Utilization rates of static sites (e.g., Clusters, Satellite Clinics, fixed facilities) increased	BDHS ('93-'94), BHDS ('95), NGO MIS's, ICDDR,B Sample Registration System	'93-'94	??% ever visited SC, FWC, THC  35% of deliveries in health facilities							
(2) Proportion of services delivered through mechanisms more cost-effective than doorstep service increased	BDHS ('93-'94), BHDS ('95), NGO MIS's, ICDDR,B Sample Registration System	'93-'94	42% modern methods from FW/FWA							
(3) Prevalence of long-term contraceptive methods among women and men increased	BDHS ('93-'94); BHDS ('95); ICDDR,B Sample Registration System	'93-'94	11.4% prevalence of long-acting method use							

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(4) Appropriate organizational vision (specifying activities, performance targets, core competencies, and strategic positioning) developed by each niphp partner, and reviewed/revised as necessary	NIPHP partner Vision Statements, annual reports		??							
(5) Share of products and services provided through either social marketing or the commercial sector increased	BDHS ('93-'94); BHDS ('95), customer surveys	'93-'94	52% ORS, 20% OCs, 53% condoms from pharmacy or shops							
(6) Share of revenues from cost recovery (client fee and other) increased	Individual program MIS's, NGO and SMC financial statements	1996 (?)	NGO's: 0% - 7% SMC: 62% of operating costs							
(7) Cost per client served reduced	JSI cost study; Individual program MIS's; NGO financial statements; ICDDR,B OR surveillance; repeated cost studies	1996 (?)	??							

**Note:** Sustainability indicators will in some cases conflict with other NIPHP intermediate results and indicators. For example, NIPHP will introduce a number of new services, and aims to substantially increase the quality of all services. These initiatives may initially *increase* costs or *reduce* efficiency, but over the longer term are expected to result in more efficient and sustainable organizations and services.

We have identified 33 potential indicators in the five Intermediate Results.

**Basic Package**

- (1) CPR - total and method mix;
- (2) % of fully immunised children by age 1 year;
- (3) TT2 coverage rate for women giving birth in last year;
- (4) Coverage rate for ANC (ie 2 visits by qualified provider);
- (5) Vitamin A coverage rate for under-3s;
- (6) % of low parity couples (2 or less children) using contraception;
- (7) % of under-3s suffering diarrhea and treated with ORT last 2 weeks;
- (8) % ARI cases among under-3s last 2 weeks treated by trained provider;
- (9) % USAID-funded NGOs offering 4+ high impact services from BSP;
- (10) # condoms sold in proximity to targeted high risk populations.

**IEC**

- (1) % of individuals and families making informed decisions on their own health (eg % mothers/ children who see a qualified provider for ANC, ARI or child birth care)

**Quality**

- (1) % of service delivery providers complying with standards/protocols;
- (2) % of service sites having appropriate personnel, equipment, supplies and facilities;
- (3) Increased continuation rates for FP, EPI and ANC;
- (4) % of completed referrals completed ?;
- (5) Compliance with advice ?;
- (6) Medical barriers removed (geographical and parity)

**We have identified 33 potential indicators in the five Intermediate Results (cont'd).**

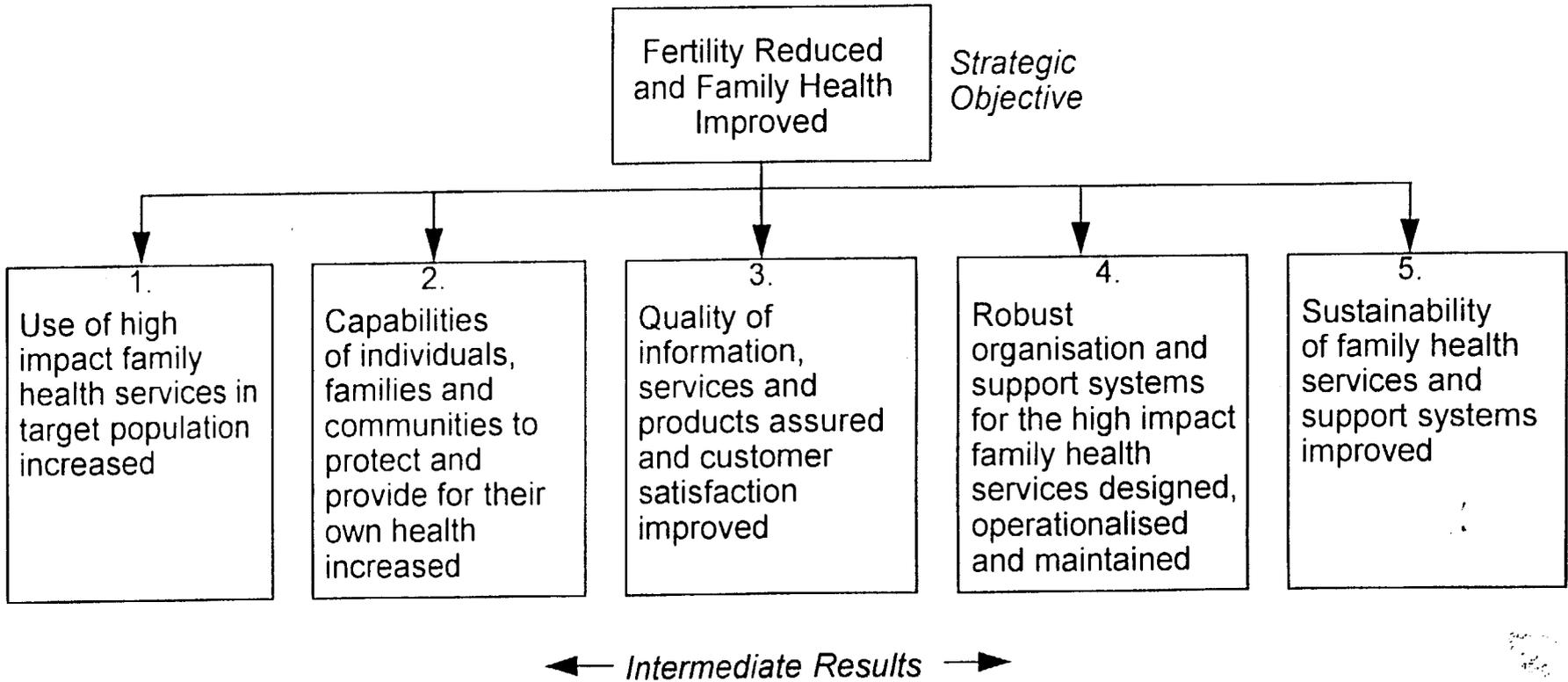
**Organisation and Systems**

- (1) Stock-out rate of essential FP commodities reduced to \_\_\_ at the field level;
- (2) Stock-out rate of essential BPS commodities for the USAID funded NGOs reduced to \_\_\_ at the field level;
- (3) % of FP logistics activities performed by GOB without external TA;
- (4) Number of OR findings/results implemented by other CA;
- (5) Number of OR activities conducted to operationalize the different components of the BPS;
- (6) Increased demand for quality services by target groups;
- (7) Modify/test/implement/evaluate a National IEC strategy to include all elements of BPS in a timely manner;
- (8) Completeness of reporting for selected diseases by the national surveillance team;
- (9) Design, test and implement national quality standards for high impact family health services.

**Sustainability**

- (1) Utilization rates of static sites (e.g., clusters, satellite clinics, fixed facilities) increased.
- (2) Proportion of services delivered through mechanisms more cost-effective than doorstep service increased.
- (3) Prevalence of long-term contraceptive methods among women and men increased.
- (4) Appropriate organizational vision (specifying activities, performance targets, core competencies, and strategic positioning) developed by each NIPHP partner, and reviewed/revise as necessary.
- (5) Share of products and services provided through either social marketing or the commercial sector increased.
- (6) Share of revenues from cost recovery (client fee and other) increased.
- (7) Cost per client served reduced.

**Our Strategic Objective and the Intermediate Results combine to give the Results Framework.**



**APPENDIX D**  
**FIRST DRAFT URBAN IMMUNIZATION (BASICS) VISION**

## URBAN IMMUNIZATION (BASICS)

### MISSION

The urban immunization partner will assist in the development of a sustainable service delivery network that is able to expand the coverage of quality, high impact family health information, services, and products in a manner that is convenient to the underserved populations in low performing areas. Our emphasis will be on working together with the GOB, municipal authorities and other partners in the development of robust child health and disease surveillance programs. We will work together more intensively with the urban health services partnership in strengthening the capacity, quality and sustainability of urban health institutions and service providers and the promotion of community involvement. We will accomplish our mission through the provision of highly skilled technical assistance, problem solving, collaboration with national authorities, training of national leaders and selective placement of a small team of field staff.

### VISION STATEMENT:

We are currently involved in assisting the national EPI program in a highly successful effort to achieve its targets in urban areas. Following a period of intensified effort in poliomyelitis eradication, until 2002, we expect to phase out our technical assistance in this area by 2004. Our phasing out of urban EPI will be made possible by the substantial progress currently being made by urban authorities in supporting urban immunization. We will build on our other core competencies in:

1. Integrated management of childhood illness.
2. Developing national child health policies, programs and standards
3. Disease surveillance
4. Experience in supporting urban health
5. Improving essential drug logistics management.

*Core* At the national level, we will work with GOB and other partners in the introduction of a robust *program* integrated management of child illness including the development of national policies, standards, training curriculum, monitoring and evaluation systems. A high priority activity will be the development of the national disease surveillance system concentration initially on EPI target diseases. At the urban level, we will work more intensively with the urban service delivery partner to develop the child health component of the basic service package including EPI. We will also collaborate in strengthening the capacity of MOLG and urban authorities to support coordinate and manage urban health programs with focus on slums.

We will achieve these results through the provision of highly skilled technical advisory services and some support to training and IEC for disease surveillance. We will transfer our experience in managing health programs to the urban authorities through our technical field staff.

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In urban areas we will partner closely with the urban service delivery component. BASICS and the urban service delivery partner will also work closely with the quality and OR partners. In the performance of our national level activities, we will partner with GOB, urban, rural, quality and OR components as well as external parties e.g. WHO and UNICEF.

**Performance Targets:**

Disease Surveillance

1. Increase proportion of reported cases of Acute Flaccid Paralysis from 10% to .
2. Increase proportion of reported cases of Neonatal Tetanus from 2% to .

Integrated Management of child Illness

3. Increase EPI coverage nationally from 54% to 75% and in urban areas from 64% to 85%. (this is an intermediate result indicator for NIPHP)
4. Increase proportion of facilities providing integrated management of sick child in urban areas to 50%.
5. Develop and adopt national standard for integrated management of child illness.

Urban Authority Capacity Building

6. Reducing EPI coverage gap between slum and non-slum population from 20% to 5%.
7. Decrease EPI drop-out (BCG-Measles) from 33% to 10%.
8. Increase proportion of EPI outreach sites merged with family planning satellite sites in urban areas to.
9. Increase number of municipalities having medical officers from 12 to 64.
10. Decrease number of municipalities receiving financial support from BASICS for EPI recurrent cost from 60 to 0.
11. Increase coverage of vitamin A distribution from to .

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