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**PRSDR**



**End of Project Report:  
Program Achievements and Lessons Learned**

**1997 - 2002**



**Dhaka, Bangladesh**

**RSIDP**

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# Pathfinder International

Pathfinder International is a U.S. based private voluntary organization that provides technical and financial support to reproductive health projects in 22 countries in Africa, Asia and Latin America. Pathfinder International's mission is to improve access to the fullest possible range of *quality information and services to enable individuals and couples to make reproductive health choices*. For over 40 years Pathfinder has evolved as a technical organization to keep pace with the most recent developments in the field, responding to a changing environment for population and development work and providing technical leadership to meet emerging reproductive health needs in developing countries. Pathfinder focuses on three core areas:

- Improving access to services,
- improving service quality, and
- strengthening institutional capacity

This report is dedicated to the millions of women, men, and their families - together with children and adolescents in rural areas of Bangladesh - who have been a vital part of the RSDP.

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## LIST OF ABBREVIATIONS AND ACRONYMS

ACPR	Association for Community and Population Research
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BCCP	Bangladesh Center for Communication Programs
BRAC	Bangladesh Rural Advancement Committee
CDD	Control of Diarrheal Disease
CM	Community Mobilizer
COPE	Client-Oriented, Provider-Efficient Services
CSI	Child Survival Intervention
DPT	Diphtheria Pertussis Typhoid
DTC	District Technical Committee
ECP	Emergency Contraceptive Pill
ELCO	Eligible Couple
EMER	Ei Megh Ei Roddra (Drama serial)
EPI	Expanded Program on Immunizations
ESP	Essential Services Package
FWV	Family Welfare Visitors
DGFP	Director General, Family Planning
DH	Depot holder
FP	Family Planning
GOB	Government of Bangladesh
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
ICB	Institutional Capacity Building
IOCH	Immunization and Other Child Health Project
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IEC	Information, Education and Communication
IUD	Intra Uterine Device
MIS	Management Information System
MO	Monitoring Officer
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
NID	National Immunization Day
NIPHP	National Integrated Population and Health Program
NSV	Non-Scalpel Vasectomy
OPV	Oral Polio Vaccine
OR	Operations Research
ORP	Operations Research Program
ORS	Oral Rehydration Saline
PAC	Post Abortion Care
PNC	Post-natal Care
PO	Program Officer
QIP	Quality Improvement Partnership
QMS	Quality, Monitoring and Supervision
RDU	Rational Drug Use
RDF	Revolving Drug Fund
RSDP	Rural Service Delivery Program/Partnership
RTI	Reproductive Tract Infection
SCSG	Satellite Clinic Support Group
SMC	Social Marketing Company
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TO	Technical Officer
TOT	Training of Trainers
TT	Tetanus Toxoid Injection
UFHP	Urban Family Health Partnership
UHC	Upazila Health Complex
USAID	United States Agency for International Development

## ACKNOWLEDGEMENTS

The five-year span of RSDP has been very intense and challenging, yet the achievements are very gratifying. RSDP undertook an uphill task of *(a) moving to a new service delivery design - from FP to ESP, from vertical to integrated one-stop shopping, from free to fee for services; (b) changing people's health seeking behavior - from passive recipient of services at home to seeking services from clinics; (c) changing provider's attitude towards clients, from being paternalistic to partnership in creating demand for quality services; (d) creating community-wide well-informed knowledge of services and supplies, quality and cost; and (e) enhancing NGO capability of implementing ESP - setting up clinics, managing performance and funds efficiently, coordination with local GOB officials and private sector for logistics and supplies.*

This end-of-project report documents amazing success and achievements during the last five year and provides a solid foundation for additional success in the future. The report, however, acknowledges that enormous challenges, both continuing and emerging, still lie ahead.

Over the past five years, RSDP has received support from many different sources. RSDP would like to acknowledge the following organizations and individuals for their role in the accomplishments of this successful program:

We are grateful to The Government of Bangladesh - the Ministry of Health and Family Welfare, Directorate of Family Planning and Directorate Health Services for their trust and confidence in Pathfinder's capacity to take up such a daunting task of changing the model of service delivery and their best possible cooperation during the implementation of RSDP at all levels - from national to the local.

USAID provided sustained financial support over the life of RSDP. Without USAID support, the success achieved in the past five years would not have been possible. The technical assistance from past and present HPN team members, as well as USAID supported TA agencies, was of great benefit to RSDP. We appreciate USAID Contract Office staff for facilitating Pathfinder's compliance with financial management.

Pathfinder's two partners in RSDP - BCCP and BRAC--and other NIPHP partners, especially QIP, SMC, ICDDR,B, DELIVER, IOCH, UFHP, deserve many thanks for their cooperation.

We thank NGO leaders and their project staff, for their dedication and excellent efforts in accepting the new service delivery design and implementing it with strong commitment. Community members and leaders accepted us as their trusted friend and provided support for the services offered in their communities. House-owners of satellite clinics, depholders, and other volunteers enormously contributed to RSDP's success. We gratefully acknowledge and recognize their contribution and support.

The leadership support from Pathfinder President, Dan Pellegrum has always been invaluable and inspiring to RSDP. We have always turned to Senior Vice President, John Dumm at times of critical need and he has always been there to help RSDP. Tom Fenn has been our problem solver and a strong friend to RSDP. We are thankful to many other colleagues at HQs for their continuous financial, administrative, and technical support.

The hard-working RSDP staff across all levels of project implementation, without which this project would not have been so successful. Heather Story and Tayla Colton have been our added technical resource for RSDP; their contribution is generously acknowledged, as we do for Kathy Le for her assistance on this report. Birsen Bayazit assisted us in our work for RSDP closeout. We thank her for a tedious closeout job well done.

My Pathfinder colleagues, in particular Dr Shabnam Shahnaz, and others across board worked very hard beyond their call of duties and put in their head and heart together for the success achieved; I have been privileged to lead such an excellent and committed team of beaming spirits. We worked together, learned together, we were a good team, together we have made the RSDP vision come true. Please know how much I value your contribution, even if I don't name you all individually.

Let's keep our spirit high, as high, if not higher, as we did in the past five years in RSDP, be proud of our successful legacy, which we have achieved together, and move on...

Mohammad Alauddin, PhD  
Country Representative,  
Pathfinder International, and Chief of Party, RSDP

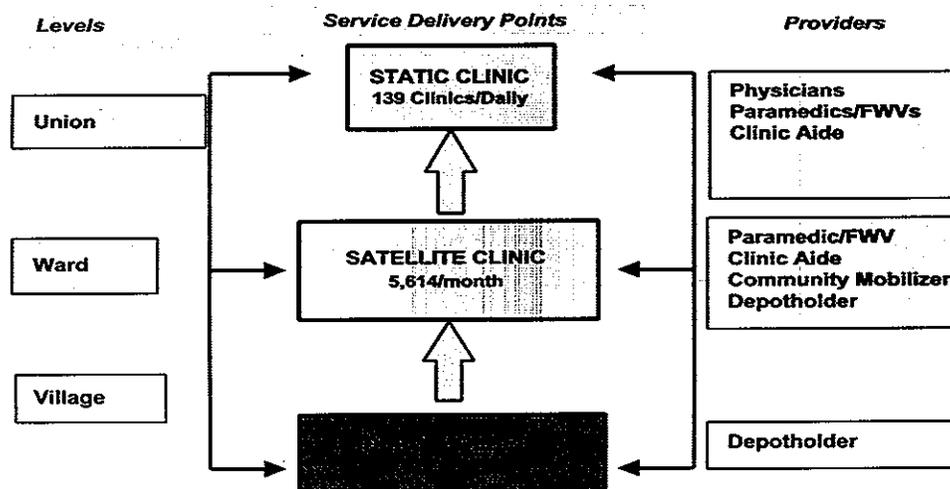
## I. EXECUTIVE SUMMARY

In August 1997, Pathfinder International was awarded funding by USAID for the Rural Service Delivery Partnership (RSDP). Pathfinder's RSDP partners included the Bangladesh Rural Advancement Committee (BRAC) until 2001, and the Bangladesh Center for Communication Programs (BCCP). As a part of the National Integrated Population and Health Program (NIPHP), RSDP focused on the USAID's twin Strategic Objective to "reduce fertility and improve family health." RSDP's mission was to increase accessibility and utilization of high-quality, high-impact family health services by rural families in Bangladesh. The Partnership focused on low-performing and under-served rural areas, strengthening NGO capabilities, improving GOB-NGO-private sector collaboration, and generating community support for family health services. The partnership fostered an environment resulting in well-informed proactive families and individuals who sought services and demanded quality. As a result of RSDP's efforts, Bangladesh rural families in targeted areas now have access to receive high-quality information and services based on the Essential Services Package (ESP).

The formation of RSDP led the shift in program implementation from single to multiple organizations, and in service delivery from a traditional door-to-door service delivery program to fixed service delivery points managed by 18 national and local NGOs. These NGOs managed a system of service delivery points covering 171 rural upazilas up to July 9, 2001 and since then, 139 upazilas in rural Bangladesh. The focus of the service delivery design was to shift from fieldworker-based doorstep delivery to static and/or satellite clinics. As a result of this work, services are now delivered as an essential service package from one of three service delivery points, static clinics, satellite, clinics and depotholders.

The tiered service delivery points were estimated to reach between 20-40% of people in the upazilas with an Essential Services Package for family health care. RSDP's tiered network of service delivery system proved to be cost-efficient and sustainable. RSDP NGOs delivered ESP through a three-tiered structure at the thana-level and below. At the bottom tier was the depotholder, followed by the satellite clinic and

**RSDP's Three-Tiered Service Delivery Structure**



then the static clinic. RSDP provided support to these service delivery points from 18 NGOs, 5 Technical Assistance Units (4 TA Units since July 9 2001) serving the major regions of Bangladesh, and RSDP personnel and partners. Together, this structure ensured the delivery of high quality services to approximately 9 million people in rural Bangladesh, averaging 806,952 service contacts per month.

The essential package includes family planning and other reproductive health care, child health care, communicable disease control, limited curative care, and behavior change communication. More specifically, RSDP had the following intermediate results:

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

#### A. Summary of Program Highlights

To achieve these intermediate results, RSDP developed a cluster of expertise, skills, and strategies such as skill transfers, IEC and social mobilization, systems development, and the introduction of service delivery innovations. A selection of program accomplishments are highlighted below:

1. **RSDP successfully increased the number of customers served from each of the three service delivery points (static, satellite and deponent), and the use of all essential services.** The average monthly customer flow at RSDP delivery points increased by over 631% since 1997. In FY 2002 RSDP served approximately 9 million customers. Average monthly

customer flow per upazila in 2002 increased from 117 to 742 customers per month at static clinics (512% increase), from 375 to 1,898 customers per month at satellite clinics (406% increase), and from 382 to 3,381 (932% increase) customers per month for Depotholders since 1997. RSDP has achieved these increases despite the loss of 33 BRAC sites in 2001.

2. **Under RSDP, Pathfinder implemented a highly successful Newlywed Program that promoted smaller families, delayed first childbirths, adequate birth spacing, and antenatal care.** The program functioned through identification and registration of newlywed couples, targeted visitation by deponent, and orientation meetings. Program efforts contributed significantly to an increase in knowledge and use of contraceptives by both male and female newlyweds, as well as an increase in the use of antenatal services. The program also highlighted the role of deponent as a source of important information for the community.
3. **RSDP provided regular training in clinical skills, quality assurance, management & finance, and other topics to ensure NGO staff, clinic managers, and clinic staff are well equipped to do their jobs on a daily basis.** Through the head office and four TA Units based in regional offices, RSDP provided regular technical assistance and tracked the progress of clinic sites through monitoring and supervision visits. RSDP, with the assistance of the Quality Improvement Partnership (QIP) and other partners, produced numerous manuals and guidelines covering various topics on ESP. NGOs were extensively trained in strategic planning and goal setting for annual workplan development, and in the development of renewal proposals. In addition, NGOs were also trained to conduct RAPID Assessments, allowing for self-assessment of performance.

4. **RSDP's extensive MIS collected valuable information that was used for programmatic decision-making and project management.** The MIS process itself was valuable as a means to build NGO capacity to track performance and manage local clinics. An extensive MIS system was established, starting at the clinic level, where data was compiled and sent to NGOs and RSDP in order that logistics (contraceptives and medicines), clinic services provided, training status, and personnel could be tracked and problems identified.
5. **RSDP cut program operating costs, increased clinic and depholder revenues, increased their marketshare of FP and health services, decreased reliance on government-subsidized services, and encouraged NGOs to obtain their own clinic site.** RSDP conducted studies that resulted in more efficient use of staff time, resources and correction in missed opportunities. As a result of a study called "Cost of Services and Willingness to Pay," there was an 8% increase in service delivery points without any additional staff. The study found that communities largely accepted fee-based services and an increasing number of customers paid for services. At the end of the program, only 20% of pill customers and 10% of condom customers obtained their supplies free. 45 clinics (out of 139) were housed in NGO-owned buildings and did not pay rent. NGO linkages with the private sector were established; dependency on GOB sources significantly declined-33% of pill and 4% of condom users were supplied with SMC products. The majority of NGO contributions to the Revolving Drug Funds were replaced by SMC-provided money.
6. **RSDP built long-term support for the program by strengthening relationships with the community, government, and other partners in Bangladesh.** RSDP developed a relationship with the government over the years to ensure contraceptive and medicinal supplies are received on a regular basis by the clinics.

The government was also responsible for approving RSDP clinic sites. RSDP developed Satellite Clinic Support Groups (SCSG) to foster better relations with the local communities.

## **B. Summary of Lessons Learned**

### *1. Increasing Use of "Essential Service Package"*

- ✓ A three-tiered service delivery design is very effective in increasing access to ESP services.
- ✓ The establishment of a sound infrastructure at the beginning of a program is essential in order to start service delivery.
- ✓ NSV and Norplant services can be provided successfully in a rural setting.
- ✓ Holding joint NIPHP-EPI session yields the best result in achieving greater accessibility and coverage for EPI.
- ✓ Distribution of ARH materials through schools is often a good way of avoiding community sensitivities around this topic.

### *2. Increasing Knowledge and Behavior Change*

- ✓ BCC activities that are linked with service delivery helps to increase utilization of services among special target groups.
- ✓ Community mobilization, rigorous marketing, and communication with customers increase use of services.
- ✓ The establishment of an effective monitoring system to supervise and monitor BCC activities increases accountability in the implementation of these activities.
- ✓ Interpersonal communication is essential to ensure community participation and utilization services. Community Mobilizers and depholders played a very vital role in interpersonal BCC activities.

### *3. Improving Quality*

- ✓ High turnover rate of clinic staff and absences due to vacation or other reasons

greatly inhibits the consistency and quality of services delivered at RSDP sites.

- ✓ Transfer/adaptation of urban technology to rural setting for improved physical infrastructure for clinical services is possible.
- ✓ Program managers who understand the technical aspects of the program can provide better support to service providers.

#### 4. *Improving NGO Management*

- ✓ Solid research and evaluation can be done quickly and with meaningful results that can be immediately incorporated into program operations.
- ✓ The implementation of tools, policies and guidelines is most effective when complemented with ongoing training and guidance.
- ✓ Basic training for NGOs on utilization of data for decision-making is required for improved NGO management.
- ✓ To prevent inaccurate recording of program data, regular technical assistance needs to be provided not only for the collection and recording of data but also for checking their validity and reliability.
- ✓ Conducting evaluation and research at the local level enables NGOs to be more accountable and willing to address the findings.
- ✓ For effective program implementation, NGO leaders need to have a clear and adequate understanding of program objective and strategies.

#### 5. *Increasing Sustainability*

- ✓ Effective GOB-NGO collaboration at the local level is critical for effective implementation of program activities.
- ✓ Using funds generated by program activities to construct clinic building is a good way to demonstrate support for the community as well as strengthen community ownership of the program.

### C. Summary of Remaining Challenges

While RSDP was immensely successful, the challenges to reducing fertility and improving family health in Bangladesh are still enormous. Lessons learned from the last five years will provide a sound base from which to address many of the remaining challenges. The following are key challenges that will need to be addressed in order for more progress to be achieved:

- Fertility rate remains high in Bangladesh; it is even higher in rural areas; increased coverage in rural areas is needed for further reduction in fertility.
- Women in rural areas rely excessively on oral contraceptives and acceptance of long-term methods is low.
- Supply of injectable is yet to match the demand of current and potential injectable users; availability of long term method is low in rural areas; building infrastructure facilities for clinical services tend to be difficult and expensive.
- Child mortality rates continue to be high with an estimated one out of every eleven children dying before the age of five; without community based child survival services, reduction of infant mortality is likely to remain high.
- Maternal mortality rates remain high with an estimated 377 deaths per 100,000 live births. Post Abortion Care (PAC), EOC and midwifery services are often unavailable in most areas.
- Due to cultural inhibitions, Bangladesh's large adolescent population continues to have limited access to family planning information and contraception. Although HIV/AIDS among high-risk populations remains low at 0.02%, the lack of appropriate information and awareness, coupled with an active commercial sex industry and high incidence of other sexually transmitted infections make Bangladesh susceptible to a major outbreak of new HIV infections. Challenge for rural areas is of no less magnitude. Susceptibility of HIV/AIDS transmission to rural population is apprehended because of large contacts of

rural males and females with urban sector, because of ease in use of transport and mobility between rural and urban areas.

- Service delivery challenges also remain with how drop-out rates and difficulties with scaling up service delivery.

- Of the poorest who came to the RSDP clinics, two-thirds came for limited curative care which requires medicine for cure; the poorest need medicine and other services free under safety net.

## II. PROGRAM OUTPUT: SERVICE DELIVERY INDICATORS

Throughout the life of the program, RSDP monitored programmatic progress by carefully tracking service delivery outputs. This effort allowed RSDP to assess the strengths and weaknesses of the program for informed decision-making. In addition, the final measurement of these outputs highlight RSDP's success at increasing both the number of customers served and the range of services provided. Even with the withdrawal of BRAC from the partnership, RSDP was able to maintain positive progress across all performance indicators.

**Table 1: Achievement Against RSDP NIPHP Performance Indicators**

Sl	Indicators	Sep97 - Sep98	Oct98 - Sep99	Oct99 - Sep00	Oct00 - Sep01*		Oct01-Jun02
		171 upazilas	171 upazilas	171 upazilas	171 upazilas (Oct00-June01) (with BRAC)	139 upazilas (Oct00 - Sep01) (without BRAC)	139 upazilas
1	Eligible couples in the direct service delivery areas	1,873,923	2,147,915	2,202,115	2280919	1651468	1713143
2	<b>Number of customers</b>						
	Static Clinic	240,622	501,117	913,000	908165	986661	927779
	Satellite Clinic	816,426	1,614,542	3,043,676	2926953	2718999	2374489
	Depotholder	1,117,358	2,534,264	4,505,642	4875969	4468696	4229144
3	<b>Contraceptive distribution</b>						
	Pill (monthly)	101,818	186969	285,052	365190	265745	303628
	Condom (monthly)	133,158	369742	602,360	794465	696552	866871
	Injectable (monthly)	11,743	31034	55,618	69770	59259	71446
	IUD Insertion (yearly)	2,176	5843	9,489	8343	9097	7856
	Tubectomy (yearly)	27	11	4	21	11	19
	Vasectomy (yearly)	6	9	2	361	360	578
4	<b>FP Users Referred</b>						
	Monthly Injectable Ref.	6,653	2983	640	1793	1086	1358
	Yearly IUD Ref.	3,832	2168	346	545	536	714
	Yearly Norplant ref.		1755	1,460	1267	1491	1743
	Yearly VSC Ref.	2,557	2406	1,759	1588	1210	954
5	<b>Yearly Side-Effect Management:</b>						
	Pill	9,211	16,704	24081	56355	51640	97170
	Injectable	5,532	12,601	25414	46657	41085	32764
	IUD	1,145	1,315	2077	3486	3279	2864
6	<b>EPI (annual estimation)</b>						
	Measles dose under <1	61,380	87,579	154867	136570	109199	111445
	DPT1 dose	38,332	92,047	166867	159599	122685	123126
	DPT2 dose	41,764	87,760	152069	141485	111586	113867
	DPT3 dose	75,927	82,267	137453	124924	97465	102539
	BCG dose	68,740	90,950	163301	157448	122050	123077
	NID OPV contacts (Round 1/ Round 2)			2220732/ 2230468	2503995/ 2791301	1645780/ 1931287	961018/ 1005152
7	<b>Vitamin A dose distributed (NIDs/Vitamin A week)</b>						
	Vitamin A dose distributed (NIDs/Vitamin A week)	47,247	516,633	1817044	865345/ 1110900	530680/ 770596	772437
	Vitamin A dose distributed outside campaigns			85645	58771	44841	47603
8	<b>CDD (annual estimation)</b>						

\* BRAC activities continued up to July 9, 2001

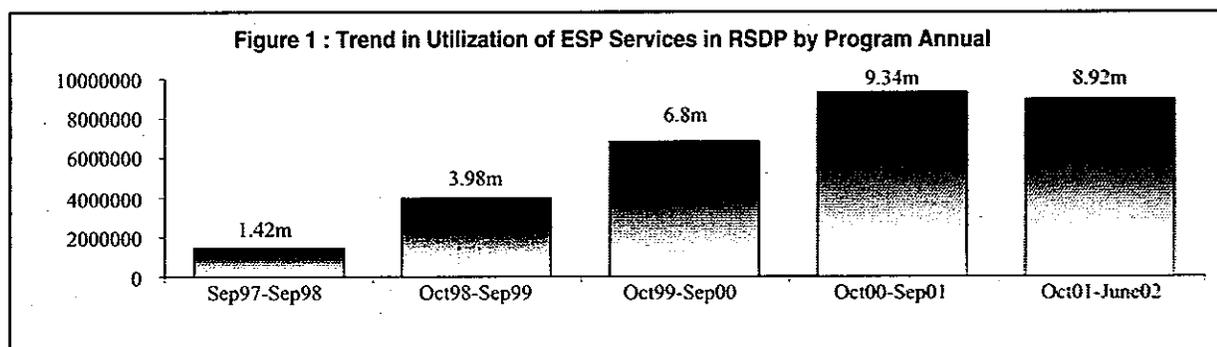
	CDD treated under 5 plan A (no dehydration)	49,273	242,161	586637	703721	661008	665804
	CDD treated under 5 plan B (some dehydration)	35,756	121,644	213224	228158	179944	126160
<b>9</b>	<b>ARI (annual estimation)</b>						
	ARI treated <5 with Pneumonia	3,599	16,829	43761	55104	46186	32901
<b>10</b>	<b>Pregnant received ANC visits (annual estimation)</b>						
	ANC1	67,228	94,087	152795	138103	135727	108516
	ANC2	42,316	81,526	156085	104453	99125	80666
	ANC3+	8,652	47,208	71904	96699	82718	112335
<b>11</b>	<b>Pregnant women received TT (annual estimation)</b>						
	TT1	30,012	63,113	113942	113392	101936	81215
	TT2+	83,731	112,673	215389	177865	161830	141977
<b>12</b>	<b>PNC Services (annual estimation)</b>						
	PNC	24,024	47,181	69019	80204	51667	70792
<b>13</b>	<b>STD/RTI cases treated (annual estimation)</b>						
	Female:						
	Vaginitis syndrome	6,729	18,274	41576	49380	55681	31755
	Other Syndrome	5,286	8,380	14619	14845	15829	56073
	Male						
	Urethral Discharge	1,298	1,624	3345	4559	5112	7958
	Genital Ulcer	445	327	434	525	1306	1435
<b>14</b>	<b>NGO Cost Recovery</b>						
	Program cost (\$)	3,421,628	3,583,772	4,490,501	3369538	3247074	2767706
	Service Charge (\$)	89,655	143,923	261,279	334361	257072	275669
	Profit from Revolving fund (\$)		29,356	53,621	60171	41550	21802
	Community Contribution (\$)	103,540	144,793	173,432	170519	130200	43990
	Total program revenue (\$)	193,196	318,072	488333	565051	428822	297471
	Percent*		9%	11%	17%	13%	12%
<b>15</b>	Number of Static clinics operating	172	175	175	175	139	139
<b>16</b>	Satellite sessions organized per month	4,550	6,005	7291	7729	5413	5614
	With EPI sessions		3,046	4752	5225	3187	3622
	Without EPI sessions		2,959	2539	2504	2225	1992
<b>17</b>	<b>Staffing and % Annual Turnover</b>						
	FWVs (current #/% turnover)				808/13%	453/17%	463/13%
	MOs (current #/% turnover)				31/39%	6/51%	7/45%
	Community Mobilizers (current #/% turnover)				512/10%	456/10%	453/3%
	Other (current #/% turnover)				9936/4%	6731/4%	6669/5%

\*It should be noted that this column measures RSDP achievement with and without BRAC's contribution for the period of October 2000 to September 2001. The "without BRAC" results relate to 139 RSDP upazilas, while the "with BRAC" results relate to 171 upazilas.

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

RSDP made a consistent effort over time to expand and increase the use of essential services, particularly among critical populations, through its tiered service delivery structure. RSDP's beginning, in 1997, marked the first step in the transition from door-to-door service delivery to that of fixed service delivery points. This concept emphasized obtaining multiple services at each client contact (i.e., a person

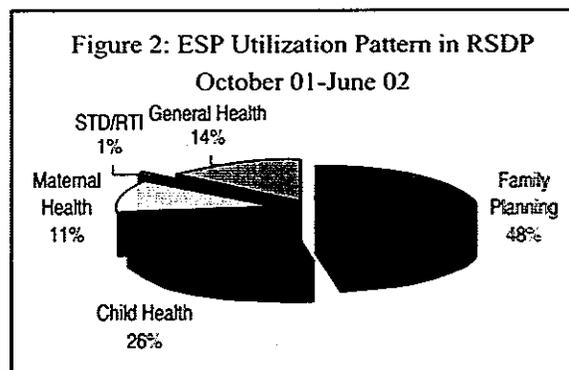
coming for child immunizations also receives nutrition advice and Vitamin A supplements), coined "one-stop-shopping." In addition, service providers referred individuals who need services not provided by RSDP to external sites, thus ensuring that the patient has adequate knowledge of treatment options and that the appropriate services were received.



A. Project Accomplishments

RSDP efforts have resulted in marked improvements in the reach of service delivery points and use of specific essential services. Figure 1 illustrates the increase in services provided by RSDP sites since 1997. As the ESP became more widely available, the mix of services

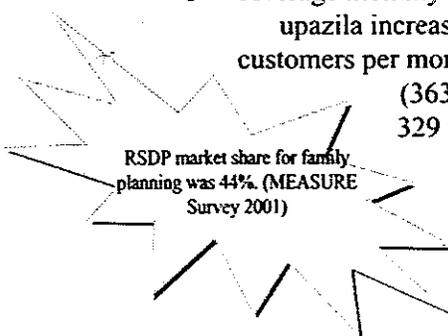
also increased. RSDP customers had access to multiple types of services. Figure 2 provides a picture of the overall use of ESP in RSDP, by service type. Family planning accounted for 48 % of services provided. Highlights are provided below.



1. Customer Reach

- Average monthly customer flow per upazila has increased by over 600% since 1997.
- ESP services have been offered to approximately 11 million people, including 2 million families, 2.2 million couples, and over 1.7 million children since 1997. Over 5.6 million customer contacts were made each year.

- Average monthly customer flow per upazila increased from 90 to 417 customers per month at static clinics (363% increase), from 329 to 1399 customers per month at satellite clinics (325% increase), and from 445 to 2152

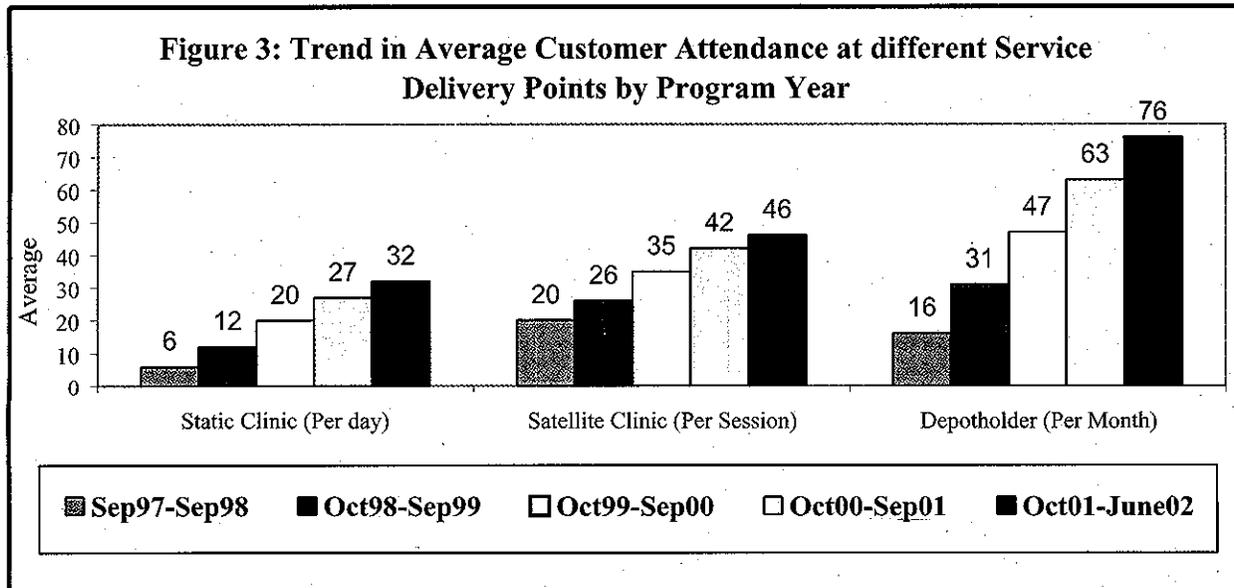


(384% increase) customers per month for depotholders since 1997.

- Since 1997, the number of upazilas with static, satellite, and depotholders seeing more than 10 customers per day dramatically increased. By 2002, the average daily customer flow rose to 34.
- The number of satellite clinics offered services in an upazila per month, on

average, grew from 10 to 48 from 1997 to 2002.

- Programs for special populations such as newlyweds and adolescents were conducted. BCCP reached newlywed couples with information about reproductive services and BRAC reached adolescents with their family life education programs.



## 2. Family Planning

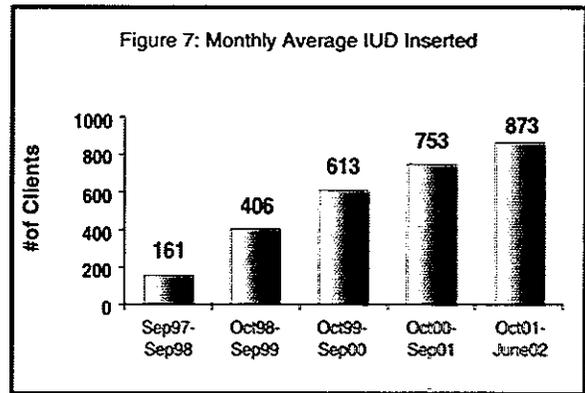
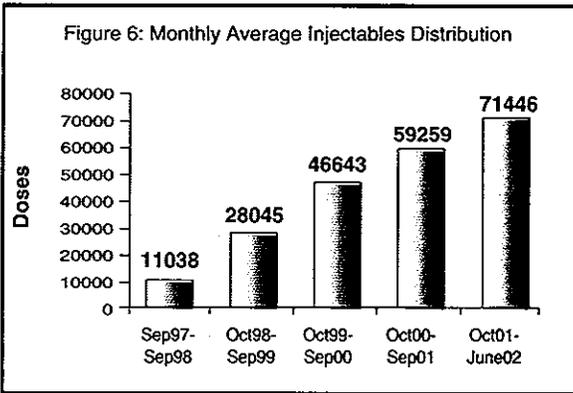
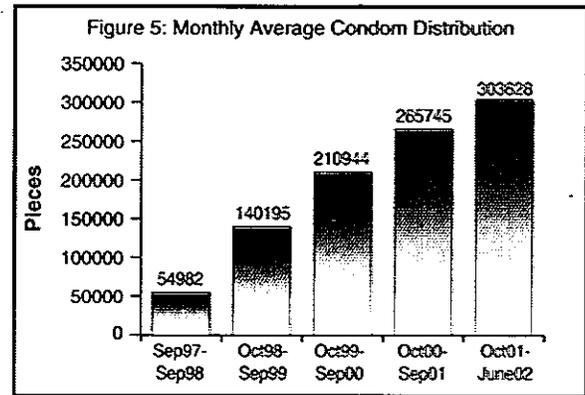
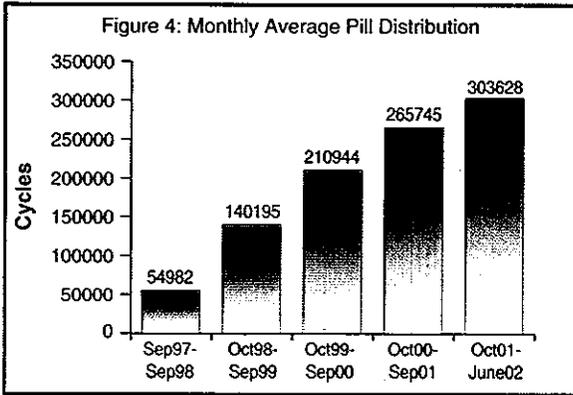
- Overall, family planning service use has increased by 601% since the beginning of the project. Use of all family planning methods-both clinical and non-clinical-increased steadily, with encouraging results for long-term methods. The top three percentage increases occurred for IUDs, condoms, and injectables.
- Clinical contraception services expanded significantly since 1997. As of June 2002, 26 clinics offered NSV and 18 sites offered Norplant services. Expanded availability yielded 51% increase of NSV and 373% of IUD over the life of the project.

- Among the non-clinical methods, pill use has increased by 5% and condom by 12%. Of the non-clinical customers who used condoms, 23% were male.
- Emergency Contraceptive Pill (ECP) pilot test results from two upazilas were scaled up to 4 additional upazilas.

1. Among the RSDP supply sources, depotholders are the main source of supply for pill and condoms; injectables are mostly available at satellite and static clinics; and static clinics are the main source for implants/Norplant's and IUD insertion

2. In the catchment areas, more than 70% of injectable users received their services from RSDP.

(MEASURE Survey 2001)



### 3. Child Health Services

- RSDP made tremendous strides in the area of child health. Overall, RSDP child health services and treatments combined are 18 times greater than at program inception. All child health services and treatments increased, with special contributions during National Immunization Days for Polio vaccination and Vitamin A distribution. Vaccination coverage including BCG, DPT-1, 2, and 3, Polio, and measles increased dramatically. In addition, ORS, ARI, and common cold treatments also increased.
- RSDP emphasized routine EPI. RSDP areas have an estimated 1,070,550 children under 5 years of age. All static clinics and 70% of satellite clinics offer EPI. Of that number, 111,445 have completed immunization during the

period from October 2001 to June 2002.

During the 1st round of 10th NID, 960,000 children received polio doses and 770,000

RSDP market share for child immunization was 9%. (MEASURE Survey 2001)

children vitamin A. In the second round, one million children were given polio doses. RSDP found 90-95% immunization coverage rates of all children less than five years old during National Immunization Days. RSDP was also involved in the house-to-house search for non-immunized children after the NIDs. Measles vaccination, which is considered the last dose for completion

<sup>1</sup>DHS, 1999-2000 estimates that 12.9 percent of the total population are children <5 years

of immunization, steadily increased for children between 12 and 23 months old. According to the MEASURE Survey 63% of children age 12-23 months in RSDP areas had received measles in 2001.

- RSDP worked closely with the GOB in the area of ARI. RSDP succeeded in having 3 RSDP upazilas included in the GOB's National Workplan to implement a community-based ARI program. Furthermore, GOB has plans to replicate training and BCC materials, which Pathfinder developed through pilot tests under RSDP. If completed, these materials could pave the way for scaling-up community based ARI in both in NGO and GOB.
- RSDP successfully introduced a TT program for school-going adolescents in its working areas. In each of 139 upazilas, at least two education institutions have been brought under this TT program. Most eligible adolescents in classes VIII-X of these institutions were given TT immunizations.

#### 4. Maternal Health Services

- Since program inception, the use of maternal health services has increased by 33%. This increase is attributable to consistent maintenance of the Family Registration by NGOs. The Family Registration system allowed NGOs to identify pregnant women and provide follow-up ANC services, including ANC 3 visits.

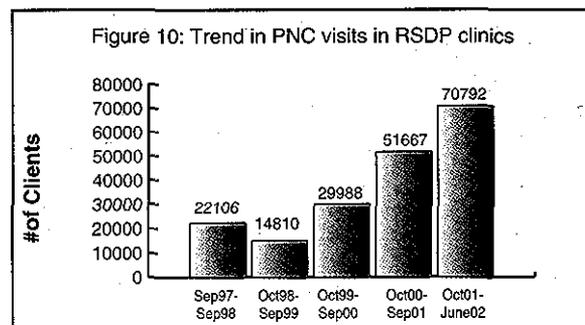
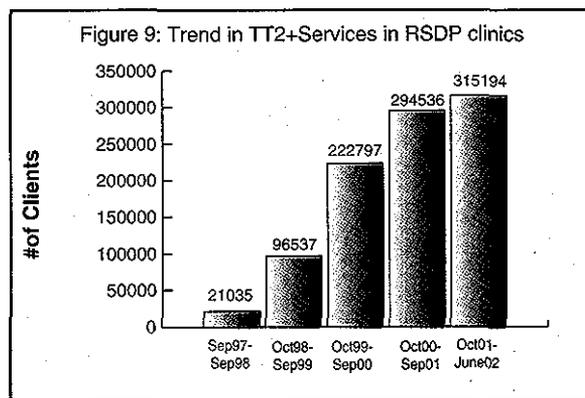
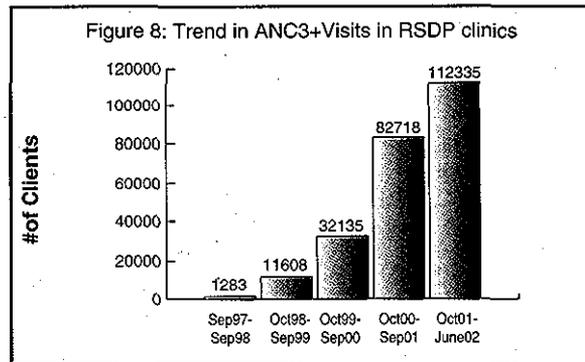
RSDP Market share for ANC was 59% MEASURE Survey 2001

- Antenatal care and TT2+ injections combined have increased nearly six-fold. Under RSDP, a standard of three minimum ANC visits per pregnancy was put into effect, with an increase of ANC3 visits per pregnancy by 8,656% since 1997. In addition, over 823,550 TT injections were given to pregnant women.

- The increase in usage of maternal health services was due in part to an emerging change in the behavior of mothers-i.e. a willingness to use PNC services. Use of both PNC services increased dramatically; post-natal care visits increased by 220% over the life of the project, since 1997. More importantly, RSDP found that both first PNC visits and revisits increased, suggesting that women were becoming increasingly aware of the need for multiple PNC visits. PNC services emphasize breastfeeding counseling and distribution of Vitamin A.

#### 5. Reproductive Health Services

RSDP clinics provided general reproductive



health services, which focused on male involvement, STDs & RTIs treatment, and HIV/AIDS information. RSDP routinely observed World AIDS Day with a massive educational campaign in all RSDP upazilas to raise AIDS awareness. In continuation with the observance of World AIDS Day, RSDP chalked out an elaborate program to create massive awareness in its catchment areas during the whole month of December 2001. Discussion with adolescents, students and teachers, meeting with satellite support group, meeting with community people like youth groups, rickshaw-pullers, bus and truck drivers and helpers were included in the program activities. RSDP clinics distributed leaflets focusing on the danger of HIV/AIDS, which included information on prevention, to high-risk customers.

In addition, specific attention was paid to two HIV/AIDS high-risk upazilas-Shibalaya and Goalanda, where Pathfinder organized two satellite clinics per month in Aricha Ghat area and served truck drivers, helpers, and women at risk in the Ghat area. Goalanda upazila also organized one satellite clinic per month in the red-light area to offer RTI/STD services to commercial sex-workers.

### 6. Adolescent Reproductive Health Services

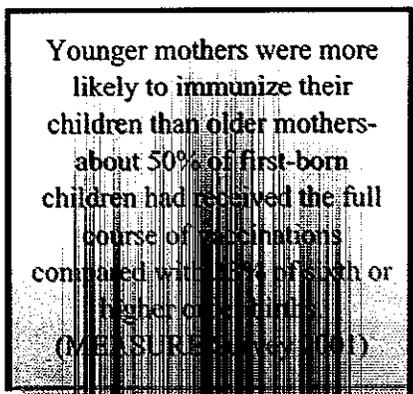
Recognizing the unmet reproductive health needs of the adolescents, RSDP undertook several program initiatives. As a member of the Adolescent Working Group with UFHP, UNICEF, UNFPA and BCCP, RSDP helped to develop a Frequently Asked Questions (FAQ) booklet called "Nijeko Jano" (Know Yourself) for adolescents. Forty education institutions (15 Girls, 21 co-ed High School and 4 Madrasha) were selected to distribute this booklet. As of May 2002, all 40 educational institutions have successfully distributed the booklets to about 8,500 school-going adolescents. In addition, approximately 2,000 non-school going adolescents received

this booklet from RSDP satellite clinics.

Given the early marriage age in Bangladesh, newlyweds (15-19 years old) were a special target group within the adolescent population. The increasing size of newlywed population coupled with the huge unmet RH need made this a priority group under RSDP. To address the alarming need, Pathfinder implemented a highly successful Newlywed Program that promoted smaller families, delayed first childbirths, adequate birth spacing, and antenatal care. The program functioned through identification and registration of newlywed couples, visitation by depholders, and orientation meetings. Program efforts contributed significantly to an increase in the knowledge and use of contraceptives by both male and female newlyweds, as well as an increase in the use of antenatal and EPI services. The Newlywed Program also highlighted the role of depholders as a source of important information for the community.

### B. Lessons Learned

- ✓ A three-tiered service delivery design is very effective in increasing access to ESP services. RSDP experienced an increasing customer flow at all three levels of service delivery points over five years of program implementation.
- ✓ The establishment of a sound infrastructure at the beginning of a program is essential for the start of service delivery.



RSDP discovered that regardless of previous experience, most upazilas required several months of preparation before they were ready to offer services. Major activities in the initial project stage that helped to establish a sound infrastructure for service delivery included: selecting appropriate places for static clinics, recruiting staff and

depholders, selecting satellite clinic locations, orienting service providers, and obtaining GOB area allocation, DTC approval, and contraceptive supply.

- ✓ NSV and Norplant services can be provided successfully in a rural setting. RSDP implemented a pilot program to provide NSV services at 27 Sites and Norplant at 13 sites. Based on positive experience from the pilot program, NSV and Norplant programs can be expanded to other rural sites as well.
- ✓ EPI services can be made available at all static clinics either through direct RSDP service provision or collaboration with GOB EPI. However, EPI for satellite clinics may not be possible everywhere. RSDP successfully provided EPI services at 70% of satellite clinics. For the remaining 30% of satellite clinics, Pathfinder collaborated with GOB to mobilize community to use EPI services.
- ✓ Distribution of ARH materials through schools is a good way of avoiding community sensitivities around this topic. Using schools as a source of ARH materials ensured that students receive pertinent information and that counseling was available from teachers.
- ✓ Holding joint NIPHP-EPI session yields the best result in achieving greater accessibility and coverage for EPI.

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

The Bangladesh Center for Communications Program (BCCP) is Pathfinder's primary partner in the development and dissemination of information, education, and communication efforts, or behavior change communication (BCC). BCCP works together with other members of RSDP to plan, develop materials, and provide training and guidelines for increasing health-related information and behavior.

BCC planning activities included collaborative work with the Government of Bangladesh and BCCP in the development of a national strategy for BCC and a national strategy for HIV/AIDS. These activities allowed RSDP to integrate its activities into countrywide efforts to increase health-promotion behaviors. BCCP has also played an important role in the development of RSDP's IEC strategy and that of individual upazilas covered under RSDP.

##### A. Project Accomplishments

Under RSDP, BCCP developed a wide range of BCC materials for the local communities as well as service providers. BCC materials were developed for the community to ensure that community members are aware of service delivery locations and have knowledge of national and international events (such as National Immunization Day). Materials for service providers focused on information and educational tools for more effective delivery of services and on compliance with U.S. laws. Special target groups, such as newlyweds and pregnant mothers, were targeted for distribution of BCC information. The essential services package was also promoted via materials such as green umbrella symbols, newsletters, EPI calendars, and videos promoting healthy

behaviors. In addition, BCCP oversaw the development of a national television drama that promoted the use of health services. BCC accomplishments under RSDP are highlighted below.

##### 1. Television Drama Serials

Under RSDP, two drama serials were developed and produced in collaboration with BCCP. The first serial, *Shabuj Chhaya* had thirteen episodes and was aired in a prime time spot on national television BTV. *Shabuj Chhaya* told vivid stories about the lives of people associated with the health care system and service delivery in Bangladesh. *Shabuj Chhaya* received over 600,000 responses from viewers in response to the weekly quiz contest. The weekly contests offered five first place prizes (Tk 500 each) and 20-second place prizes (*Shabuj Chhaya* calendar).

Eyi Megh Eyi Rudra (EMER) was a 26-episode drama serial broadcasted on Bangladesh television. Each of the 26 episodes contained information on important health topics related to the essential services package. The drama centered on the lives of both urban and rural Bangladeshis, their worldview, sorrows, and hopes. EMER was an opportunity to promote the health care and service delivery system of RSDP and UFHP clinics marked with the new "Smiling Sun" symbol. The health messages, as delineated in the drama, were reinforced during the 'Health Information' part of the show, which was introduced in the serial as an appendix of the drama and provided in-depth information on various health topics.

EMER was extremely popular and attracted a large number of viewers. The television serial topped the 'Top Ten' list of the most popular program of Bangladesh television and was rated the most popular drama serial for the entire period of broadcasting. The quiz portion of the television drama serial drew in more than 800,000 participants, many of who were from the more remote parts of the country.

### **2. Radio Magazine Program**

In August 2001, RSDP launched a radio magazine program for adolescents entitled Jante Chai Janate Chai on Bangladesh Betar. The program consisted of 52 episodes, where each episode dealt with a particular health issue and delivered a relevant social message to bring about desired behavior change. The issues covered included physical and emotional changes, nutrition, personal hygiene, sexual harassment, early marriage, pregnancy, contraceptives, STD, AIDS and drug addiction. The themes were presented through an entertaining program that included music, short plays, quizzes, letter sessions, and celebrity interviews. In some episodes a doctor is invited to answer queries and offer professional advice.

The program—which was made possible through valuable assistance from the Ministry of Health and Family Welfare, Govt. of Bangladesh, USAID, UNICEF, UNFPA, RSDP, UFHP and Johns Hopkins University/Center for

Communication Programs—was broadcast nationwide every Friday at 11:00 a.m. Every aspect of this program was tested with the utmost care to ensure that it made an impact in the mind and lifestyle of Bangladesh's 30 million adolescents. The success of the program resulted in more than 7,000 letters from listeners being sent to BCCP.

### **3. Branding Campaign**

As part of 'Smiling Sun' branding campaign, 106 billboards bearing smiling sun symbol were erected in prime locations throughout the country. Closely monitored by BCCP, there were three kinds of billboards—one promoted RSDP, a second promoted UFHP, and a third promoted both RSDP and UFHP.

The branding campaign also included the television drama and radio programs mentioned above, as well as numerous commercial spots on both television and radio. Specific BCC



materials were also developed to facilitate interpersonal communication at the community level. The well-orchestrated and comprehensive BCC campaign, which combined both mass media and interpersonal communication, successfully established linkages between mass media messages and local level communication, thus fostering community mobilization. Media messages were developed for a variety of health topics, such as family planning, delayed marriage, delayed pregnancy, RTI/STD, and HIV/AIDS.

#### 4. Development, Distribution, and Utilization of BCC Materials

Throughout the program, RSDP conceptualized, designed, developed, pre-tested, produced and distributed numerous BCC materials—from leaflets and brochures to posters. BCC materials covered a wide range of topics, including child-

health, ANC, ARH, STI/RTI, family planning, and HIV/AIDS. Printed materials were targeted at specific groups, such as mothers, newlywed couples, men, and adolescents. The chart below provides several examples of printed BCC materials produced during RSDP.

**Table 2: Examples of BCC Print Materials Under RSDP**

Material	Target Audience	Use Guideline
Brochure promoting ANC-SD-PNC services	Pregnant and post-partum mothers	Community Mobilizers used the material as talking points while facilitating group meetings on this issue. A total of 20,000 brochures were distributed to pregnant and post-partum mothers.
Brochure for the Newlywed Couples	Newlywed Couples	Community Mobilizers used the material as talking points while facilitating group meetings on this issue. A total of 39,365 brochures were distributed to newlywed couples.
Poster to promote STI services	Adult people of the community	A total of 200 posters were distributed in the high-risk areas, as identified by RSDP, of Goalanda and Shibalaya.
Brochure to promote services on Adolescent Reproductive Health	Adolescents of the community	Community Mobilizers used the material as talking points while facilitating group meetings on this issue. A total of 50,000 brochures were distributed to adolescents.
Brochure on HIV/AIDS	Adult male and female group of the community	Community Mobilizers used the material as talking points while facilitating group meetings on this issue. A total of 30,000 brochures were distributed to adult males and females.
Brochure to promote Long Term Family Planning methods	Eligible Couples	Community Mobilizers used the material as talking point while facilitating group meeting son this issue. A total of 30,000 brochures were distributed to ELCOs.
Brochure on RTI/STI	At risk group	Community Mobilizers used the material as talking points while facilitating group meetings on this issue. A total of 14,000 brochures were distributed in the high-risk areas of Golanda and Shibalaya.
Instructional strip on condom use	Adult customers	Distributed among the customers when they purchase condoms. A total of 100,000 strip were produced for distribution.
Child Health Brochure on EPI, CDD, ARI, Vit-A	Guardians of children under 5 years	Community Mobilizers used the material as talking points while facilitating group meetings on this issue. A total of 111,200 brochures of all the four categories of child health disease were distributed to guardians of children under the age of 5 years.

#### 5. BCC related training and Workshop

To increase the efficacy and sustainability of BCC activities, RSDP also undertook significant BCC training efforts in areas such as family health and social communication, message development workshop, and HIV/AIDS

awareness. These workshops were designed to provide both managers and service delivery providers with information on how to promote BCC in their areas.

## 6. Interpersonal Communication Refresher Training

From December 8, 2001 to February 3, 2002, 479 RFMs and CMs attended a series of 2-day refresher trainings on interpersonal communication. The refresher training empowered the RFMs and CMs to better understand and contribute to the BCC campaigns by effectively linking media messages with appropriate BCC materials during interpersonal communications, thus reinforcing BCC messages. Other objectives of the workshop included enhanced knowledge about segmenting target audience and increased ability to organize local level meetings on family health issues.



Participants are doing group exercise in the BCC refresher training

### B. Lessons Learned

- ✓ Linking BCC activities with service delivery helps to increase utilization of services among special target groups. The observation of National Days with BCC activities—such as inviting the community to service delivery points—increased the utilization of services by underserved groups including children, pregnant women, and newlyweds. Such activities created awareness relating to the theme of the day as well as increased utilization of service delivery points.
- ✓ Community mobilization, rigorous marketing, and communication with customers increase the use of services. RSDP found that making services available doesn't guarantee increased use; availability of services must be complemented by a strong BCC campaign.

- ✓ Comprehensive interpersonal communication is essential to ensure community participation and utilization of services. Strong interaction with the community increased community mobilization and support for services. Mass media campaigns alone did not ensure increased customer flow and service utilization.

- ✓ Like other community-based programs, the success of a BCC

program mostly depends upon proper and appropriate monitoring, as well as technical assistance and hands on orientation. The RSDP TA units played a significant role in this provision and brought a visible change in the attitude of RSDP upazila team members in delivering interpersonal communication.

- ✓ BCC training and refresher training for all service providers enhances the efficacy of a BCC plan. Since paramedics and clinic aides played an important role in RSDP's provision of counseling to customers, they also require proper counseling training. If service providers are given the information and skills to pass on BCC messages, then customers will get correct information and explanation about their desired services and customer flow will increase.

Even those women who were not using a contraceptive method, 44% of them mentioned NIPHP NGOs as a source of family planning

- ✓ The establishment of an effective monitoring system to supervise and monitor BCC activities increases accountability in the implementation of these activities. Since RSDP's MIS only recorded information on a few BCC activities, it was difficult to ensure that BCC initiatives were properly implemented.

## V. INTERMEDIATE RESULT 3: IMPROVING QUALITY OF SERVICES AT NIPHP FACILITIES

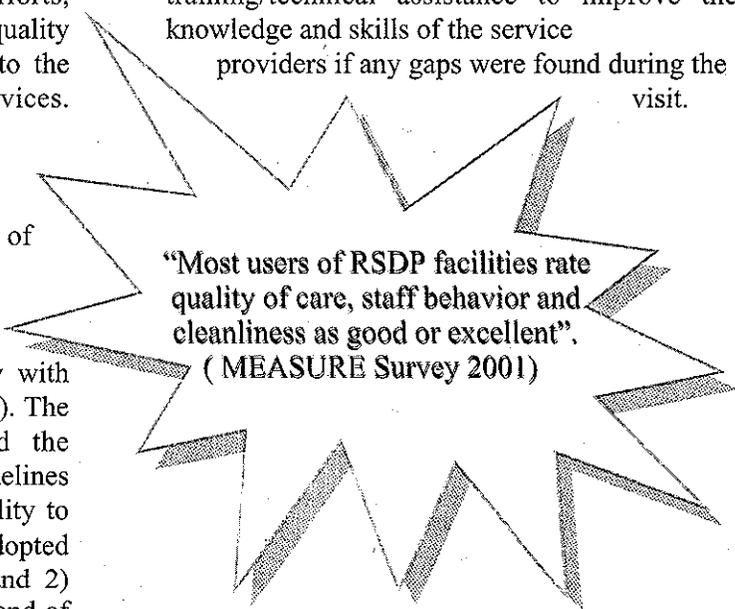
Quality runs throughout RSDP efforts, beginning with the development of quality materials and guidelines, and extending to the delivery and assurance of quality services. Pathfinder conducted many activities to assure quality since program inception. Considering the vision of the program, RSDP planners felt the necessity of installing a quality assurance (QA) system at RSDP supported service delivery points. To install a quality assurance system Pathfinder worked collaboratively with the Quality Improvement Partnership (QIP). The planners at RSDP and QIP reviewed the international and national tools and guidelines and the existing QA system for applicability to the new ESP service delivery model and adopted two direct: 1) Quality Assurance visit and 2) COPE Exercise. In addition, towards the end of the program, RSDP worked with UFHP and QIP to develop a Quality Management and Supervision (QMS) system that was instituted by NGOs on a sustainable basis.

### A. Project Accomplishments

#### 1. Quality Assurance (QA) Visit

RSDP conducted routine quality assurance visits that covered specific aspects of quality at static and satellite clinics. QA visits were conducted at RSDP sites with the objectives of analyzing program performance, identifying problems, recommending solutions, and providing TA if necessary. Each RSDP static clinic had one QA visit per year, with each visit lasting 2 days. RSDP and QIP jointly developed the QA visit guidelines, as well as the responsibilities of individual team member during the QA visit. The QA team usually consisted of representatives from both RSDP and the appropriate NGO. QA Team members often provided on-site

training/technical assistance to improve the knowledge and skills of the service providers if any gaps were found during the visit.



"Most users of RSDP facilities rate quality of care, staff behavior and cleanliness as good or excellent".  
( MEASURE Survey 2001)

#### 2. Client Oriented Provider Efficient (COPE) Exercise

The COPE exercise was used to improve the quality of the services provided by RSDP. COPE was based on a framework that emphasized the needs and rights of both customers and clinic staff. As a result, COPE not only contributed to the improved quality of services, but also increased customer demand for quality and staff understanding of quality. The COPE process contained several tools for staff to identify problems through self-assessment, and to plan for quality. Key steps of the COPE exercise include:

- The introductory session, in which COPE is explained to participants;
- Self-assessment through guide, customer interviews, and record review;
- The action plan meeting; and
- Follow-up COPE exercise, to assess

#### Quality Monitoring and Supervision (QMS)

A system by which designated NGO managers, in cooperation with clinic managers and personnel, can measure, identify, and prioritize problems related to quality; identify and implement solutions; document processes and results; and follow-up to maintain quality and continue on the path to improving quality

progress on the action plan and incorporate new findings on the action plan.

The COPE Team consisted of two members, one from QIP and one from RSDP, as well as an NGO observer. The presence of the NGO observer, usually the Monitoring Officer or Project Manager of the respective NGO, contributed to RSDP's efforts to improve both quality and NGO management of clinics. The NGO observer received first-hand experience on how to assess the quality of services and recommendations on how to improve quality. The goal was to increase NGO capacity to assess and improve quality based on a clear and effective process.

### 3. Support Activities for Quality Assurance

- Guidelines were developed to set standards for clinical equipment and supplies in RSDP NGO clinics.
- Paramedics were trained to provide services under ESP.
- A variety of service delivery guidelines, job aids and manuals were developed and supplied to the service providers.
- NGO Project Managers, Monitoring Officers and Thana Managers were trained on supervision and quality management of ESP Services.
- NGO Project Managers and Monitoring Officers were oriented on QA Visits and COPE Exercise.
- Guideline and reporting format for QA visit Recommendation Implementation Status Follow-up for TA units were developed.

### 4. Quality Management and Supervision

The purpose of the Quality Monitoring and Supervision (QMS) system was to institutionalize the quality assurance activities by integrating them with the NGO management and supervision system. Through QMS, greater responsibility for maintaining quality at the service delivery sites was shifted to the NGOs and clinics. NGO supervisory and managerial staffs, with support and guidance from

Pathfinder through on-site QMS visits, were responsible for assessing and improving systems/processes at their respective clinics. Supervisors worked with the clinic staff to identify quality gaps using self-assessment data, observations, clients' records, daily service registers, and exit interviews.

The QMS model developed by the QMS Development team consists of two related elements: monitoring and supervision, and quality improvement. These elements come to play both at the NGO level and the individual site level. An NGO supervisor (or a combination of clinical and non-clinical supervisors) provided support for each of these elements while working with a clinic team or staff member.

### 5. Technical Standards Development

With the assistance of the QIP, RSDP produced numerous ESP manuals covering topics such as rational drug use and family health, and training curricula for service delivery providers. Pathfinder also created technical assistance guidelines and tools for TA Units and managers to use in the field to assess and assure quality.

### 6. Using Data to Assess Quality

RSDP routinely emphasized the use of data as a means to track and assess program performance. From the beginning, RSDP collected a variety of data on service delivery statistics, covering customers served at service delivery points, types of services received, and customer gender and age. This information allowed RSDP to

judge whether an appropriate number of customers were being reached and services delivered. However, this information did not directly indicate the quality of services being delivered. As a result, RSDP began to develop quality assurance indicators. RSDP also began development of

The average composite quality assurance index (obtained through field visits) increased from 38% in the 1<sup>st</sup> round to 56% in the 2<sup>nd</sup> round and finally to 86% in the 3<sup>rd</sup> round.

MIS to track training, quality assurance, and BCC activities.

RSDP also involved local partners in the collection and use of data for the assessment of quality. RSDP worked with NGOs to conduct a rapid assessment of their catchment areas, allowing for assessment of aspects of service delivery such as method mix and identification of areas in need of greater attention. Pathfinder conducted a Family Registration process—in which depholders collect information about every household in their catchment area—and used this information to conduct selective visitation of critical populations. Field managers, NGOs, and TA units used this information to judge catchment area coverage, and plan for improved service delivery.

To further improve client follow-up and referral, RSDP NGOs designed an internal client follow-up system and an external referral and follow-up system. Both these systems enhanced NGO ability to use data for programmatic planning and decision-making.

### **B. Lessons Learned**

✓ High turnover rate of clinic staff and absences due to vacation or other reasons greatly inhibits the consistency and quality of services delivered at RSDP sites. In particular, many paramedics left their positions, creating a gap in service delivery. As a result, RSDP learned that it is important to train clinic aides to act as a backup to paramedics. The backup training worked well to improve the consistency of service delivery and had the added benefit of transferring new skills to the clinic aides who otherwise would not have had the opportunity to be trained. In addition to paramedics, NGOs also experienced high turnover rates with physicians recruited during RSDP.

✓ To ensure continuous service delivery, it is best to hire service providers who work and live in the same community. RSDP

discovered that service providers who lived and worked in different communities had a much lower retention rate than those that lived and worked in the same community. Managing customer flow is an important element of quality assurance. RSDP encountered the problem of having more customers arrive at a clinic than could be served at one time. As a result, customers were being turned away and without receiving needed services. Pathfinder conducted an analysis of customer flow to determine the point at which customer flow becomes unmanageable (referred to as the "optimal number"). Rather than turn patients away, RSDP experimented with new models of customer management, such as giving customers different times to come for services.

✓ Program managers who understand the technical aspects of the program can provide better support to service providers. RSDP organized Supervision and Quality Management Workshops for NGO management staff to explain the technical and quality aspects of the program as well as each of the ESP components. The workshop provided a unique opportunity for project and upazila managers to interact and share experiences. As a result, NGO management staff were more comfortable supporting service providers.

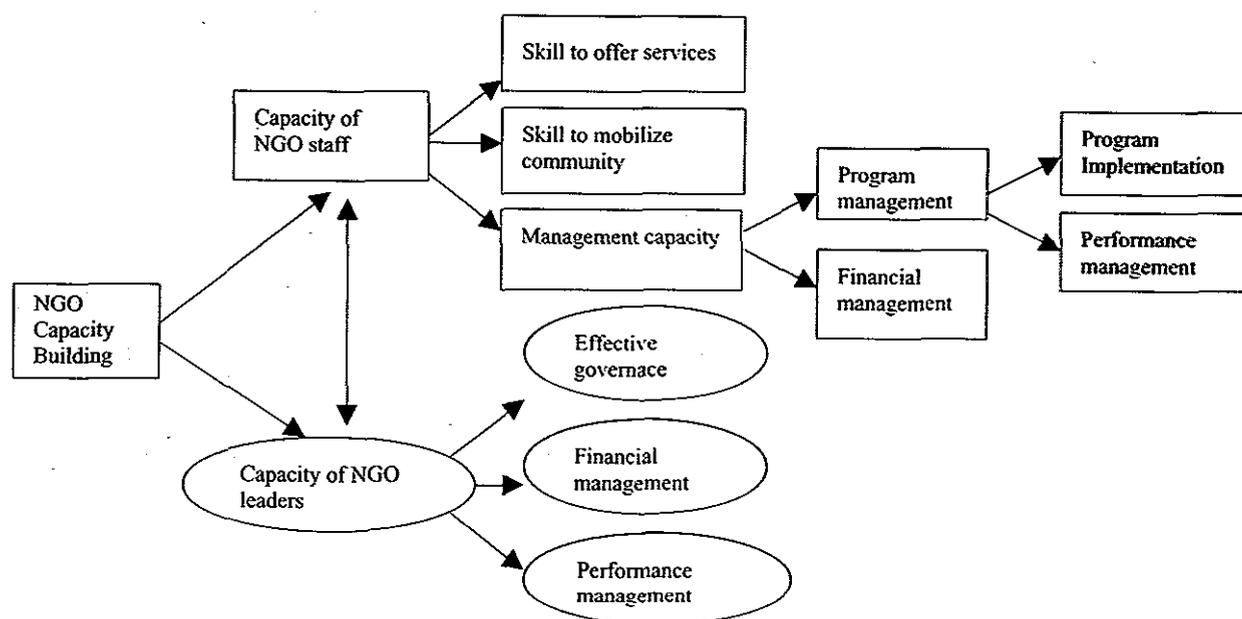
✓ Privacy is an important requirement for the provision of quality services. In rural settings, especially at satellite clinics, the lack of separate exam rooms affected client privacy and hindered the provision of services, such as IUD insertions. RSDP addressed this problem by using mosquito-type nets to increase privacy for the client.

✓ Quality can not be fully ensured unless customers are also fully aware and conscious about it and demand it as well.

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

Beginning in 1997, RSDP implemented an institutional capability building (ICB) approach developed by Pathfinder. Pathfinder's ICB approach focused on strengthening management in both national and local NGOs. During the first two years, RSDP paid special attention to increasing competence of service providers to offer complete essential service package (ESP) and educating the community to utilize services from different levels of service delivery points. In the third year, the focus shifted to enhancing the capacity of supervisory and management staff to manage the program efficiently. In the fourth year, several initiatives were taken to improve the capability of the NGO leaders and board members to participate in the design, implementation and monitoring process of the NGO program. In the final year, RSDP consolidated all ICB efforts for achieving and optimizing program outputs in order to make the program more sustainable. The following framework illustrates Pathfinder's approach to institutional capacity building:

Figure-11: Conceptual Framework on Pathfinder ICB Approach



### A. Program Accomplishments

RSDP implemented a number of tools, policies and guidelines to improve overall NGO management. Successfully implemented tools and guidelines include those for financial management, revenue generation, referral, BCC, monitoring, and other technical areas. In addition, regular technical training and consultation was provided to NGOs to support the transfer of skills and understanding from program headquarters to program partners. Skill transfers occurred for topics including development of workplans and proposals, creating communication messages, assessing quality of services, conducting self-assessment,

conducting financial and administration management, and expanding the knowledge and responsibilities of service delivery providers.

#### 1. Strategic Planning and Workplan Development

To ensure that all NGOs possessed a common understanding of RSDP's goals and objectives, routine meetings were held with NGO staff. These meetings provided RSDP with an opportunity to interact with NGO staff to transfer pertinent planning and management skills. As a result, NGOs became increasingly active in the development and implementation of

program objectives and activities. Examples of these meetings include:

- Annual orientation meetings were held to enhance NGO staff's understanding of RSDP objectives and strategies. These meetings enabled managers to organize similar orientations for upazila team members, with assistance from NGO central staff and RSDP TA unit officers.
- Workplan development meetings were held with NGOs, where Pathfinder staff worked closely with NGO staff to develop clear and concise workplans.
- Pathfinder provided substantial technical assistance to enhance the capacity of NGOs in the development of renewal proposals including activity-based, time bound and cost conscious budgeting.

## **2. Routine Monitoring and Supervision**

Routine monitoring and supervision responsibilities were increasingly transferred to NGOs during RSDP. As NGOs became increasingly capable of tracking data and performance, RSDP staff worked with NGO staff to transfer monitoring and supervision skills and responsibilities. Pathfinder helped to develop NGO capabilities in ESP performance, finance and administration, and MIS data collection and analysis. Activities that have increase NGO capacity in monitoring and supervision include:

- In addition to individual monitoring visits, RSDP implemented the approach of joint monitoring visits to NGO sites. The joint team consisted of NGO central staff, RSDP TA unit staff, in some cases, RSDP HQ's staff and in others, COP and NGO leaders. Monitoring visits generally covered issues such as quality, MIS, finance and administration, and other areas in need of assistance. This approach has significantly improved the ability of NGOs to identify TA needs and performance weaknesses.
- NGO Managers, with assistance from Pathfinder, developed a guideline for conducting Monthly Performance Review Meeting. RFMs were trained to review

ESP output performance across teams and between previous and last month, and overtime implementation process—including staff performance. Performance weaknesses and management gaps were identified and plans were made to improve overall performance. These reviews ensured increasing local level accountability as well as transparency of performance.

- RSDP organized a workshop with MIS Officers to discuss MIS implementation status, problems with MIS implementation, common mistakes, and feedback on NGO reporting. In the workshop, NGO staff reaffirmed their knowledge, which enabled them to implement the revised MIS smoothly. The MIS officers also developed action plan to address gaps in MIS reporting discovered during the workshop.

## **3. Utilization of Program Data**

Baseline Surveys, RAPID Assessments, and Family Registration were very helpful to identify program gaps and design program activities accordingly. Pathfinder conducted Baseline Surveys in December 1998 and RAPID Assessments with selected NGOs in May 2000 to determine the ESP utilization status in the RSDP areas and RSDP's contribution to ESP users. This analysis helped NGOs to design program activities, address service gaps in the program. Family Registration in RSDP catchment area was conducted in October 2000 to get information about critical target groups, including ELCOs, potential clinical contraceptive users, pregnant women, children under one, children under five, and adolescents. Introduction of Family Registration and subsequent updating of information on critical target groups helped NGOs set more specific program goals.

Mapping workshops provided RSDP with valuable information to improve program implementation. Initial upazila maps were developed at the beginning of the project and were updated during a series of one-day long workshops from August 13 - September 3, 2000

Managers from 171 upazilas updated maps of the static and satellite clinics and catchment areas in their respective upazilas. The mapping exercise provided Field Managers with an update on changes in coverage over the first three program years and produced a set of 171 standardized maps for the program. The mapping workshops were a great success and reiterated the benefits as well as challenges of serving RSDP catchment areas and ELCOs. Updating upazila maps in conjunction with the completion of the Family Registration process provided Field Managers with the opportunity to have a clear view of the areas served, and to address the challenges of delivering services in hard-to-reach areas. The process of mapping increased accountability by showing the number and the location of RSDP customers and the coverage spread within each upazila. Field Managers routinely used mapping data for program planning, monitoring and evaluation.

#### **4. Quality Assurance and QMS**

Recognizing the importance and difficulties of maintaining high-quality services in rural clinics, RSDP paid extra attention to transferring quality assurance skills to NGOs. Multiple workshops and training sessions were held with NGO staff to familiarize them with quality assurance and supervision/management skills helped increase and/or maintain quality services. As a result of RSDP's efforts, quality of ESP services increased dramatically over the past five years. Below are highlights of RSDP efforts to help NGOs increase quality of services:

- The RAPID assessment survey was introduced to NGOs, allowing for self-assessment of performance by NGO staff.
- NGOs were trained to conduct the COPE Exercise and took a more active role in Quality Assurance visits through observation of RSDP QA Teams.
- In collaboration with EngenderHealth, Pathfinder routinely held special workshops on Supervision and Quality Management of ESP Services for NGO managers. These workshops not only stressed the need for vigilant quality assessments, but also

provided NGO staff with guidance on how to improve quality.

- Workshops on strengthening the quality of clinical services were routinely held for NGO Project Managers and MIS Officers.
- As a part of RSDP strategy to develop NGO capability, Pathfinder jointly conducted QA visits with NGO staff.

In addition to the initiatives above, RSDP also implemented a Quality Management and Supervision system, through which greater responsibility for maintaining and improving quality of care was shifted to NGO staff. NGO supervisory and managerial staff, with support and guidance from Pathfinder and QIP, and through training and on-site QMS visits, gradually assumed a greater role in assessing and improving systems/processes at clinic sites. For QMS to be successfully implemented, the RSDP developed the capacity of NGO managerial and supervisory staff. NGO supervisors needed general training in monitoring and supervision, especially in data analysis, interpretation, and problem-solving methods. Furthermore, on-the-job support through technical assistance from Pathfinder was also crucial in the initial stages of QMS implementation.

#### **5. BCC Localization**

In collaboration with BCCP, RSDP increased NGO capacity to develop and implement BCC plans. An initiative was undertaken in 1998 to initiate a BCC localization plan, with the objective of enabling NGO planning of BCC outreach activities according to local needs, abilities, and cost. In accordance with this strategy an interpersonal communication-based upazila BCC Plan format was developed. This BCC plan was introduced at a common understanding workshop held in 1999, where NGO staff received training in effective social communication, development of BCC materials, and monitoring of BCC activities. The upazila BCC plan had three stages:

1. Individual BCC Plan: An advance plan that incorporated the BCC activities to be implemented by each individual staff member.

2. Monthly upazila BCC Plan: Advance collective BCC activity plan to be implemented by the whole team in one month.

3. Yearly BCC Plan: Aggregation of monthly upazila BCC Plan that the upazila planned to be implemented in one year.



The introduction of the upazila BCC plan facilitated the implementation of BCC outreach activities by upazila team members in an organized and coordinated way. As a result, NGOs were capable of holding community meetings and developing and distributing BCC print material, such as posters, leaflets, and signboards. A couple of NGOs with Pathfinder assistance developed customized leaflets to promote their service delivery points and services with encouraging result.

## 6. Financial Management

Working on the belief that sound financial management is an important part of improving overall NGO management, RSDP emphasized the transfer of financial capabilities to NGO staff. To accomplish this, Pathfinder provided financial training and accounting guidelines, and routinely monitored NGO financial activities. Financial training was provided to NGO staff in order to maintain clear financial records and to improve day-to-day administrative and financial operations. RSDP provided Pathfinder's F&A manual to all NGOs and required all NGOs to comply with policies outlined in the manual. These guidelines and skills greatly facilitated sound accounting practices at each NGO—especially as revenue generation activities increased.

To ensure understanding and compliance with Pathfinder provided RSDP F&A guidelines, NGOs were closely monitored. Pathfinder monitored the use of and compliance with F &

A manual and corrective actions were taken when necessary. NGO involvement in monitoring activities was encouraged to

facilitate better understanding of financial management.

For example, in preparation for audits, RSDP organized orientation sessions for NGO project managers and accounts officers to explain the audit process and the paperwork necessary to complete an audit. NGO staff were

also encouraged to accompany RSDP staff on monitoring trips to gain experience in assessing financial management weaknesses and identifying best practices.

## 7. Logistics and Supplies

As a part of institutional building and strengthening local capability, logistic stock situation analysis skills were increasingly transferred to NGOs. NGO staff was trained to identify logistic stock-out situations and how to take corrective measures. NGOs were encouraged to negotiate directly with pharmaceutical companies, with whom they had signed MOUs, to ensure appropriate stock levels. As a result of these actions, the overall logistic situation under RSDP improved considerably. Injectable shortages decreased from 38 upazilas in March 2001 to 26 upazilas in March 2002. Similarly, the stock-out situation for Vitamin A decreased from 85 upazilas in June 2001 to 31 upazilas in March 2002.

## B. Lessons Learned

✓ Solid research and evaluation can be done quickly to produce meaningful results that can be immediately incorporated into program operations. RSDP undertook several large-scale initiatives to conduct research and evaluation. Chief among them was a Rapid Assessment of NGO catchment areas in which RSDP utilized rigorous methods and engaged local field staff to

interview a sample of women about various indicators including the use of family planning methods. The resulting Rapid Assessment data provided immediate information for assessing problematic areas, programmatic decision making, and achievement acknowledgment.

- ✓ The implementation of tools, policies and guidelines is most effective when complemented with ongoing training and guidance. It was important for RSDP to provide NGOs with ongoing training and TA on new tools and guidelines to ensure proper program implementation. RSDP has implemented many tools, policies and guidelines successfully over the years, including those for financial management, revenue generation, referral, BCC, monitoring, and other technical areas.
- ✓ Basic training for NGOs on utilization of data for decision-making is very important. RSDP discovered that the collection of new data from the Rapid Assessment and Family Registration survey did not ensure that the data would be used by the NGOs for decision-making purposes. NGOs required training in how to interpret and present data. Guidelines and exercises (such as mapping) were provided to NGO staff to facilitate this process. RSDP Call to Action provided data based decision to the field for immediate follow-up and served as training and referrals materials for action.
- ✓ To prevent inaccurate recording of program data, regular technical assistance needs to be provided for the collection and recording of data. Pressure to provide consistent evidence of increasing program inputs created pressure on NGO staff to report inaccurate data.
- ✓ Conducting evaluation and research at the local level enables NGOs to be more accountable and willing to address the

findings. Under RSDP, NGOs conducted research with close technical assistance from Pathfinder (such as the Rapid Assessment) to better understand program performance, identify gaps, and make relevant programmatic decisions.

- ✓ For effective program implementation, NGO leaders need to have a clear and adequate understanding of program objective and strategies. NGO leaders who attended RSDP orientations on NGO Workplan Development and NGO Performance Review Meetings, were more efficient in giving specific feedback and guidance to improve program performance. Related to this is the active participation of the NGO leaders in the workplan/renewal development process, which is essential for institutional capacity building.
- ✓ Onsite technical assistance is an effective approach for improving NGO efficiency. RSDP technical officers made an average of four visits per year to each upazila to provide hands-on technical assistance and guidance. These trips helped NGOs to complete clinic set-ups, obtain area allocation from local GOB officials, identify satellite clinic spots, select depositories, develop programmatic objectives, and analyze project performance.
- ✓ Peer training is an effective way to improve program efficiency and strengthen management capacity. RSDP successfully implemented the peer training approach, which had the objective of establishing an upazila-level NGO network for the sharing of information and skills. The peer coaching approach was used to implement Family Registration orientation, orientation on post abortion care, infection prevention training for counselors, and orientation on monthly performance reviews.

## VII. INTERMEDIATE RESULT 5: INCREASED SUSTAINABILITY OF NIPHP SERVICE-DELIVERY ORGANIZATIONS

The success of a program such as RSDP can be partially measured through its ability to foster sustainable projects. From the program's inception, RSDP sought to develop a sustainable program in which NGOs would increasingly manage and support ESP services. To this end, NGOs needed to be able to establish the infrastructure for comprehensive ESP services, retain trained personnel at the clinics, conduct program planning, increase revenue generation, supervise, monitor, and evaluate performance, understand how to adequately manage financial and administrative concerns, and nurture relations with the GOB and other agencies.

### A. Project accomplishments

#### 1. Improve NGO Management

RSDP efforts to improve NGO management, including financial, administrative, quality assurance, and monitoring and supervision are elaborated in the previous section under IR 4 and presented in four compendiums of guidelines. These efforts have contributed to the overall sustainability of NGO delivering ESP services in rural Bangladesh by encouraging the use of best practices and thorough understanding of guidelines and protocols.

#### 2. Expansion of ESP Services

The expansion of ESP services—both in terms of increased access and broader range of services—greatly contributed to the sustainability of service provision. Access to ESP services encompasses both the availability of those services in as many upazilas as possible, as well as the quality of the services and clinics. RSDP steadily increased availability of ESP services—such as Norplant, NSV, IUDs, injectables, PAC, ARI—by providing assistance to develop NGO capacity to deliver ESP services through improvements in infrastructure, ensuring quality and, in many ways, expanded service delivery in all RSDP clinics.

In terms of infrastructure, RSDP encouraged NGO efforts to obtain rent-free clinic accommodations for fixed service points to strengthen financial sustainability. NGOs that own their own clinics were more likely to be financially stable at the end of the program. Furthermore, the physical conditions of the clinics were improved—through the use of funds generated by the NGO—whenever possible to attract and maintain customer patronage. NGOs were encouraged to follow sanitation guidelines and building codes.

RSDP believed that high-quality services also ensures high customer flow, which contributes to overall program sustainability. To increase the sustainability of high quality services, RSDP provided NGOs with quality assessment tools/techniques and routine refresher training to clinic staff in all ESP areas. An upazila-level NGO network and support group, which shared best practices and skills and provided a motivation for performance competition, was created through RSDP's innovative peer coaching approach. The peer coaching approach was successfully implemented to transfer skills in family registration orientation, infection prevention and counseling training for clinic aides, MIS orientation, and PAC training. In addition, as the RSDP progressed, the program scaled-up ESP services to all upazilas by encouraging NGOs to integrate services so as to promote the "one-stop-shopping" theme.

#### 3. Revenue Generation

To improve financial sustainability and address customer demand for quality drugs, RSDP encouraged the implementation of a number of cost recovery measure, which enabled NGOs to recover nearly 9% of their program costs. To generate revenues RSDP enabled NGOs to implement a revolving drug fund (RDF), and charge nominal service fees. By the end of the program, the revolving drug fund was fully operational in all RSDP upazilas to the extent that NGOs were capable of negotiating directly with pharmaceutical companies for drug

supplies. NGOs were also trained to use LMIS to track stock levels and to conduct research to determine appropriate pricing. The success of the RDF led to a 382% increase in revenue generated over the course of the program.

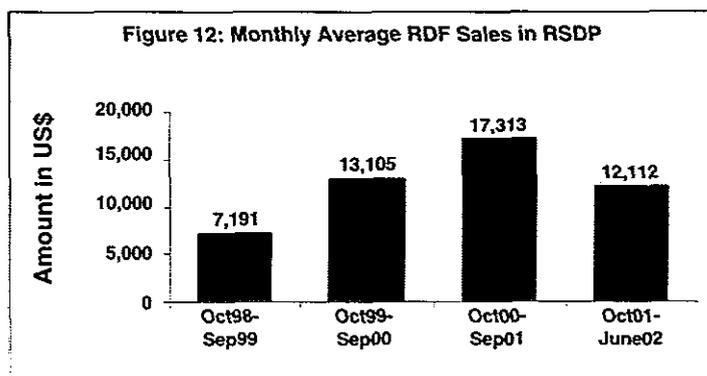


Figure-12 shows the average monthly sales of RDF medicine.

In the shift from free services to fee-based services, RSDP clinics and depotholders also charged nominal fees for services, such as ANC laboratory tests, contraceptives, and referral fees. Operations research was conducted jointly by the NGOs and Pathfinder to ensure that the fees were appropriate for socially and economically disadvantaged Bangladeshis. The availability of ANC services in all RSDP static clinics and some satellite clinics enabled NGOs to earn program income through the provision of laboratory tests, as a part of ANC services. Similar to the RDF, income from laboratory tests steadily increased; by June 2002, NGOs earned an average of Tk. 1202 per month, per upazila-an increase of 189% since the establishment of fee-based services. Contraceptives such as the pill and condoms were also provided at a small fee to clinic customers. Lastly, depotholders were given the opportunity to increase revenues through referral fees (50% of the clinic fee was given to the depotholder), distribution of iodized salts, and provision of other services at a small fee. These charges, when added to a fixed honoraria, provided a strong base for the sustainability of the depotholders.

The success of the fee-based services at RSDP service delivery sites was documented in the Cost of Services and Willingness to Pay study, which analyzed the willingness of Bangladeshis to pay for services. The study found that the community largely accepted fee-based services,

and an increasing number of customers were paying for services. Only 20% of pill customers and ten percent of condom customers obtained their supplies free. Towards the end of the program, nearly 80% of customers were paying nominal fees for services.

#### 4. Community Support

Another means of increasing sustainability was through strengthening community support for RSDP clinics and activities. Community acceptance of and support for health services directly affected the health service seeking behavior of individual and their families. Recognizing the importance of community involvement, RSDP initiated several different kinds of activities to increase community awareness and participation, the most significant of which was the Satellite Clinic Support Groups (SCSG). SCSGs were formed to increase community involvement and support for satellite clinics. These groups consist of key community members who encouraged the use of RSDP services. SCSG members, who were instrumental in the organization of satellite clinics, shared a common set of responsibilities:

- Provide support to ensure physical set up of satellite clinic;
- Assist providers to maintain cleanliness of SC;
- Provide support to CM in organizing different community meetings;
- Organize monthly SCSG meeting;
- Share experience to strengthen satellite clinic activities;
- Identify problem and help providers resolve those; and
- Ensure proper utilization of services.

To ensure that all segments of the community were reached, Pathfinder was careful to recruit a variety of people from the communities; SCSGs usually consisted of a house owner, an

adolescent girl, a satisfied contraceptive user, a social worker, a concerned depholder, and a local GOB representative. Nearly 6000 SCSGs were formed by RSDP.

Other activities designed to increase community support of RSDP services included strengthening of depholder referrals, distribution of BCC materials, and community-level meetings on HIV/AIDS, and other topics of ESP.

### **5. Collaboration with GOB and Other Agencies**

RSDP recognized that other agencies/organizations, such as the GOB, were essential to the efficient and effective operation of the program. RSDP consistently sought to collaborate with the Government of Bangladesh (GOB) and other public, non-profit, and private agencies to deepen the impact of service delivery as well as to foster the sustainability of these services. Collaboration efforts took many shapes—from joint technical reviews to sharing of training knowledge and materials. Relations with other agencies were mutually beneficial, where best practices and successful interventions were built upon and replicated to contribute to a reduction in fertility and improvement of family health in Bangladesh. Examples of RSDP's collaborations include:

- BRAC provided cascade training for RSDP Depholders.
- Pathfinder supported team training of GOB officers for the development of local-level action plans. The training of thana-level officers was led by Professor Sagar Jain of the University of North Carolina.
- Pathfinder conducted workshops with GOB officers to orient them on NIPHP-RSDP and UFHP goals and objectives, including NGO participation under NIPHP.
- In cooperation with central and local GOB officials, RSDP NGO clinics met all required standards for performing NSV and Norplant. Convinced by the standard of quality, GOB selected one NGO clinic as a center for NSV/Norplant training and six other clinic sites for IUD training.

- RSDP's strong relationship with the GOB ensured that RSDP service delivery sites were provided with contraceptive and other medical supplies.
- Pathfinder collaborated with the GOB and UNICEF for the implementation of a community-based ARI program. Pathfinder contributed to the development of the policy and program details for this new intervention, which was also implemented through depholders in 3 RSDP areas.
- RSDP partner NGOs worked with five pharmaceutical companies to obtain supplies for the Drug Revolving Fund. NGOs developed MOUs with pharmaceutical companies to supply medicine at institutional price-i.e., lower than retail price.
- NGOs get supply of SMC products towards a strategy of shifting customers from more to less subsidized supply system so that burden on GOB reduces, reliance on private sector increases.
- RSDP worked with 10 pre-selected training institutes to obtain training services for NGO staff.
- RSDP's accomplishments were due in part to the successful partnerships between RSDP and our NGO partners. Subprojects that were managed by NGO partners contributed to the achievement of RSDP's goals of reducing fertility and improving family health.

### **B. Lessons Learned**

- ✓ Effective GOB-NGO collaboration at the local level is critical for effective implementation of the program. Critical events for collaboration between the GOB and NGOs included area approval, DTC recommendation for static clinic, merging satellite clinic with EPI centers and regular supplies of contraceptives, Vitamin A and EPI logistics. Collaboration was also required for undertaking any pilot programs, such as the "Community-based ARI Program," where logistic and policy support was required from local GOB officials.
- ✓ Sustainability concepts need to be clearly defined to NGOs. Program activities

designed to increase sustainability—financial, technical, etc.—should be clearly defined so that NGO leaders understand the objectives of such activities.

- ✓ Using funds generated by program activities to construct clinic buildings is a good way to demonstrate support for the community

as well as strengthen community ownership of the program. 45 RSDP static clinics were located in NGO-owned buildings, 15 of which were constructed with land donated by a local philanthropist.

## VIII. REMAINING CHALLENGES

While RSDP was immensely successful, the challenges to reducing fertility and improving family health in Bangladesh are still enormous. Lessons learned from the last five years will provide a sound base from which to address many of the remaining challenges. The following are key challenges that need to be addressed in order for more progress to be achieved:

- Fertility rate in Bangladesh remains high; still higher in rural areas; rural areas need more coverage with services.
- Rural women rely excessively on oral contraceptives and acceptance of long-term methods is low. Use of Injectable has been increasing but supply is yet to match with demand for current and potential users. Availability of clinical contraception remains low in rural areas and setting up service facilities is difficult and becomes expensive.
- Child mortality rates continue to be high with an estimated one out of every eleven children dying before the age of five. The leading causes of child mortality include poor nutrition, respiratory infection, diarrhea and measles. Immunization coverage is about 52% and has not increased significantly since 1990. Scaling up ARI services, including the addition of services for newborns will significantly contribute to child survival but will be difficult to do without adequate cooperation between service providers and communities, and especially without community-based child survival services.
- Maternal mortality rates remain high with an estimated 377 deaths per 100,000 live births. 92% of deliveries take place at home without skilled attendants, and emergency-obstetric care is essentially nonexistent in rural areas, where emergency transport is problematic. Expanding range of maternal health care to include delivery services shall require a cadre of trained midwives—a costly and difficult endeavor. Programs are needed to educate women and communities of pregnancy danger signs. A significant percentage (roughly 25%) of maternal deaths is due to abortion complications, but PAC usually only includes counseling and treatment is virtually nonexistent in rural areas.
- Due to cultural inhibitions, Bangladesh's large adolescent population continues to have limited access to family planning information and contraception. Though age at first marriage is increasing, early marriage is still commonly practiced and the median age at marriage for women is 15 years. Many married adolescents still do not practice delayed childbirth and proper birth spacing largely because service reach remains low for the newlyweds in rural areas.
- Although HIV/AIDS among high-risk populations remains low at 0.02%, the lack of appropriate information and awareness, coupled with an active commercial sex industry and high incidence of other sexually transmitted infections make Bangladesh susceptible to a major outbreak of new HIV infections. Because of large rural contact, both for males and females, with urban areas, the susceptibility of HIV/AIDS transmission to rural population is increasing, yet rural areas are not getting enough attention for HIV/AIDS prevention work in Bangladesh.

- Service delivery challenges also remain. Drop-out rates are still high and there is a need to encourage higher continuation rates. Scaling-up most services, especially ECP, will be a daunting task. In addition, training of service providers will need to continue in order to ensure the use of best practices. For example, the present cadre of

paramedics require training on treating common illnesses and providing effective limited curative care; the poorest of the poor needs more of curative care services and highly subsidized medicines. As a result, equity/poverty alleviation through services remains an important challenge.

## IX. RSDP PRESENTATIONS, PUBLICATIONS

1. Mohammad Alauddin PhD, Salah Uddin Ahmed, MBBS. **"QMIS Enhances Local Level Management Capacity for Quality Improvement - Lessons from Rural Bangladesh"**. APHA. Philadelphia, November 2002.
2. Shabnam Shahnaz, MBBS, MPH, Ferdousi Begum, MBBS, MPH and Mohammad Alauddin, PhD. **"Improving Adolescent's Reproductive Health Services Irrespective of their Marital Status: Achievement and Lessons Learned from Rural Bangladesh"**. APHA. Philadelphia, November 2002.
3. Shabnam Shahnaz, MBBS, MPH, Ferdousi Begum, MBBS, MPH and M. Alauddin, PhD. **"HIV/AIDS Prevention Program of Pathfinder International for the "At Risk" Population of Rural Bangladesh"**. APHA. Philadelphia, November 2002.
4. Toslim Khan, MS and Mansur Ahmed, MA. **"Staff Turnover: Challenge to the NGOs Working in Rural Bangladesh"**. APHA Philadelphia, November 2002.
5. Mohammad Alauddin, PhD, A.K.M. Towfique Aziz, MSC, **"How does the poor fare in NGO service area -The experience of ANC use in Rural Bangladesh"**. APHA. Philadelphia, November 2002.
6. Mohammad Alauddin, PhD, **"Serving the Poorest of the Poor with Essential Health Services: Achievements and Lessons Learned from Rural Bangladesh"**. 129th APHA Convention, Atlanta, October 2001.
7. Heather Story, Toslim U. Khan, MS & Kamrul Ahsan, MSC **"Use of Household Data for Planning of Health Service Delivery in Rural Bangladesh"**. 129th APHA Convention, Atlanta, October 9, 2001.
8. Mizanur Rahman, PhD, Tayla C. Colton SM, Mohammad Alauddin, PhD **"Rapid Assessment: A Program Improvement Tool for Local Managers"**. 129th APHA Convention, Atlanta, October 2001.
9. Shabnam Shahnaz, MBBS, MPH, Ferdousi Begum, MBBS, MPH & Tayla C. Colton, SM **"Ensuring the Safety of Customers and Providers in Rural Clinics: Lessons Learned in Infection Prevention Techniques from Bangladesh"**. 129th APHA Convention, Atlanta, October 22, 2001.
10. Ferdousi Begum, MBBS, MPH, Shabnam Shahnaz, MBBS, MPH & Tayla C. Colton, SM. **"Innovative Strategies to ensure High Quality IUD Services to Rural Women: Lessons Learned from Bangladesh"**. 129th APHA Convention, Atlanta, October 22, 2001.
11. Mohammad Alauddin, PhD, Mizanur Rahman, PhD & Tayla C. Colton, SM. **"Family Planning and Reproductive Health Services through fixed Service Delivery Sites in Rural Bangladesh: Achievements and Lessons Learned"**. 128th APHA Convention, Boston, November 15, 2000
12. Mohammad Alauddin, PhD, Tayla C. Colton, SM **"Use of Diaries as Tools for Improved Performance in Bangladesh"**. 128th APHA Convention Boston, November 14, 2000.

13. Shabnam Shahnaz, MBBS, MPH, Mohammad Alauddin, PhD, Toslim U. Khan, MS. **"Addressing Adolescent Fertility in Bangladesh: New Challenges and Approaches for Pathfinder's Newlywed Program"**. 128th APHA Convention, Boston, November 15, 2000.
14. Toslim U. Khan, MS, Mohammad Alauddin, PhD, & Tayla C. Colton, SM **"Service Delivery-Linked Behavior Change Communication (BC) Activities in Bangladesh"**. 128th APHA Convention, Boston, November 15, 2000.
15. M. Alauddin **"Revolving Fund for Medicines: Pathfinder Success in Bangladesh"**. The Weekend Independent, 10th September 1999 Projanma, September/ October 1999.
16. M. Alauddin, **"Revolving fund for Medicines Pathfinder Success in Bangladesh"**. Weekend Independent, September 10, 1999, 10-12.
17. M. Alauddin and Laurel MacLaren, **"Reaching Newlywed and Married Adolescents"**. In Focus, July 1999.
18. M. Alauddin, **"A Calendar for Family Health: An Innovative Approach to Behavior Change Communication"**. Weekend Independent, April 30, 1999, 24-25.
19. M. Alauddin, **"Role of NGOs and Private Sector in Balanced Quality Service Delivery Package"**. A theme paper presented at the Seminar on Upscaling Reproductive Health Intervention: Enhancing the Role of the Civil Society held during June 29-July 2 1998, Icomp, Kualalampur, Malaysia.
20. M. Alauddin, **"NGO Partnership in NIPHP in Bangladesh"**. presented at the ICPD + 5 Roundtable on Partnership with the Civil Society to Implement the Program of Action, International Conference on Population on Development, Hotel Sheraton, Dhaka, Bangladesh, July 27-30, 1998 and published in Prajanma in September 1998.
21. M. Alauddin (edited). **"RSDP Call to Action Bangla/English Bulletin, 9 Volumes"**. June 2000 - April 2002, Dhaka, Pathfinder International.
22. **"A Compendium of APHA Papers & Research Abstracts on RSDP Experience and Lessons Learned"**. Pathfinder International, Dhaka, Bangladesh July 2002.
23. **Guidelines on RSDP BCC Activities**. Pathfinder International, Dhaka, Bangladesh.
24. **RSDP NGO Program Management (Guidelines & Standards)**. Pathfinder International, Dhaka, Bangladesh.
25. **NGO Financial & Administrative Management Guidelines**. Pathfinder International, Dhaka, Bangladesh.
26. **NGO Clinic Management Guideline**. Pathfinder International, Dhaka, Bangladesh.
27. **Special Bulletin on RSDP Interventions**. Pathfinder International, Dhaka, Bangladesh.
28. **RSDP NGOs: A Compendium of End-of-Subproject Report**. Pathfinder International, Dhaka, Bangladesh. July 2002.

## X. EVALUATIONS AND ASSESSMENTS

1. Jamil, K., Khan, M.S.H., Rahman, A.P.M, S., Nasrin, T., Rahman, M.A. Mohammad Alauddin, **Withdrawal of Doorstep Delivery of Family Planning Services. Impact on contraceptive use in four RSDP NGO Areas of Bangladesh.** Pathfinder International and Associates for Community and Population Research (ACPR), Dhaka Bangladesh, October, 1998.
2. Barkat, A., Khan S.A., Bond, K., Houvras, I, Rahman, M.A., Kabir, R., Hussain, S.J., Islam, M. **An Assessment of RSDP-BRAC's Adolescent Family Life Education (AFLE) Program.** Pathfinder International, Dhaka, Bangladesh, June, 1999.
3. Barkat, A., Mohammad Alauddin, Mc Laren, L, Houvras, I. **Pathfinder Newlywed Strategy: Results of a Program Assessment.** Dhaka, Bangladesh, June, 1999.
4. Khan, M.H.S., Rahman, A.P.M, S., Nasrin, T., Chakraborty, N., and Ahamed, M. **NIPHP Impact in RSDP NGO Areas: Baseline Survey Results.** Associates for Community and Population Research. Dhaka, Bangladesh, September, 1999.
5. Rural Service Delivery Partnership (RSDP), Pathfinder International, BRAC and BCC. **An Assessment of RSDP User Fees for ESP services and supplies and A guideline for Standardization.** Dhaka, Bangladesh, November, 1999.
6. Rural Service Delivery Partnership (RSDP) Swanirvar Bangladesh. **Characteristics of RSDP Depot holders: A Survey of Community Preferences in 36 Upazilas.** Dhaka. May, 2000.
7. Rural Service Delivery Partnership (RSDP), Pathfinder International, BRAC and BCC. **A Rapid Assessment of Awareness and Utilization of Essential Family Health Services: The Case of Kalihati Upazila, Bangladesh.** Dhaka, Bangladesh, May 2000.
8. Uddin, J.M. **Assessment of Record-Keeping and Reporting System of Rural Service Delivery Partnership.** Operations Research Project, Health and Population Extension Division, ICDDR,B: Centre for Health and Population Research and Pathfinder International/Bangladesh, Dhaka, August, 2000.
9. Bangladesh Centre for Communication Programs. **Behavior Change Communication Training for Rural Service Delivery Partnership (RSDP).** October, 2000.
10. Bates, L., Islam, M.K., Schuler, S.R., and Alauddin, M. **From Home to Clinic: The Next Chapter in Bangladesh's Family Planning Success Story: Rural Sites.** Pathfinder International, Dhaka 2000.
11. Professor A Bayes Bhuiyan. **Assessment of BRAC Safe Delivery Activities and Implications for Expansion in the Rural Services Delivery Program (RSDP).** OGSB Maternity Hospital and Training Centre, Dhaka, Bangladesh, March, 2001.
12. Khan, M.M., Ahmed, S., Protik, A.E., Saha, K.K., Ali, D. Sohel, N., Dhar, B.C., Quayyum, Z., **Cost of Providing Services and Willingness and Ability to Pay for ESP Services in RSDP Areas of Bangladesh.** Dhaka, Bangladesh. ICDDR,B, 2001.

13. Alauddin, M. Sorcar, N. R., Raju, R. U. A., Rahman, H., Kamal, S. *To What Extent RSDP Addresses Missed Opportunity: An Assessment*. Pathfinder International, Dhaka, Bangladesh, November 2001.
14. Jasim Uddin, Cristobal Tunon, AKM Sirajuddin. *Developing GOB-NGO Health Teams: Effects of Management Training in Selected Rural Thanas of Bangladesh*. Operations Research Project, ICDDR, B. Dhaka, Bangladesh, June 1999.
15. Syed Jahageer Haider,. *A Study of the Follow-up of the Training on Improving Management and Performance (IMP) of Delivery of ESP*. READ, Dhaka, Bangladesh. February 2000.

## XI. RSDP GUIDELINES, MANUALS AND STANDARDS' EXHIBITS

