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# Midterm Performance Evaluation of the Bangladesh NGO Health Service Delivery Project (NHSDP)

**February 2017**

This publication was produced for review by the United States Agency for International Development. It was prepared by Najmul Hossain, Soliman Guirgis, Rose Schneider, Usha Vatsia and Carina Stover through the Global Health Program Cycle Improvement Project (GH Pro).

Cover photo: Infant and mother in Bangladesh. Source: USAID/Bangladesh.

# MIDTERM PERFORMANCE EVALUATION OF THE BANGLADESH NGO HEALTH SERVICE DELIVERY PROJECT (NHSDP)

February 2017

USAID Contract No. AID-OAA-C-14-00067

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**Global Health Performance Cycle Improvement Project**

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20004

Phone: (202) 625-9444

Fax: (202) 517-9181

www.ghpro.dexisonline.com

This document was submitted by GH Pro to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.

# ACKNOWLEDGMENTS

The midterm performance evaluation of the USAID-DFID Bangladesh NGO Health Service Delivery Project (NHSDP) entailed reviewing NHSDP-related technical and administrative documents, as well as data sets generated by the project. The NHSDP team cooperated fully in providing the documents and spent countless hours with the evaluation team members to respond to their queries.

The evaluation team sincerely thanks Dr. Halida Akhter, NHSDP Chief of Party; Bruce Rasmussen, NHSDP Deputy Chief of Party, Health Service Delivery; Shiril Sarcar, NHSDP Deputy Chief of Party, Finance and Operations, and others for their patience and assistance. The team conducted field interviews and group discussions in Dhaka, Chittagong and Cox's Bazar. These included interviews with senior and mid-level Government of Bangladesh officials, Pathfinder implementing partners, representatives of development partners, project directors of NHSDP-partner non-governmental organizations (NGOs), Surjer Hashi clinic managers and staff, community leaders and health workers. The role of Dr. Md. Saikul Islam Helal, NHSDP Policy and Coordination Advisor, was crucial in arranging several meetings. The Government of Bangladesh is highly appreciative of USAID's sustained assistance in family planning and health, and in particular, NHSDP's effort. This appreciation was evident during discussions with senior and mid-level officials of the Ministry of Health and Family Welfare and Ministry of Local Government.

The team wishes to express its sincere appreciation and gratitude to the government, non-government officials, NGO officials and other key stakeholders for their valuable insights and suggestions. The interviews were most useful in drafting the report. Special thanks go to USAID/Bangladesh's Office of Population, Health, Nutrition, & Education team, including Deputy Director Marietou Satin, Health and Population Officer and NHSDP COR Miranda Beckman, Senior Family Planning Advisor Brenda Doe, Clinical Services Lead Ferdousi Begum, and Senior Monitoring, Evaluation, & Research Advisor Kanta Jamil for their guidance and assistance throughout the study period. Tahsina Tarannum, Zakir M. Hossain, and K. M. Shamsuzzaman provided valuable technical and logistics support, and the evaluation team is thankful to them.

Finally, the team thanks Melinda Pavin, Deputy Director/Technical Advisor, and Carolyn Keefe, Senior Program Manager, of Global Health Program Cycle Improvement Project (GH Pro) for their support and guidance, and the skilled support of report editor Dina Towbin.

The GH Pro Phase 1 Team was composed of Dr. Najmul Hossain, Dr. Soliman Guirgis, Rose Schneider, and Usha Vatsia. The Phase 2 Team was composed of Carina Stover and Nasima Safa. Dina Towbin also assisted with the editing of the final report. The Phase 2 Team updated some of the Phase 1 findings.

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# ACRONYMS

| | |
|---|---|
| ANC | Antenatal care |
| ANGEL | Adolescents and Newlywed Girls Events of Life |
| BC&M | Behavior change and marketing |
| BCC | Behavior change communication |
| BCCP | Bangladesh Center for Communication Programs |
| BDHS | Bangladesh Health and Demographic Survey |
| CEmONC | Comprehensive emergency obstetric and newborn care |
| COR | Contracting officer's representative |
| CSP | Community service provider |
| DCOP | Deputy chief of party |
| DFID | Department for International Development (UK) |
| DGFP | Directorate General of Family Planning |
| DGHS | Directorate General of Health Services |
| DSF | Demand-side financing |
| EmOC | Emergency obstetric care |
| EmONC | Emergency obstetric and newborn care |
| EPI | Expanded Program on Immunization |
| ESP | Essential Services Package |
| FDSR | Family Development Services & Research |
| FP | Family planning |
| GH Pro | Global Health Program Cycle Improvement Project |
| GoB | Government of Bangladesh |
| HR | Human resources |
| IPC/C | Interpersonal communication and counseling |
| IR | Intermediate result |
| JHU-CCP | Johns Hopkins University-Center for Communication Programs |
| LAPM | Long-Acting and Permanent Methods |
| M&E | Monitoring and evaluation |
| MDG | Millennium Development Goals |
| MIS | Management information systems |
| MOCAT | Modified organizational capacity assessment tool |
| MOHFW | Ministry of Health and Family Welfare |
| MOSW | Ministry of Social Welfare |
| MOWCA | Ministry of Women and Children's Affairs |
| NGO | Non-governmental organization |

| | |
|---|---|
| NHSDP | NGO Health Service Delivery Project |
| NMC | NGO Membership Council |
| POP | Poorest of the poor |
| RH | Reproductive health |
| SBA | Skilled birth attendant |
| SH | *Surjer Hashi* (Smiling Sun) |
| SHCSGs | Surjer Hashi Community Support Groups |
| SSFP | Smiling Sun Franchising Program |
| TFR | Total fertility rate |
| USAID | United States Agency for International Development |

# GLOSSARY AND TERMS

**Behavior change communication**[1] (BCC) is a process that motivates people to adopt and sustain healthy behaviors and lifestyles. Sustaining healthy behavior usually requires continuing investment in BCC as part of an overall health program.

**Emergency obstetric and newborn care** (EmONC) includes a set of nine lifesaving interventions, known as "signal functions," that the World Health Organization has recommended to reduce maternal and neonatal mortality. Basic (BEmONC) facilities are those that performed at least six of seven functions in the three preceding months (administered parenteral antibiotics; parenteral oxytocic drugs; parenteral anticonvulsants for pre-eclampsia and eclampsia; performed manual removal of placenta; removal of retained products; and performed assisted vaginal delivery). Comprehensive (CEmONC) facilities are those that performed BEmONC signal functions and two additional functions: cesarean sections and blood transfusions. (In EmOC-C, the "-C" refers to C-section)

**Essential Service Package**[2] (ESP) is a set of public health services that should be available to all. ESP is a clinic-based approach to be delivered as close to the community as possible. Developed in 1994 during Health for All, ESP was finalized in Bangladesh in 1997.

**Points of differences:**[3] When deciding upon a brand/product's positioning in the market, the project must ensure that the end positioning has sufficient number of unique or differentiated attributes from other similar available services/products in the market.

**Table 1. Poor and poorest of the poor (POP) identification criteria**

| Serial | Urban | Rural |
|---|---|---|
| 1 | Living in poor cluster/area | Households who do not have own land |
| 2 | Living on streets/homeless/temporary shelters or slums | People living in and around areas affected by river erosions (Char) |
| 3 | Food or equivalent money is not available for more than three meals at home anytime during last week | Food or equivalent money is not available for more than three meals at home anytime during last week |
| 4 | Identified as POP/poor by government or other NGOs | Identified as POP/Poor by Government or other NGO |
| 5 | Anyone who has Surjer Hashi poor card | Anyone who has Surjer Hashi poor card |

*Note:* If 1 out of 5 criteria met, classified as poor; if more than one criteria met, classified as POP.

**Social marketing**[4] is the application of marketing tools/methodologies (market research, market segmentation, positioning, advertising, product development and accessibility) to induce and sustain behaviors beneficial to society by appealing to people's self-interest.

**Ultra clinics** are 24/7 emergency obstetric care clinics with an operating theater and capacity to do cesarean section deliveries. They can provide CEmONC services.

**Vital clinics** primarily offer a basic service package of preventive outpatient services and do not have the capacity for delivery services.

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[1] Center for Communication Programs, Bloomberg School of Public Health, Johns Hopkins University. INFO Report.

[2] The ESP of the Government of Bangladesh includes: reproductive health, including family planning; child health; BCC; communicable disease control; and limited curative care. ESP differs from previous public health approaches that were primarily community-based distribution.

[3] *Source:* Marketing literature.

[4] *Source:* USAID report on social marketing workshop.

# EXECUTIVE SUMMARY

This midterm performance evaluation of the Bangladesh Non-governmental Organizations (NGO) Health Service Delivery Project (NHSDP) examines the project's progress toward meeting its goal and objectives. NHSDP is the United States Agency for International Development (USAID)/Bangladesh's largest health initiative; this flagship project is the latest in a series of programs going back to at least 1998 that have sought to improve the ability of local NGOs to provide basic health services to the poor. NHSDP was designed in 2012, when USAID was implementing significant procurement reforms and emphasizing the need to work more directly with local organizations. In 2013, USAID received gift funds from the United Kingdom's Department for International Development (DFID) to co-fund NHSDP, which expanded the scope considerably. The DFID supplementary fund has supported the current NHSDP activities and strengthened its focus on family planning (FP) and maternal health outcomes, with a specific focus on improved service delivery for the urban poor.

The Bangladesh NHSDP was designed to address the following development problem, according to USAID/Bangladesh's current Country Development Cooperation Strategy:

> *USAID/Bangladesh DO* [development objective*] 3 strives to stabilize population and improve health and nutrition. DO3's Development Hypothesis is: if all Bangladeshis have access to quality health services at an affordable cost and are aware of the benefits of using these services, they will use these services, leading to improved health outcomes. Strengthened health systems are integral to ensuring access to quality and sustainable service provision.*

USAID designed NHSDP to complement the Government of Bangladesh's (GoB) efforts to offer quality health, nutrition and population services at low or no cost, while supporting the sustainability of local service-delivery organizations. NHSDP was designed to strengthen local ownership of service delivery through institutional strengthening interventions targeted at the network NGOs. Led by Pathfinder International under a USAID contract and implemented through a coalition of national and international partners, a primary health care Essential Services Package (ESP) is being provided to a nationwide "Smiling Sun" or *Surjer Hashi* (SH) network of 25 local NGOs. The 25 partner NGOs oversee operations of 388 static clinics, 10,186 satellite clinics, 7,321 community service providers (CSPs) and 777 service promoters throughout Bangladesh.

The contract's goal is to decrease fertility, child morbidity and maternal mortality through three intermediate results (IRs). The contract mandated that the network recover 40 percent of its operational costs, while simultaneously ensuring that a minimum of 40 percent of services are delivered to the poor. In line with USAID's global procurement reforms, the contractor was to prepare at least two sub-grantee NGOs to transition to direct USAID grantees.

This evaluation assesses the project's status, relevance and sustainability and provides recommendations for strengthening the project in its remaining years and for the design and implementation of future projects. Findings will inform USAID and other relevant stakeholders on how clinical service delivery, behavior change and marketing (BC&M), capacity development, cost recovery and other interventions can best be used to maximize public health results.

The evaluation was undertaken in two phases, resulting in recommendations of options for USAID in adopting service-delivery, BC&M and capacity-development models and cost-recovery schemes to strengthen NGOs and provide them with comprehensive programming, diverse funding and a sustained, reasonable balance of cost recovery and service delivery to the poor. Phase 1 (October–December 2015) used a mix of qualitative and quantitative methods: (1) analyzing data and information from background documentation and project reports, the project's monitoring and evaluation (M&E) plan and other surveys; (2) extensive interviews (one-on-one, group, e , field

observations and focus group discussions with partners, stakeholders and beneficiaries; and (3) field visits to project sites to gain an in-depth understanding of achievements and challenges. To ensure collection of comparable information, the team drafted standard guides for each method used. In July 2016, Phase 2 quickly reviewed the findings and responded to specific concerns that USAID highlighted in the original report to clarify and update (as needed) key findings, report on progress on the findings since Phase 1 and make recommendations, and report on updates and planned interventions related to these issues until the end of the project. Phase 2 also reviewed the NHSDP performance-based grants model and strategy.

Evaluation limitations included the selection of cities where NGO clinics were identified and visited, possible positive response bias among clients of the SH clinics who participated in the exit interviews, the proportionately larger number of focus group discussions conducted in Chittagong, the response rate (44 percent) to the e-questionnaire, ensuring adequate representation of interviews and rapid appraisal sources vis-à-vis the full scope of NHSDP activities and outcomes, the team's evaluation methodologies, and the team's dependence on secondary data available from the routine information

**Key Findings:** Operating at a critical juncture in Bangladesh's continued development, NHSDP is a large, multifaceted primary health care project that is on track in delivering most of its measurable indicators and milestones, but its project management, staffing, service delivery and service quality need some improvement. Many aspects of the contractor's performance were updated by Phase 2 and are reflected in the findings. The project's most significant progress has been in maternal, neonatal and child health, and in its ability to reach clients who qualify as poor. DFID resources are 34 percent of the total award, adding significant complexity to the project given its additional targets, indicators, milestones, reporting requirements and a fifth year of implementation. The project and USAID are aware of and addressing many of the challenges discussed in this report. While some project management improvements were noted in Phase 1, the Phase 2 team found that significant changes had resulted in increased efficiency in achieving results in the technical areas. NHSDP's emphasis on data and milestones is the major driving force for the planning and implementation, which consequently leaves limited room for innovations and creativity that can be further improved in the work planning process. Increasing local ownership and sustainability was the most difficult area to identify concrete achievements. The findings are summarized in response to each of the evaluation questions, as noted below.

### 1) What have been the successes and limitations of the project's cost-recovery component?

NHSDP has achieved the first three years' annual targets and is moving toward achieving the target for year four (40 percent cost recovery). NHSDP NGOs are also achieving the target of 40 percent serving the poor. Thus, in this context, these rates seem to be achievable. However, there are many challenges related to increased costs, income and other factors, such as competition and duplication. Phase 2 found that each quarter, the NHSDP Grants Team and NGOs analyze variance of actual income versus actual expenses in each NGO's bank account. Furthermore, a study examining the cost of service delivery, underway at the time of Phase 1 work, is now available. NHSDP guidelines offer cost-recovery plans and innovative financing strategies. Not every clinic is expected to hit the 40 percent/40 percent balance, but the overall network is. The Phase 2 team found that the management information system (MIS) had been updated so it can disaggregate data.

Interviews, field visits and a review of several USAID-funded studies[5] suggest that adjustments in pricing strategies of several SH clinic services can lead to increased revenue generation (cost recovery) without compromising service utilization. NHSDP has provided technical assistance to NGOs to adjust their cost recovery. Phase 2 found that cost-recovery improvements are being made through cost controls and increased revenue flow from service expansion and an increase in the number of customers.

According to various Ministry of Health and Family Welfare (MOHFW) officials, there are small (10–50 beds), government-established hospitals that are not functional due to a shortage of management and staff. An expression of interest was released to ascertain NGOs' interest in being subcontracted to provide management and clinical services to these facilities. According to USAID, NGOs have responded, but to date, the GoB has not made a further announcement. As part of a small pilot, approximately 16 NHSDP-supported SH clinics are partnering with the government on a demand-side financing (DSF) scheme, and there is opportunity to expand this pilot (Table 2).[6,7] The GoB implements DSF in 53 *upazilas* where there are 25 SH clinics, of which 16 are participating in DSF currently. There is scope for additional SH clinics to participate in the DSF program, and NHSDP is talking to the government about including more clinics. Phase 2 examined behavior change communication (BCC) activities and found that they help to increase the numbers of customers, leading to a potential increase in revenues and clinics' cost-recovery rate. It is recommended that NHSDP encourage quarterly reviews to share results.

**Table 2. NHSDP SH clinics: DSF grantees**

| Sl | District | Upazilla | NGO |
|---|---|---|---|
| 1 | Comilla | Daudkandi | BAMANEH |
| 2 | Cox's Bazar | Ramu | FDSR |
| 3 | Kustia | Daulatpur | PSKS |
| 4 | Gaibandha | Gobindaganj | PSF |
| 5 | Sirajganj | Shahjadpur | PSF |
| 6 | Dinajpur | Khansama | Kanchan Samity |
| 7 | Narsingdhi | Raipura | PSTC |
| 8 | Kishorganj | Tarail | Swanirvar |
| 9 | Manikganj | Harirampur | JTS |
| 10 | Jamalpur | Dewanganj | Swanirvar |
| 11 | Panchagarh | Debiganj | Swanirvar |
| 12 | Madaripur | Shibchar | VFWA |
| 13 | Moulavibazar | Sreemongal | SUPPS |

*Note*: Although 13 clinics are listed here, it was reported that the number of clinics was increased to 16 as of late August 2016.

### 2) What have been the successes and limitations of network expansion, especially for key ESP services: FP/reproductive health (RH), antenatal care (ANC), delivery, child health and nutrition?

NHSDP has 51 milestones (plus 10a and 11a, which translate percentages to numbers for the same item), including three for the now-cancelled IR 3.2, and 15 deliverables (see Table 3). Phase 2 found that

[5] Hamid and Derriennic. 2015. "Provider-Based Prepayment Feasibility Study: Health Service Costing Methodology (draft)." Health Finance and Governance Project, 2013.

[6] Because this is only for delivery, only limited clinics 8are available.

[7] See www.lcgbangladesh-blog.org for additional information on GoB financial schemes.

nearly all milestones and deliverables are already achieved or on track to be achieved by the end of the project.

**Table 3. Summary of NHSDP project deliverables**
Based on Modification #9 approved in August 2016 (year three, fourth quarter)

| No. | Deliverables/Reports | Means of Verification Sent to COR | Due Date | Present Status *Updated by DCOP-SD: August 2016* |
|---|---|---|---|---|
| 1 | Revised initial contractor work plan submitted to USAID | Submitted final version of draft work plan for approval | Within 1 month of an award | Completed |
| 2 | Revised operations manual submitted to USAID | Operations manual | Within 2 months of an award | Completed |
| 3 | Revised M&E plan submitted to USAID | Approved M&E plan | Within 1 month of an award | Completed–periodic revisions, last approved by USAID July 2015 |
| 4 | Revised environmental compliance plan submitted to USAID Mission Environmental Officer | Approved environmental compliance plan | Within 3 months of an award | Completed–periodic updates, last approved by USAID in May 2014 –Waste management plan approved by USAID in May 2015 |
| 5 | Monthly statistical reports submitted to USAID | Statistical report | Within 1 month after the reporting month ends | On track |
| 6 | Monthly financial management report submitted to USAID | Financial management report | Within 1 month after the reporting month ends | On track |
| 7 | Quarterly performance report submitted to USAID | Performance report | Within 1 month after the reporting quarter ends | On track |
| 8 | Annual performance report submitted to USAID | Performance report | Within 1 month after each calendar year ends | On track |
| 9 | Annual NGO work plans submitted to USAID | Approved work plan | Within 1 month after each calendar year ends | On track |
| 10 | Midterm study conducted and submitted to USAID | Midterm study | By June 30, 2015 | Pending |
| 11 | Final report submitted to and approved by USAID | Submitted draft final report | Within 30 days of contract completion date | End of project |
| 12 | Level of effort report | Submitted level of effort expended report | Within 1 month after the reporting quarter ends | On track |
| 13 | Subcontractor's terms of reference | Submitted terms of reference for clearance | Within 1 month of modification | On track |
| 14 | Management plan | Approved management plan and organogram | Within 1 month of modification | On track |
| 15 | Communication strategies | See D.3 of the contract | Within 120 days of Mod #1 effective date | Completed |

Milestones that may be considered to be lagging include:

- 1.1.8: Women-centered services were a bit behind at the end of year three but may be on track by now—further assessment will be done in year five.
- 1.1.10: Couple-years of protection has been lagging throughout the project, with achievement against target for the first three quarters of year four at 97 percent, somewhat better than year three at 93 percent.
- 1.1.17: Measuring client satisfaction has not been easy. A revised client exit interview form and data collection system are being introduced to improve this process.

A very small number of milestones and deliverables need further clarification, as noted in the "status" column. Some definitions and means of verification are not clear, and the NHSDP team reports that it is currently updating these.

The most significant areas of progress have been: prescribing pregnant and lactating women 30IFA (85 percent), vitamin A supplementation for children under 5 through U.S. Government-supported programs[8] (71 percent), immediate support for newborns within 72 hours[9] (71 percent), and postnatal care within 48 hours of childbirth (60 percent). NHSDP's technical support for maternal and child nutrition services have strengthened performance in these areas.[10] Progress on delivery by skilled birth attendant (SBA) has been mixed. With the additional 33 clinics capable of performing C-sections that were added to the network, C-section deliveries grew at a faster pace—35 percent from 8,156 to 10,984—compared to normal facility births,[11] and these rates are in line with national trends. Contraceptive rates as measured by couple-years of protection have stagnated,[12] mirroring national trends, including the number of injectables provided, where annual progress has not met the expected achievement.

At 47 percent, nutrition (infant and young child feeding counseling and under-5 growth monitoring) and adolescent/youth access to RH services lag below the midpoint target of 55 percent, although some of this is due to a slow start, i.e., no progress in the first year. Treatment of childhood pneumonia with antibiotics and ANC first and fourth visits lag slightly, between 52–54 percent. Progress for gender mainstreaming (milestone 8) has been much slower than planned and is more than a year behind now due to NGO budget constraints, political unrest and challenges related to internalization of gender sensitivity and practices by NGO and clinic staff.[13,14] Slow performance in nutrition, gender and adolescents is attributed to these areas being new to this iteration of the project; staff have been on a learning curve before advancing with partners and clinic staff.[15] A focus on women and the age of marriage in the remaining life of the project could improve both women's access to education and better health/ nutritional outcomes for mothers and infants/children as a result of delaying first pregnancies.

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[8] This is dependent on the GoB's National Immunization Days, as USAID uses the GoB's supplies. Success here depends on the GoB.

[9] This is a DFID indicator. Both the GoB and U.S. Government use 48 hours.

[10] NHSDP Year 3 Annual Performance Report, October 2015.

[11] NHSDP CYP by Method and Delivery, November 19, 2015.

[12] NHSDP, CYP by Method & SBA Deliveries, November 22, 2015.

[13] NHSDP Key informant and group interviews with NHSDP ESP unit staff.

[14] NHSDP Year 3 Annual Performance Report, October 2015.

[15] Phase 1 key informant and group interviews with NHSDP ESP unit staff.

Coordination with select urban governance bodies to improve urban health governance to provide needed services has not yet been achieved; a draft memorandum of understanding has been shared with the Urban Primary Health Care Services Delivery Project for final comment and approval.[16]

NHSDP has been working in the Chittagong Hill Tracts and is exploring the potential to extend services through partnerships with other organizations already working in the region, such as UNDP.[17] Performance data from this region indicate significant uptake of certain services.

According to the NHSDP database, the project made more than 32 million service contacts (individual visits to NGO partner clinics) during its second year and 39 million in the third year. At least 35 percent of the selected service contacts in categories that achieved the target ratio were provided to the poor during the project's first year; this reached 43.4 percent in July 2015. The target of 40 percent coverage of poor with service contacts was achieved in year three by NHSDP-supported NGOs.

**Factors affecting performance** include issues involving management and leadership, internal project coordination, staff retention and training, quality monitoring and insufficient monitoring officers, manuals/guidelines/job aids (addressed by NHSDP), limited understanding of gender's relevance to the project among some key informants (with some growing awareness of gender-based violence), urban health coordination, and CSP engagement arrangements and poor pay.

In terms of the role of BCC, Phase 1 found the Adolescents and Newlywed Girls Event of Life (ANGEL) Initiative to be an excellent venue to address adolescents and young adults and that BCC studies and strategies are an important component of this initiative to inform the planning and evaluation of its activities. BCC could be a stronger component in service delivery.

NHSDP designed and conducted a mystery client study to assess provider behavior and quality of counseling based on client satisfaction. The study results show that more than 75 percent of respondents found overall clinic services to be satisfactory or good; and more than 60 percent found counselling satisfactory or good. In addition, as a part of quality monitoring and supervision, NHSDP asked clinic managers to conduct regular exit interviews of SH clients (10 interviews per clinic per month) to assess quality aspects of services provided, and it found that the overall satisfaction of clients interviewed was about 90 percent.

The project is on track for the eight milestones of IR 2. Revisions of the training plans and interviews with NGO and clinic staff show that the project has made extensive efforts and investment in developing guidelines/protocols and in conducting training programs, mainly for clinic staff.

The ESP unit's technical assistance approach has been challenging to implement because each NGO's clinics are in different parts of the country and each technical lead is responsible for supporting all ESP services.

**3) Given the revisions to NHSDP's SOW since the contract was awarded due to increase in total funding, assess project-level performance issues, identify deficiencies and propose strategies for improvement, taking into consideration the limited timeframe for implementation.**

Phase 1 found that the limited coordination across the health sector supports significant information gathering but does not eliminate oversupply of services in some areas and limited services in others.

[16] NHSDP Milestone Tracking Sheet, October 2015.

[17] NHSDP Year 3 Annual Performance Report, October 2015.

There is a lack of coordination and planning between GoB, NGOs, private health service providers and development partners.

However, Phase 2 found that the MOHFW has recently (since the Phase 1 team was in country) formulated the Inter-Ministerial USAID-DFID NHSDP Advisory Committee to leverage existing project resources and enhance collaboration with other ministries and USAID-funded NGOs. This committee creates ownership and strong bonds with ministries and GoB departments, led by the MOHFW, and improves coordination of service supply across areas. The committee is creating ownership through a range of collaborative activities and benefits for NHSDP.

**4) What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding building/strengthening NGO capacity?**

Phase 1 found that the institutional capacity of local NGO partners had been strengthened in several ways. NHSDP's initial NGO capacity development baseline assessments were a major achievement. The institutional strengthening unit also conducted nine NGO focus group discussions to identify issues and developed a SWOT tool for self-assessment of the 25 NGOs. These best practices and tools supported the compilation of the baseline assessment status of the NGOs. NHSDP developed individual NGO road maps in June 2013. Then NHSDP conducted an additional assessment using an adapted MOCAT (modified organizational capacity assessment tool) methodology to identify more in-depth NGO needs and reported out in 80-page MOCAT assessments/plans. Assistance to NGOs was planned as individual and group training, technical assistance, mentoring and phone support. NGO road maps were to evolve based on additional information from the first annual MOCAT in 2014. While the initial assessments were successful, Phase 1 document review found weakness in later capacity-development activities.

The Phase 2 team found that, based on the results of the NGO baseline analyses, institutional strengthening benchmarks were developed for each of the SH NGOs. The purpose of these benchmarks was to provide a tangible way to measure NGO institutional strengthening progress, as well as to identify areas where project assistance would be required across a majority of the NGOs. A set of benchmarks for the network was developed based on the results of the baseline analysis, and from that set, benchmarks appropriate to the individual needs of each NGO were assigned to them as part of their institutional strengthening road maps. These benchmarks were then updated, and related technical assistance was mapped out as part of a project-wide integrated plan, which reflected technical assistance targeted at both the NGO and clinic levels across all three of NHSDP's IRs.

The MOCAT assessment was conducted in the project's second year. Initially, the plan was to conduct one every year; this timeline was changed to conduct the next MOCAT in year five as the end-line assessment of progress toward sustainability within the three pillars. However, instead of the MOCAT, NHSDP with headquarters short-term technical assistance developed an "institutional strengthening verification/ validation tool" for monitoring progress against NGOs' institutional strengthening benchmarks; the project has been implementing this tool on annual basis. The NHSDP institutional strengthening team is monitoring the progress of SH NGOs' capacity-building activities through a variety of methods and consistently providing technical assistance to them when needed.

The milestones related to the direct transition of up to two NGOs to USAID funding (sub-IR 3.2) were successfully met within the first six months. Several weaknesses were recognized by NHSDP and the NGOs as the process advanced. In addition, during these crucial months, several major changes in the second NGO (PSTC) and NHSDP took place. With the timing critical, NGO staff struggled to more effectively engage their board to proceed with the transition process. NGOs conceded that additional NHSDP support would have been valuable. Generally, the NGOs recognized that the support from NHSDP and Pathfinder was effective, supportive and collegial. Finally, as a result of not receiving direct USAID funding, the NGOs experienced some difficult issues with restructuring budgets and the intense

reporting requirements that resulted from returning to direct NHSDP funding. With the deletion of IR 3.2 in Amendment 9 in 2015, the direct transition of NGOs to USAID funding was cancelled.

**Needs defined by NGOs:** Discussions and e-questionnaires soliciting NGOs' opinions provided insights into their collaboration with NHSDP. NGOs were appreciative of the first year's assessments of capacity-development needs, the resulting road maps, and the training and technical assistance provided. On a Likert scale, NGOs rated the effectiveness of NHSDP support at 3.14 out of 5. When asked about their initial needs in 2013 in the road map's 10 areas, NGOs defined their initial needs in all 10 areas.

IR 2 envisioned an empowered and enlightened community having household-level knowledge to practice model health behavior facilitated by the SH service delivery network. This network was specifically envisaged to promote improved healthy behaviors and care-seeking practices through BCC/knowledge management and by actively engaging communities. To attain these objectives, the Phase 2 team found that the project has emphasized key interventions such as demand generation through BCC campaigns, building capacity of the clinic staff in interpersonal communication and counseling (IPC/C), and promoting media advocacy.

Phase 2 found that service promoters and CSPs are working in communities on a variety of supportive activities. As result of these community mobilization and BCC campaigns, the service contacts in SH clinics have contributed to an increase of 12 percent in clientele going to satellite clinics compared to static clinics (when comparing the two in 2013 and 2015), according to NHSDP clinic monitoring data. Results show that approximately 75 percent of clients are served by CSP/satellite clinics, versus 25 percent at static clinics. The Phase 2 team found that many of these activities have resulted in increasing the customer flow at the service-delivery sites. Key activities have had a direct impact on customers coming to the clinics and changing their health-seeking behavior in an increased number. It should be noted that these statistics are collected monthly, fluctuate from month to month, and are reported to USAID on a quarterly basis.

To further strengthen the delivery of quality health services, NHSDP conducted a mystery client clinic exercise/survey in clinics across the country (see question 2, above). The Phase 2 team found the mystery client concept to be a strong and effective research technique that serves as a performance improvement tool. It helps to monitor and, in certain circumstances, evaluate service-delivery programs, health facilities and providers by providing information on good practices that may be overlooked during routine clinic activities. Mystery client information is fed back to the clinic so it can improve service provision.

**Activities related to the recommendations**: The Phase 2 team found that NHSDP had implemented a wide range of NGO capacity-building activities and regularly provided technical assistance for capacity-development activities. In an extensive documentation review, the Phase 1 team did not find significant NHSDP support for NGO Membership Council (NMC) development, although the Phase 2 team learned that this approach had been revised since Phase 1. NHSDP stated that USAID is seeking something more than activation/development of the NMC as previously defined and that they envision a broader and deeper role for an "apex body" or "umbrella organization" for the existing loose network of SH NGOs.

### 5) What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding demand creation for service utilization at NHSDP clinics?

Promoting and sustaining optimal healthy behavior across SH communities, clients, service providers and partners is a crucial NHSDP component that should cut across its different strategies and activities on different levels. BC&M through BCC, community mobilization, social marketing and knowledge management should be appreciated and envisioned as integral components of the project's overarching strategy. BC&M contributes to the four project dimensions of performance. The BCC team has

accomplished significant results under IR 2 and its sub-results and milestones. More than 75 percent of clients found overall clinic services satisfactory or good, and more than 60 percent found IPC/C services satisfactory or good (per the mystery client study). Phase 1 found slim appreciation and understanding that BCC's role should be a crosscutting integrated approach that complements and contributes effectively to other project components, with no effective programmatic and organizational platforms to operationalize this concept.

**6) How has NHSDP standardized service-delivery models, strategies and tools across the SH network (NGOs and clinics), and how can this be improved?**

On technical issues, NGOs related that there is a real need for a mechanism that adequately coordinates across the many partners. With many silos in NHSDP's technical division, there are multiple different communications and actions of training and support. NGOs report that decisions are essentially made by NHSDP, not with NGOs as partners in service delivery, and that guidelines are not based on reality and are often too complex. The required reporting is considered a very heavy burden on the staff. USAID's current focus is ensuring that quality standards are in place, and that any proposed clinic expansion meets a community need and will be a sustainable investment. Therefore, clinics must demonstrate that they have the capacity, and that there is a need, before expanding their services.

## CROSSCUTTING THEMES

During the midterm evaluation, the teams uncovered several crosscutting themes relating to the evaluation questions, as follows:

### Management issues affecting NHSDP

(Questions 2, 4, 5, 6): **Organizational structure**: NHSDP's organizational chart was changed several times. Several institutional changes moved the institutional strengthening unit under the responsibility of the finance and administration unit and changed links to the service delivery, BCC and M&E units. Later, NHSDP requested that the capacity development/institutional strengthening director position be a lower senior manager position supervising one staff member. These changes were part of an overall attempt to address the funding crisis resulting from USAID not awarding transition grants to two large NGOs.[18] The changes in staffing, responsibilities, authorities and links with other divisions led to diminished potential for a strong capacity-development force. NHSDP organizational structure changes have also affected the ESP unit; staff changes have been frequent, affecting programming. In addition, staff turnover is a concern, and the division of responsibility between Pathfinder staff and partner organizations (CARE and BCCP) is not always optimal.

**NGOs' human resources (HR) systems:** The need for sufficient qualified HR has been reported as a key issue in NHSDP 2013 road map assessments and was discussed frequently by NGOs and confirmed in Phase 1 key informant interviews. USAID acknowledges that recruitment and retention of quality staff is an important issue but states that contract regulations allow for increases of no more than 5–10 percent and that this does not permit project salaries to keep pace with current market trends in Bangladesh. It was not clear to NGO staff interviewed—some of whom may have been new—that the NGOs set staff salaries and can use the performance-based grant bonuses to augment them.[19]

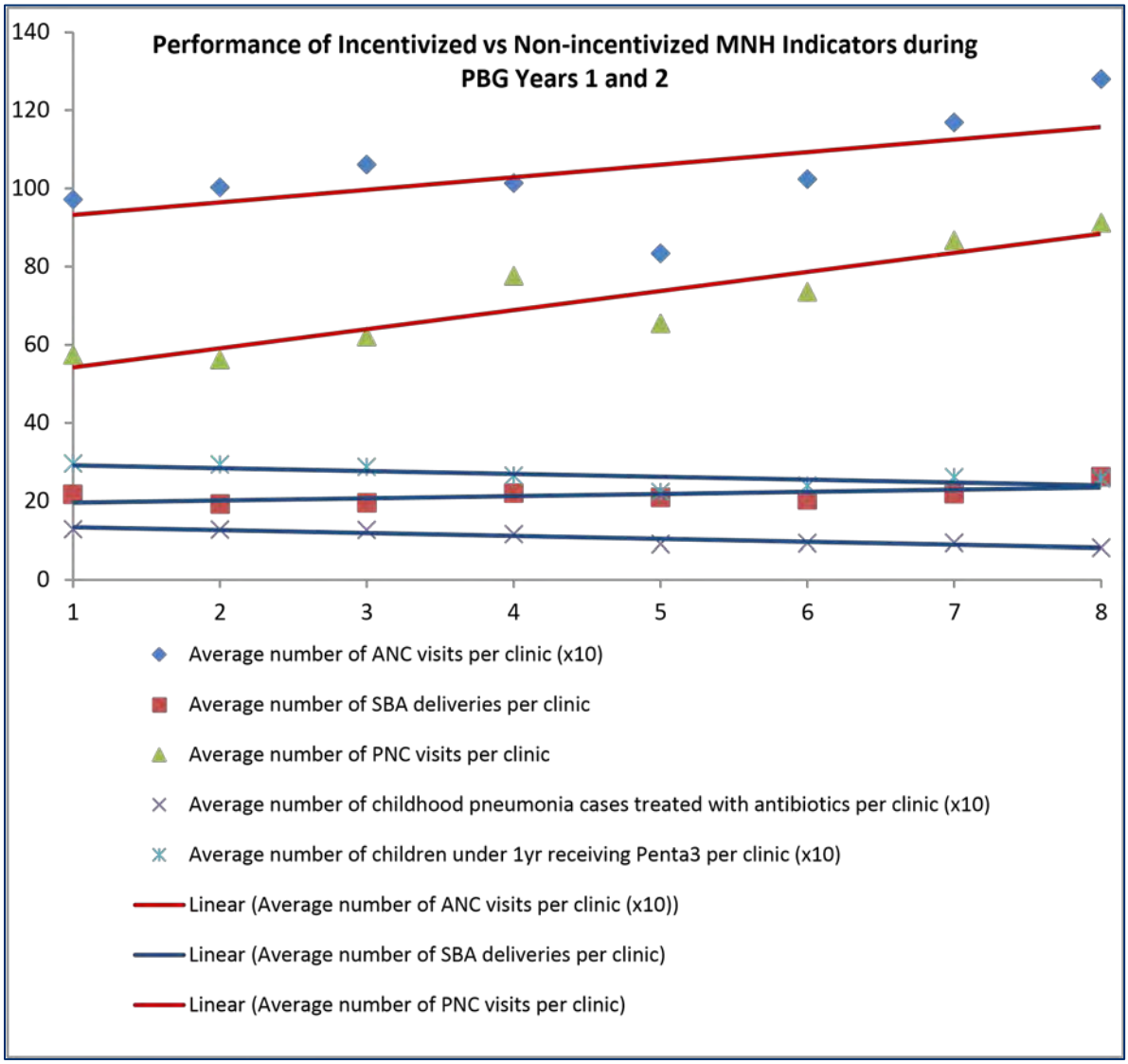
To move NGOs toward local ownership and sustainability without compromising the provision of quality services to the poor and underserved, the Phase 2 team found that the NHSDP strategically ties

[18] According to the Phase 1 team, these changes were also a reflection of the limited priority for capacity development.

[19] Ten performance-based grant indicators are identified, NGOs are eligible for 1 percent of the total grant bonus for achieving these metrics; 1 percent penalty may result if achievement is poor. These bonuses go to NGOs and can be used as the NGOs see fit, for example, for bonuses, new equipment, upgrades, and so on.

performance-based grants to four dimensions of NGO performance: service uptake and coverage, quality, equity, and institutional strengthening. (See Figure 1, below, showing indicators.)

**Figure 1. Performance of incentivized vs. non-incentivized MNH indicators during performance-based grants, years one and two**




(Questions 1, 2, 4, 5, 6): **Reporting systems**: The USAID COR has discussed with Pathfinder headquarters the multiple discordant MIS systems and the need for technical assistance to streamline them. Technical assistance was received in February 2016, and the reporting system was updated to go online as a result.

**Oversight systems:** USAID oversight and issues of concern (the need for clear NHSDP reporting, more comprehensive capacity-development progress, and more effective processes for BCC approaches and activities to support NHSDP overall programming) were discussed with USAID. Frequent transitions in USAID staffing and USAID priorities have affected oversight. At the time of Phase 1, Local Solutions Development was an important element of USAID programming, and the Office of Population, Health, Nutrition and Education's technical office reported that it felt strongly that the mandate to graduate NGOs to direct funding should be prioritized over sustainability. USAID Forward was softened

around the same time that the NGOs were not graduated. Once the contract modification was approved, USAID and NHSDP were able to focus more on sustainability instead of the direct funding mandate. To date, there have been five Contracting Officers involved in the contract and three Contracting Officer's Representatives (CORs). The present COR was assigned as the alternate in January 2015 and as COR in February 2015.

USAID staff discussed that oversight is made more difficult by the NHSDP reports that are not clear or internally consistent. The full extent of guidance and oversight by USAID to NHSDP on project management and technical, capacity-development and other systems could not be reviewed in-depth by the Phase 1 team, in part, due to all the transitions. When the Phase 2 team was in country, it found that many of these issues had been resolved (see Question 2, Internal Project Coordination, below).

(Questions 2, 4) **Logistics:** Clinic staff may need to be advised by their NGO, reinforced by NHSDP staff, that their NGO can purchase needed equipment.

(Questions 2, 4, 6) **Service expansion:** Network expansion was achieved, in part, by adding 67 new clinics to ensure that the project met its overall targets once the two NGOs left the network in the third year. Because the two NGOs did not graduate to receive USAID approval for direct funding, the project has struggled to accommodate the cost of sustaining these NGOs and the new clinics, cutting funding back in other areas. During year three, the project focused on efficiency, rationalization and standardization of staffing patterns of clinics rather than expansion. According to Phase 1 interviews with NHSDP staff, "Currently, there is no plan for upgrading clinics due to the (project's) lack of funds to do so."

Referral networks need a follow-up mechanism to ensure referrals for poor patients. Vital clinics are reportedly not referring clients, and some only provide referrals in certain circumstances. USAID reports progress in this area on recent monitoring visits.[20] The clinics have begun calling them to check on their delivery and recognized that this is an opportunity to increase SBA (where trained people sit), essential newborn care, postnatal care and postpartum FP.

**Gender:** This iteration of the project was designed to add focused services for unmarried and married adolescents and youth, additional nutrition services in line with the GoB's, and mainstreaming gender to make services more accessible to women and girls and gender equitable, including an emphasis on joint decision-making among couples and involving men to increase family access to ESP services. As discussed below, progress for these new areas has been slow for various reasons.

**Key conclusions, recommendations, and lessons learned**

**Conclusions**

- **Question 1:** USAID-established targets in terms of cost recovery and targeting the poor and POP are on track. Efforts to identify, monitor and analyze the POP information were improved.

**Recommendations**

- **Question 1:** Cost recovery and local investment (including from the GoB) could help increase sustainability of NHSDP initiatives. USAID continued discussion with the MOHFW to develop opportunities to expand investment in Bangladeshi health services.
- **Question 2:** Given the magnitude of work and infrastructure established in the NHSDP and its predecessors, USAID should consider network sustainability as a backbone for the next project, with emphasis on: (a) participatory strategic planning with NGOs to develop solid corporate

[20] USAID/Bangladesh COR comments on Phase 1 draft report, February 1, 2016.

systems and create viable organizational structures, (b) evidence-informed BCC and social marketing strategies and plans, and (c) collaborative win-win partnerships with the MOHFW and the private sector.

- **Question 2:** Service quality needs to be improved across the network in areas such as staff retention, training capacity, intensified monitoring using cross-functional teams (technical/M&E/grants), implementation of quality standards,[21] governance capacity, referral tracking of the poor/POP, improved inter-unit collaboration on the project, and improved environment and infection control at facilities.
- **Question 3:** USAID should consider the frequency and types of reports required from the project to go beyond the numerically focused report to reflect the innovation, integration between different activities, lessons learned and best practices toward achieving project goals and objectives.
- **Question 3:** A clear USAID vision of its future health project and the role of NGOs in it is needed to define the capacity and sustainability to be achieved. NHSDP can use its final life-of-project to test models.
- **Question 5:** Service quality needs to be improved across the network, for which ensuring implementation of the project's minimum quality standards—established in the 2015 rationalization[22]—is essential.
- **Question 5:** USAID should consider BCC and social marketing as an integral crosscutting component in NHSDP successor program/s.
- **Question 6**: The project should explore further participation in GoB-promoted DSF schemes and its social health protection schemes under the Health Care Finance Strategy 2012–2032.
- **Question 6:** Improved compensation to the CSP and concurrently greater accountability are necessary.

**Lessons Learned**

- **Question 4:** A program that depends on collaboration with independent NGOs with different dynamics, contexts and structures must be ready from inception with feasible options/plans for NGOs' technical, organizational and financial sustainability, informed by a participatory strategic planning process for building consensus with NGOs.
- **Question 4**: Building NGO capacity to meet only USAID and contractor requirements does not prepare them to function with independence and to successfully contract in the future with public and private agencies in the health sector.
- **Question 5:** Generating the right type of data regarding service delivery utilization is essential for effective decision-making and management of this large and complex project. In-house capacity and the willingness of the NGOs and NHSDP project management are essential to reach the POP more effectively and to report on their usage of SH clinics.
- **Question 6**: NHSDP can take advantage of its reputation to develop stronger relationships with various units of the MOHFW and other stakeholders.
- **Question 6**: CSPs impart a key role in creating awareness and bringing clients to SH clinics.

[21] NHSDP Rationalization Workshop Year 3, August 19-20, 2015.

[22] Ibid.

**Crosscutting recommendations**

- **Vision:** A clear vision is needed to develop NGO capacity development, BC&M, and other areas within NHSDP's overall plan and NHSDP's future role in these areas and their sustainability in the NGOs in the final two project years.
- **Participatory management platform:** USAID and NHSDP should conduct high-level, in-depth discussions to develop a management structure and platform that ensures integration between different project components and allows effective participation of the project subs and partners in planning, management and evaluation of their assigned technical roles within the project's objectives and framework.
- **Data collection:** Examine expanding Bangladesh's community-level electronic data collection system that uses tablets and reports to MOH headquarters.
- **Logistics**: Orient project directors and clinic staff to the logistics system to be able to purchase needed clinic equipment and supplies, and to negotiate with their NGO and NHSDP to replace equipment and supplies that are essential for managing NHSDP systems on a timely basis.
- **Improving project support to NGOs:** Input from NGOs provides opportunities for NHSDP to strengthen its working relationship with partner NGOs and will help to restructure NHSDP support to NGOs in the future.
- **USAID oversight and reporting:** The need for future, active, in-depth USAID oversight would help ensure not only that contractual requirements are met but also that NHSDP has strengthened, innovative, high-quality clinical, BC&M and capacity-development activities and services, strong management systems, and the 25 NGOs and an NMC-type body have in-depth institutional capacity.
- **Accreditation**: In the design of a future health program, USAID can consider supporting the use of an external accreditation program, if research/literature supports its benefits and an analysis of its feasibility and costs are done in the context of Bangladesh.
- **Information sharing**: It is suggested that opportunity for information sharing and discussion between the partners be increased to allow learning and improved project performance.

# I. INTRODUCTION

The Non-governmental Organizations (NGO) Health Service Delivery Project (NHSDP) midterm performance evaluation was designed to assess the project's status, relevance and sustainability and provide suggestions for the selection, design and implementation of future projects. The evaluation's results will be used to inform USAID and other relevant stakeholders of how Bangladesh's clinical service-delivery program can best be used to maximize public health results and to educate USAID/Bangladesh in guiding the design of future service-delivery programs. The evaluation will recommend possible options for USAID in adopting service-delivery models and cost-recovery schemes to move toward diverse funding and sustaining a reasonable balance of cost recovery and service delivery to the poor.

The evaluation was carried out in two phases. The initial evaluation (Phase 1) was conducted in October–December 2015 through the Global Health Program Cycle Improvement Project (GH Pro); the in-country work took five weeks. The Phase 1 team was composed of Najmul Hossain, team leader; Soliman Guirgis, service marketing and demand-generation specialist; Rose Schneider, non-profit organizational capacity-development specialist; and Usha Vatsia, maternal, neonatal, and child health and family planning specialist. In addition, a team of local professionals was recruited to conduct interviews in sites where the team could not travel and to coordinate and manage in-country logistics. The Phase 2 team conducted its work in June–July 2016 through GH Pro; the in-country work took two weeks. The team was composed of Carina Stover and Nasima Safa. Dina Towbin provided ongoing editorial guidance throughout the report development. See Annex 1 for both scopes of work.

The audience for this evaluation includes USAID/Bangladesh, the United Kingdom Department for International Development (DFID, co-funder of NHSDP), the Government of Bangladesh (GoB), the NGO network, NHSDP management and technical team members, development partners, USAID's Bureau for Global Health and Bureau for Asia, relevant bilateral and multilateral donors working for health and service delivery, and other similar donor-funded project personnel.

**Evaluation questions**: The evaluation report was initially structured by intermediate results (IRs). With USAID/Bangladesh concurrence, the final report has been restructured around the six evaluation questions, with multiple underlying issues. The questions are as follows:

1) What have been the successes and limitations of the project's cost-recovery component?
2) What have been the successes and limitations of network expansion, especially for key ESP services: family planning/reproductive health (FP/RH), antenatal care (ANC), delivery, child health and nutrition?
3) Given the revisions to NHSDP's SOW since the contract was awarded, due to increase in total funding, assess project-level performance issues, identify deficiencies and propose strategies for improvement, taking into consideration the limited implementation timeframe.
4) What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding building/strengthening NGO capacity?
5) What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding demand creation for service utilization at NHSDP clinics?
6) How has NHSDP standardized service-delivery models, strategies and tools across the *Surjer Hashi* (SH) network (NGOs and clinics), and how can this be improved?

# II. EVALUATION METHODOLOGY AND LIMITATIONS

## METHODOLOGY

Phase 1 used a mix of quantitative and qualitative methods of data collection, consisting of analyzing data and information from (1) background documentation and project reports, the project's monitoring and evaluation (M&E) plan, and other surveys; (2) extensive interviews (one-on-one, group, or e-questionnaire survey and rapid appraisal), field observations and focus group discussions with partners, stakeholders and beneficiaries; and (3) field visits to project sites to gain an in-depth understanding of project achievements and challenges.[23]

Quantitative information was derived from project data and formative research from a variety of project documents, as well as data from an e-questionnaire and clinic survey. The team also used findings from documents from several other relevant organizations and national-level data sets. Qualitative information was generated through individual interviews (key informant and clinic client exit interviews), group discussions, focus groups and field observations. The team used structured questionnaires to generate quantitative and qualitative data and information from Pathfinder International, the 25 NHSDP target NGOs, and a sample of "Smiling Sun" or SH clinics. To ensure that comparable information was collected during field visits, the team drafted standard guides for each method. The Phase 1 team selected locations and interviewees with guidance from USAID/Bangladesh to minimize the possibility of bias and maximize the outcomes of the evaluation process (Table 4). The largest cities covered, Dhaka and Chittagong, have the highest number of NHSDP SH clinics. The third location included was Cox's Bazar, a mid-size town in the Chittagong Division. Adjacent semi-urban and rural locations were also covered. The sampling coverage ensured representation of densely populated urban locations and of a relatively small town. See Annex II for more details on the methodology, limitations and survey instruments.

**Table 4. Survey data collection coverage**

| Method | | Dhaka | Chittagong | Cox's Bazar | Total |
|---|---|---|---|---|---|
| Key informant interviews | | 23 | 9 | 6 | 38 |
| Group discussions | | 4 | 1 | 0[24] | 5 |
| Focus group discussions | | 1 | 1 | 3 | 5 |
| NGO e-questionnaire | | Instrument sent to 25 NGOs; 11 responded | | | |
| Clinic survey | Urban | 3 | 6 | 2 | 11 |
| | Rural | 2 | | 1 | 3 |
| Exit interviews of clients | | 17 | 20 | 19 | 56 |

The Phase 2 team conducted a rapid review of relevant documents and text submissions in response to evaluation follow-on questions provided by USAID. The team conducted limited field visits to partner offices and static and satellite clinics to view the facilities, interview staff and clients, and review behavior change communications (BCC) materials and coverage statistics. The team conducted interviews in

[23] Household Income Expenditure Survey, 2010; Bangladesh Demographic and Health Survey (BDHS), 2014.

[24] No group discussion was held at Cox's Bazar because, unlike Dhaka and Chittagong, Cox's Bazar has one NHSDP partner NGO, Family Development Services & Research (FDSR). The team interviewed the FDSR project director in Cox's Bazar. The NGO's executive committee members reside either in Dhaka or Chittagong, so the team interviewed them in group discussions in one of the two cities.

Dhaka with USAID, NHSDP, CARE/Bangladesh, Bangladesh Center for Communication Programs (BCCP) and the Ministry of Women and Children's Affairs (MOHFW).

## LIMITATIONS

Understandably, limitations are found in any review of a project, especially in a country such as Bangladesh, where there are security and cultural constraints that limit information sharing. Both the Phase 1 and Phase 2 teams strove to overcome these limitations by focusing on validated information shared and using simple methods of information/data collection that would accommodate constraints in the country. Whenever possible, they used revalidation techniques to verify that information collected was indeed representational of the actual situation at the time of each phase's work. The following are some of the limitations faced despite attempts to overcome them:

- The selection of cities where NGO clinics were identified and visited was purposive due to time and security constraints on travel, especially of the three international consultants.
- A positive response bias could exist among clients of the SH clinics who participated in the exit interviews where the clinic managers encouraged them to participate; clients may have felt a responsibility to respond positively. Interviewees might also have had concerns that their responses might affect their future access to care.
- A limitation could be the proportionately larger number of focus group discussions in Chittagong because of the availability there of all four local team members, while in other locations, the local team member numbers were smaller.
- The response rate to the e-questionnaire–the number of NGOs that responded was less than half (11/25, 44 percent)–could be considered a limitation, but it may also be considered a good rate statistically. The results reported by the NGOs that have completed the e-questionnaire may be different compared to the NGOs that did not respond (raising the possibility of a non-response bias).
- The language issue in interviews and discussions is also another potential limitation.
- Ensuring adequate representation of interviews and rapid appraisal sources vis-à-vis the full scope of NHSDP activities and outcomes is a limitation.
- The evaluation team used a purposive sample, not a random sample, for primary data collection among beneficiaries, providers or facilities; therefore, data are not derived from a representative

- The Phase 2 team had a limited amount of time for document and data reviews and in-country visits. Travel was limited to Dhaka due to security restrictions during the team's time in country.

# III. PROJECT BACKGROUND

The NHSDP was designed to address the following development problem, as stated in USAID/Bangladesh's current Country Development Cooperation Strategy:

> *USAID/Bangladesh DO3 strives to stabilize population and improve health and nutrition. DO3's Development Hypothesis is: If all Bangladeshis have access to quality health services at an affordable cost and are aware of the benefits of using these services, they will use these services, leading to improved health outcomes. Strengthened health systems are integral to ensuring access to quality and sustainable service provision.*

USAID designed NHSDP to complement the GoB's efforts to offer quality health, nutrition and population services at low or no cost, while supporting the sustainability of local service-delivery organizations (see text box). NHSDP was designed to strengthen local ownership of service delivery through institutional strengthening interventions targeted at the network NGOs. Led by Pathfinder and implemented through a coalition of national and international partners, a primary health care Essential Services Package (ESP) is being provided to a nationwide "Smiling Sun" network of 25 local NGOs. The NGOs oversee operations of 388 static clinics, 10,186 satellite clinics, 7,321 CSPs, and 777 service promoters throughout Bangladesh. NHSDP provides around 39 million service contacts annually, according to NHSDP documents. The NGOs vary in scope and size. Some operate in a defined geographic area, and some are nationwide. Some NGOs have oversight for as few as four clinics, others as many as 55 (average is 15 clinics per NGO, mean 10).

As shown in the NHSDP results framework (see Figure 2, below), NHSDP efforts were designed to contribute to all IRs under Development Objective 3. Expanded access to and use of the ESP, resulting from NHSDP efforts, were to measurably improve health outcomes and contribute to decreasing fertility and maternal, infant and child mortality. The project design follows the framework's structure.

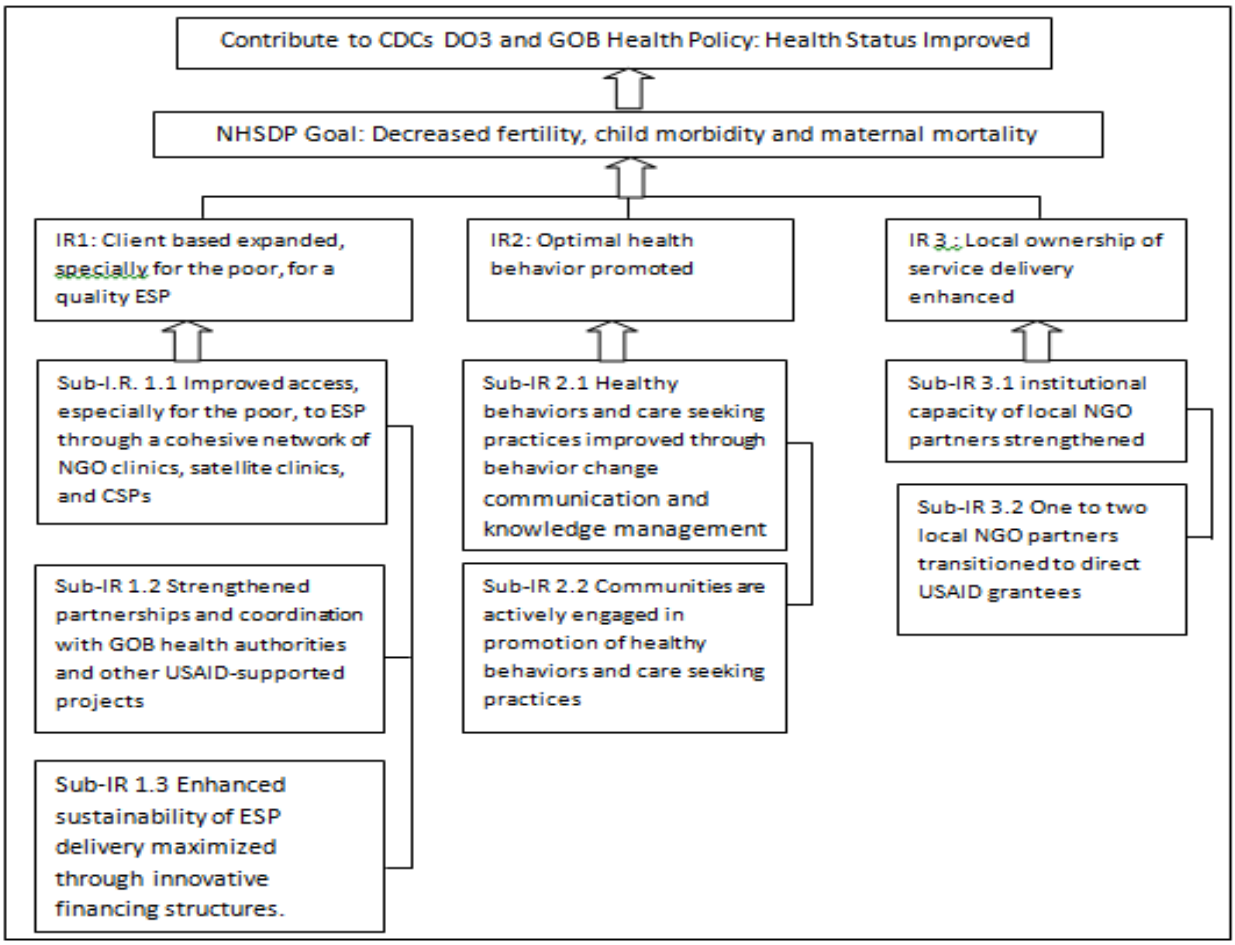
**Vision for the HPN Sector**

Within the broader context of the MDGs, the GoB's vision for the HPN sector as described in its Sixth Five-Year Plan (FY 2011–2015), was as follows:

- To ensure access and utilization of HPN services for every citizen of the country, particularly elderly, women, children, poor, disadvantaged and those living in difficult areas
- To revitalize community health care under an effective and integrated upazila health system with ESP
- To reduce maternal mortality
- To reduce the rate of child mortality
- To control HIV/AIDS, TB, leprosy, malaria
- To reduce the total fertility rate
- To ensure adolescent and reproductive health care
- To decentralize and to strengthen local-level planning to obtain better results in implementation of programs
- To bring self-sufficiency in the production of medicines of international standard and to promote their export
- To ensure nutrition to children and women
- To take effective measures to promote alternate medicines and to improve the quality of care
- To control/eliminate infectious diseases
- To meet challenges of emerging, re-emerging and non-communicable diseases, health hazards due to climate change and emergency response to catastrophe
- To enhance national capacity for pre-service education (SBA/nursing, paramedics, midwifery), provide in-service training and better management of human resources
- To improve the quality hospitals and maternity services and to make these accessible especially to the women, children and poor

*Source:* Government of the People's Republic of Bangladesh. *Sixth Five Year Plan FY2011-FY2015.*

**Figure 2. NHSDP results framework**




NHSDP was designed and funded in December 2012 through a USAID contract agreement with PI, with the goal of decreasing "fertility, child mortality and maternal mortality," and the intermediate results of: (1) expanded client base, especially for the poor, for a quality ESP; (2) optimal health care promoted; and (3) local ownership of service delivery enhanced. NHSDP was designed to balance serving the poor with increasing local NGOs' sustainability. In 2013, DFID began providing gift funds to USAID to co-fund NSDHP, which expanded the scope considerably. DFID funding has supported the current NHSDP activities and strengthened its focus on FP and maternal health outcomes, with a specific focus on improved service delivery for the urban poor.

## COUNTRY CONTEXT

In the past two decades, Bangladesh has made laudable progress in its health, nutrition and population sector, as well as in its social and economic sectors. Increased life expectancy at birth, reductions in fertility levels and sustained child immunization coverage have all contributed to the reduction in infant and child mortality and a significant decline in maternal mortality. Bangladesh has also seen sustained economic growth at a rate of six percent, and in 2015 moved up from a low-income to a lower-middle income country. The country has made great strides in many areas, such as increases in literacy.

The Millennium Development Goals (MDGs) Report 2011 applauded Bangladesh's progress toward MDGs 3, 4 and 5 as noteworthy. Bangladesh was one of the few countries in the world to achieve both MGDs 4 and 5. Gradual improvement of basic health and nutrition services also contributed to a

substantial reduction of under-5 mortality (from 94 deaths per 1,000 live births in 1999–2000 to 53 in 2011), for which Bangladesh received the United Nations MDG Award in 2010.[25]

In terms of health services delivery, ANC visits for pregnant women by medically trained providers[26] increased from 33 percent in 1999-2000 to nearly 64 percent in 2014, and delivery by medically trained providers increased from 12 percent to 42 percent during the same period. This increase in skilled delivery is predominantly due to a rise in facility deliveries, which increased from 8 percent to 37 percent from 1999 to 2014.[27]

Bangladesh also demonstrated substantial progress in implementing an effective FP program. The decline in total fertility rate (TFR) with an increase in contraceptive prevalence rate is commendable. The BDHS 2014 reported a reduction in TFR from 6.3 births per woman in 1975 to 3.4 in 1994, and a further decline in 2011 to the current rate of 2.3; however, it also shows that the TFR has stagnated.

## POPULATION, HEALTH AND NUTRITION CHALLENGES

Notwithstanding the progress achieved in the health sector, there are challenges that have to be addressed if Bangladesh is to achieve the medium-term goal of improved health indicators, stated above, and its long-term goal of universal health care coverage by 2032. Although Bangladesh's poverty level has been declining at a steady rate (e.g., from around 31 percent in 2010 to under 23 percent in 2015), further reduction is essential. Poverty adversely affects morbidity and economic activities. Cultural norms encouraging early age of marriage of women and subsequent first birth have increased the burden on the health care system and reduced educational opportunities for young women. Further integration of essential FP, health and nutrition services and improved health systems and governance are essential to promote efficient and equitable services in this sector.

**USAID's role**: Since Bangladesh's independence, USAID has been a key development partner in providing and promoting effective FP and maternal, newborn and child health services, including integration with education priorities. USAID/Bangladesh's Office of Population, Health, Nutrition and Education has 48 awards as of June 2016. About 22 are bilateral, others are field support, and the awards are administered centrally; these include the USAID- and DFID-funded NHSDP. USAID's efforts contribute to improving maternal, newborn and child health and FP services, and toward capacity building and institutional strengthening in the population, health and nutrition sector.

**NHSDP**: NHSDP has evolved from several precursor programs, including the NGO Service Delivery Program, 2002–2007, and Smiling Sun Franchise Program (SSFP), 2007–2012. During the SSFP, USAID concluded that the franchise model was not appropriate, and in the effort to reach a high (70 percent) cost-recovery goal, services to the poor were being neglected.

The NHSDP was awarded to Pathfinder as the prime contractor and the following subcontractors: CARE/Bangladesh, Bangladesh Center for Communication Programs (BCCP) in collaboration with John Hopkins University (JHU)-CCP, the Social Marketing Company, Rapport Bangladesh, Nari Uddug Kendra[28] and Brandeis University (Management Plan). In the modification period, Pathfinder's partners

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[25] NIPORT (National Institute of Population Research and Training). 2013. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra & Associates, and ICF International.

[26] Medically trained providers include: qualified doctor, nurse/midwife/paramedic, family welfare visitor, community skilled birth assistant, and sub-assistant community medical officer.

[27] NIPORT. 2013a. "Preliminary Report on the Utilization of Essential Servicers Delivery (UESD) Survey 2013 (Provisional Results)." NIPORT, Dhaka; 2014 statistics are from Bangladesh DHS 2014.

[28] Pathfinder International, Project Design Document for Partnership Use, September 2012.

were CARE/Bangladesh, BCCP in collaboration with JHU-CCP, and Brandeis University, with short-term technical assistance from the Institute for Global Health and Development.[29] The project initially supported 26 local NGOs; however, the contract with one of the NGOs was recently terminated, based on governance- and accounting-related issues.

**The ESP unit** has been overseen by a new Deputy Chief of Party (DCOP) for Service Delivery since October 2015 and since June 2014 has been led and managed by an ESP Director who has experience as a SH clinic manager and with the NGO Service Delivery Program. The organigram has changed at least three times since the project's start,[30] with the August 2015 version showing the ESP unit comprised of 10 technical experts. Pathfinder fills six of these positions, and CARE Bangladesh fills four. In addition to providing technical leadership in developing standard guidance in their respective areas, unit staff are assigned as technical leads for selected NGOs as desk officers to coordinate delivery of capacity-building technical assistance across priority ESP services for the project. Technical leads monitor clinic performance with NGOs and consult with unit colleagues to clarify and resolve technical issues.

NHSDP revised and distributed its **Clinic Management Guidelines** in English in its first year; they were further approved by USAID in year three. The project updated and translated these guidelines into Bangla in year three[31] to include a clinic-monitoring checklist that was designed to go beyond clinical issues, such as signage and branding, reception, compliance with legal and policy requirements for FP and environmental compliance, and gender. NGO project directors disseminate guidance from the project, and monitoring officers are charged with ensuring quality of service delivery through clinic monitoring activities and quarterly meetings with the project and ESP unit.

**Service expansion**: NHSDP complements the GoB's delivery of an ESP for primary health care, including FP, through a network of NGO clinics focused on providing poor and underserved urban and rural populations in Bangladesh access to five underused ESP services. The services are long-acting and permanent FP methods (LAPM), maternal health, nutrition, newborn health and acute respiratory infection treatment. Service expansion was to be achieved by adding new clinics, increasing the range of services offered, and improving referral linkages within and outside the SH network. The network was expected to graduate a number of clinics by awarding direct funding to two NGOs for which network expansion was necessary to achieve project targets.

**Institutional capacity development:** The IR 3 institutional strengthening component supports the successes that NHSDP achieved. It is a key NHSDP component that provides training, technical assistance resources and other key inputs. NHSDP's defined strategy states that IR 3.1 was to develop a baseline situational analysis for all NGOs; specific plans for each NGO; tailored strategies for human resources (HR) recruitment, training and retention; and establish secure internal controls, systems of accounting and transparency, and benchmarks to measure progress.

Expected results of sub-IR 3.1 include:

1. Updated baseline situational analysis of local NGO partners that established institutional strengths, weaknesses and focus areas for project capacity building
2. Road maps for each NGO, customized, built on baselines and related to benchmarks
3. All NGOs achieving 90 percent of benchmarks by the end of the project

[29] Attachment A, SOW and Organizational Chart, September 2015.

[30] NHSDP Organizational Charts, 2013–15.

[31] NHSDP Strategy & Guidelines, August 5, 2015.

The contract requirement under IR 3.2 stated: "Up to two NGOs identified for eventual transition to direct USAID awards within the first six months of an award." Institutional strengthening milestones linked to pre-award assessments were as follows:

- Up to two NGOs identified for transition to direct USAID awards
- Up to two NGOs successfully completing pre-award assessments to be eligible for direct award

**NGO Membership Council (NMC) development:** The project's stated NMC capacity-development objective was successfully stated in the strategy document as a mechanism to move the NGOs closer to long-term sustainability using the breadth of the NHSDP consortium partners for technical assistance to address (initially stated as) governance; leadership; financial, administrative and operational management; HR; and information systems to enhance the NGOs to sustain themselves with minimal donor contribution. NHSDP's Capacity Development Strategy (October 2013) is a coherent, explicit document for the capacity development strategy, process, key interventions and coordination by NMC of the 26 NGOs and their relationships to the GoB and private sector.

The strategy directs NHSDP development of the NMC to serve as the structure for all 26 NGOs' affiliation "as an apex body, that plays the proactive role to provide policy and advocacy related support to SH NGOs and to complement GOB health policy." The NMC was to receive technical assistance from the NHSDP Institutional Strengthening Team to review its governing body, terms of reference and legal status to function as the effective governing body responsible for the NHSDP-supported network and GoB coordination. It was to engage with the private sector and be responsible for management of the NGO network-wide system to cross-subsidize services and emphasize NGO quality services over cost recovery. After the NMC functioned with institutional strengthening unit support, it was to steer the entire 26-NGO membership structure after NHSDP phase-out.

# IV. EVALUATION RESULTS/FINDINGS

NHSDP is a large, complex and multifaceted project with a long history that evolved from several precursor programs. At a critical juncture in Bangladesh's continued development, the Phase 1 team found that, by and large, the contractor is meeting its deliverables, but that project management, staffing, service delivery and service quality need some improvement. The Phase 2 team found that many aspects of the contractor's performance had improved and reflected this in its findings. Findings are presented in response to each evaluation question. Many of the responses to the evaluation questions were crosscutting and, as such, are presented at the end of this section.

## EVALUATION QUESTION 1: WHAT HAVE BEEN THE SUCCESSES AND LIMITATIONS OF THE PROJECT'S COST-RECOVERY COMPONENT?

**Targeted cost recovery**: NHSDP's predecessor project, the SSFP, had a targeted cost recovery of 70 percent. It is argued that such a high cost-recovery objective compromised its effort to reach the poor. SSFP performance during the project's operations (2007–2013) included 200 million contacts, of which 28 percent were poor.[32] The NHSDP's objectives emphasize greater focus in targeting the poor and set the dual objective of 40 percent cost recovery and 40 percent of service contacts to the poor through its 25 local NGO clinics.

Phase 2 found that the cost-recovery targets are assigned to the NGOs based on the target of 40 percent provided by USAID to Pathfinder/NHSDP. To achieve the overall NHSDP target, the project allocates NGOs a target based on their capacity, geographical locations, previous achievements and other data; targets may widely vary among the NGOs (for example, ranging from 27-73 percent in year four). The NGOs then set rates for each of their clinics based on clinics' performance, catchment areas and capacity. The clinics' cost-recovery achievements are accomplished through the services they provide on a regular basis. Current cost-recovery rates can be sustained if the clinics continue providing the services in their respective areas in a similar and competitive manner to maintain a demand for these services. Anything that affects demand, such as decline in quality, interruptions to access, overlaps or unfair competition, may create negative issues related to financial sustainability.

NHSDP has achieved the annual targets for the first three years. NHSDP is moving toward achieving the Y4 target (40 percent cost recovery). At the same time, NHSDP NGOs are also achieving the target of 40 percent serving the poor. Thus, in this context, these rates seem to be achievable. However, many challenges remain, related to increased costs, income and other factors (competition, duplication, etc.).

NHSDP uses the following formula[33] to estimate cost recovery:

$$\text{Cost Recovery Rate} = \frac{Internally\ Generated\ Income}{Actual\ Operating\ Expenses} \times\ 100$$

[32] http://www.chemonics.com/OurWork/OurProjects/Pages/Smiling-Sun-Franchise-Program.aspx.

[33] NHSDP provided the Phase 1 team with cost-recovery data disaggregated by clinic for October 2013–September 2014, but clinic-disaggregated data were not available for October 2014 to September 2015. Cost-recovery data were not available, but data disaggregated by each NGO for October 2014 to September 2015 were made available. As designed by NHSDP, annual cost-recovery data are validated by third party at the time of NGOs' annual audit, which is currently in process. The Phase 1 team had two years of cost-recovery data by clinic for the use of this evaluation. The cost-recovery calculation method slightly changed in the ninth contract modification, which required recalculation of the cost-recovery rate for FY 2015.

Based on the above definition, the cost-recovery rate among the 388 SH clinics (October 2013–September 2014), ranges from 1 to 121 percent (Table 5),[34] with an average per clinic of 34 percent. When aggregated by the 25 NGOs, the range is lower—between 20 percent and 87 percent, and the average rate for the NGOs was 40 percent (Table 6).

**Table 5. Cost-recovery rates by NGOs and clinics**

| | Cost Recovery Rates by NGO | | Cost Recovery Rates by Clinic (excluding NGO headquarters) | |
|---|---|---|---|---|
| | October 2013-September 2014 | October 2014-September 2015 | October 2013–September 2014 | October 2014–September 2015 |
| **Range** | 20.31%–63.45% | 18%–61% | 0%–121% | 0.91%–116% |
| **Mean** | 32.97% | 35.52% | 32.35% | 33.88% |
| **Median** | 29.84% | 34.50% | 30.38% | 33.00% |

*Source*: NHSDP third-party audit of NGOs' cost-recovery rate.

**Table 6. Cost-recovery rates by NGOs**

| | Cost-Recovery Rates by NGO | |
|---|---|---|
| | October 2015–December 2015 | January 2016–March 2016 |
| **Range** | 20%–73% | 23%–87% |
| **Mean** | 43.00% | 40.69% |
| **Median** | 40.50% | 40.29% |

*Source*: NGO self-reporting (not audited or verified)

The Phase 2 team found that each quarter, the NHSDP Grants Team and NGOs analyze the variance of actual income versus actual expenses in each of the NGO's bank accounts. Furthermore, a study to examine the cost of service delivery that was underway at the time of Phase 1 is now available. NHSDP guidelines offer cost-recovery plans and varied innovative financing strategies.

At present, NGOs are sub-grantees, responsible for funding and managing the performance of their clinics (between 4 and 55). Clinics submit their reports to their NGOs, which compile and send the data to NHSDP. NGOs are held accountable for their own performance and targets. Not every clinic is expected to hit the 40 percent/40 percent balance, but the overall network is meeting that target.

Phase 2 found that the management information system (MIS) had been updated (since the Phase 1 team's departure) to address its inability to disaggregate data. It took time for all clinics to obtain computers and trained data entry operators. The system was launched in June 2015 and became fully operational in February 2016.

NHSDP also provides guidance on balancing services to the poor versus cost recovery. NGOs set cost-recovery goals for their clinics based on their geographical location (urban, rural, hard-to-reach, etc.)

[34] The evaluator calculated cost-recovery rate for each clinic. The denominator is the operating expense of the clinic. The data revealed that cost recovery ranged between 1 and 121 percent (implying one clinic recovered only 1 percent of cost while another recovered 121 percent during October 2013–2014). Even if the number of clinics serving varied during the periods discussed, this would not change the estimates.

and their clients' ability to pay. NGOs balance their cost-recovery rate between high and low cost-recovering clinics for their overall cost-recovery goal. The NGOs currently rely on NHSDP for guidance on balancing service between cost recovery and reaching the poor.

**Pricing strategy:** Key informant interviews, field visits and a review of several USAID-funded studies[35] suggest that adjustments in pricing strategies of several SH clinic services can lead to increased revenue generation (cost recovery) without compromising service utilization.[36] NHSDP has provided technical assistance to NGOs to adjust their cost recovery.

The Phase 2 team found that NHSDP NGOs' cost-recovery rates are calculated by dividing internally generated income by total actual operating costs of the supported NGOs and clinics. Definitions of income and expenditure are embedded in the contract (section C 4.5). The cost-recovery rates are certified annually by a USAID Regional Inspector General[37] listed audit firm that also assures the income and expenditures data in the financial audit. To ensure accurate reporting of income and expenditures by the NGOs, the grants managers conduct voucher reviews and financial monitoring visits each year with extensive voucher checking and quarterly reconciling of more than 1,200 bank accounts that are managed by the NGOs. Variance analysis is embedded in the quarterly sub-recipient financial reports, which the grants manager analyzes and reviews each quarter. See Annex III for the certifications of the cost-recovery rate and sub-recipient financial reports.

NGOs and the clinics collect numerous data on income and expenditures along with programmatic data. However, NGOs are not required to report all this data for M&E; rather, they only report the data relevant to the project indicators to NHSDP. This requirement does not cover reporting on expenses and utilization of services by different groups of clients.

**Pharmacy outlets, laboratory testing, imaging services and other services:** Most static SH clinics have pharmacies[38] on their premises that are open to clinic patients and outsiders. At present, these pharmacies are primarily accessed by clinic patients. Their stock of drugs and operating hours are limited to clinic hours. Most SH clinics offer only selected laboratory testing or imaging facilities. A number of SH clinics are offering some testing and imaging services beyond the ESP packages, such as sonography, diabetic testing, and other tests.

The Phase 2 team found that SH clinic marketing through promotional activities is being conducted in three ways:

- ***Overarching marketing from the national level*** is being operated from the national TV channel, where marketing of an SH clinic and its services are promoted through TV spots. Three of such spots so far been developed and aired.
- ***Marketing through community media:*** Enter-educative (combining entertainment and education) electronic materials (TV drama serial, health song, TV spots) have been developed and sent to the NGOs to broadcast through local cable TV. All these materials promote the SH clinic and its services. Local cultural groups, folk talents and local newspapers are also used for

[35] Hamid and Derriennic. 2015. "Provider-Based Prepayment Feasibility Study: Health Service Costing Methodology (draft)." Health Finance and Governance Project (HFG), 2013.

[36] While the HFG 2013 Abt Associates study did not show any association and does not support the assumption that price increases result in decreased use of antenatal and postnatal care, it is important to note that this study looked at one well-established NGO, located primarily in urban areas, with three EmOC clinics, one of which is the highest volume clinic in the network. This was a small sample taken in urban areas and not representative of the country.

[37] Office of Inspector General. Audit of USAID/Bangladesh's NGO Health Delivery Project. Audit Report No. 5-388-15-006-P, August 26, 2015.

[38] Note: The team did not examine the new independent pharmacy model.

these promotions. SH health fairs have become a good way of comprehensive marketing for clinic, service and service providers to establish SH as a quality health service brand.

- ***Local clinic service marketing*** is being done through community outreach activities, including promotional meetings, distribution of communication materials promoting clinic and services, advocacy meetings with local professional groups and engaging CSP/SH Community Support Group (SHCSG) leaders for household-level promotions.

The Phase 2 team found that cost-recovery improvements are being made through controlling costs and increasing revenue flow by expanding service and increasing the number of customers. In each budget phase, NGOs propose equipment and assets, including clinic expansions, to improve cost recovery. The proposed changes are reviewed and justified before budget allocation and incurrence. NHSDP has general guidelines for the NGOs and sometimes gives specific guidelines for proposing such expansion during the budget phase. The SH Clinic Management Guidelines contain instructions on facilities, laboratory room and layout requirement of the clinics (pp. 11–20). The Quality Monitoring and Supervision guideline contains quality assessment information on laboratory services (p. 16). The NHSDP Technical Team reports that equipment requirements are reviewed during the rationalization process and approved accordingly. NHSDP does not report on these services, but data on their extent, location and potential for cost recovery may be available from individual NGOs.

**Partnering with the GoB in subcontracting and financing schemes:**[39] Various MOHFW officials stated that there are small-sized (10–50 bed), government-established hospitals that are not functional due to a shortage of management and staff. According to USAID/Bangladesh, an expression of interest was released to ascertain interest of NGOs in being subcontracted to provide management and clinical services to these government facilities; a number of NGOs have responded, but to date, the GoB has not made a further announcement. Phase 2 discussion with the MOHFW revealed that further investigation is needed to determine how this might be done; submissions are under review and there will be an award announcement shortly.

The GoB Health Care Finance Strategy 2012–2032 provides a structure for developing and implementing health financing in Bangladesh.[40] Under its medium-term strategy (2016–2021), the social health protection scheme will be scaled up. Bangladesh's demand-side financing (DSF) scheme entails a cash subsidy to pregnant women to cover transport to a facility for ANC, institutional delivery and postnatal care and to purchase medicines, with payment on a reimbursement basis to be provided to service providers.[41] As part of a small pilot, approximately 12 NHSDP-supported SH clinics are partnering with the government on DSF, and there is opportunity to expand this pilot to other clinics.[42,43]

**Behavior change communication's (BCC) role in cost recovery:** As requested by USAID, the Phase 2 team examined BCC activities and found that they help increase the numbers of customers, leading to a potential increase in clinic revenue and cost recovery, although data do not exist to show the isolated impact of BCC on cost recovery as it is an aggregated result. BCC has included capacity-building training (for example, interpersonal communication (IPC) for counselors and service promoters) and informational and motivational materials such as leaflets, brochures, a booklet, and job

[39] Also refers to evaluation question 3.

[40] "Brief: Expanding Social Protection for Health: Health Care Financing Strategy 2012-32."

[41] Center for Health Market Innovations, 2015.

[42] Because this is only for delivery, only limited clinics are available. NHSDP has been trying to increase the numbers and will continue to engage in this advocacy.

[43] See www.lcgbangladesh-blog.org for additional information on GoB financial schemes.

aids (e.g., flipcharts). At the community level, BCC includes provision of guidelines to clinics for local advocacy meetings, community meetings and health fairs. Community mobilization also creates awareness, which results in increased customers.

## EVALUATION QUESTION 2: WHAT HAVE BEEN THE SUCCESSES AND LIMITATIONS OF NETWORK EXPANSION, ESPECIALLY FOR KEY ESP SERVICES: FP/RH, ANC, DELIVERY, CHILD HEALTH AND NUTRITION?

### Essential Service-Delivery Quality and Standards

**Performance on targets and milestones:** NHSDP's performance is monitored by tracking progress on indicators and milestones. Phase 1 analysis of cumulative performance data reported by NHSDP finds that the project has met its midterm target of 55 percent on 12 of 19 key indicators (Annex III).[44] Progress is on track for all but a few of the 24 milestones.[45,46] However, as the mission has pointed out, progress on targets may not increase in a linear fashion. Improvement may be expected to accelerate more quickly for some after certain interventions are fully implemented.[47]

The most significant areas of progress have been in prescribing pregnant and lactating women 30IFA (85 percent), vitamin A supplementation for children under 5 through U.S. Government-supported programs[48] (71 percent), immediate support for newborns within 72 hours[49] (71 percent) and postnatal care within 48 hours of childbirth (60 percent) (Annex III).[50] NHSDP's technical support for maternal and child nutrition services–including nutrition counseling, developing capacity of service providers in newborn care, comprehensive newborn care training, introduction of a revised essential newborn care checklist, and collaboration with the GoB and other partners (i.e., Concern International)–has strengthened performance in these areas.[51]

Progress on deliveries by skilled birth attendant (SBA) has been mixed (Annex III). SBA home births increased 39 percent between the first two years, 66 percent between years two and three, 129 percent between years one and three, and 349 percent over the project baseline, all of which are clearly strong, positive developments. However, with the additional 33 clinics capable of performing C-sections that were added to the network, C-section deliveries grew at a faster pace–35 percent, from 8,156 to 10,984–compared to normal facility births, which increased 16 percent, from 15,249 to 17,614, in the same period.[52,53] These rates are in line with national trends. In project year three, about half of SBA deliveries were SBA-attended facility normal deliveries, 31 percent were facility C-sections, and 18 percent were home births. Only 42 percent of deliveries in Bangladesh are assisted.

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[44] NHSDP Performance Indicator Report Life of Project, November 11, 2015.

[45] NHSDP Milestone Tracking Sheet, October 2015.

[46] NHSDP Year 3 Annual Performance Report, October 2015.

[47] USAID NHSDP COR Comments on Draft Phase 1 Report, March 14, 2016.

[48] This is dependent on GoB's National Immunization Days, as USAID uses the GoB's supplies. Success here depends on the GoB.

[49] This is a DFID indicator. Both the GoB and U.S. Government use 48 hours.

[50] NHSDP Performance Indicator Report Life of Project, November 11, 2015.

[51] NHSDP Year 3 Annual Performance Report, October 2015.

[52] NHSDP CYP by Method and Delivery, November 19, 2015.

[53] Disaggregated delivery data at baseline was unavailable.

Contraceptive rates as measured by couple-years of protection have stagnated (Annex III),[54] mirroring national trends, including the number of injectables provided, where annual progress has been subpar (Annex III). Sixteen clinics are pending approval by the District Technical Committee, and until then, they are ineligible for GoB commodities; commodities were delayed or provided in insufficient quantity to clinics; and paramedics need to receive IUD training.[55] Roving teams of service-delivery experts were deployed to increase long-acting and permanent methods (LAPM) in year three and will be continued in year four.[56] These teams are funded by another USAID project and also service GoB sites with no trained provider; NHSDP also provides a location for services where there are no trained staff, meeting both project purposes. NHSDP collects interested patients and has them come on the selected day.

At 47 percent, nutrition (infant and young child feeding counseling and under-5 growth monitoring) and adolescent/youth access to RH services lag below the midpoint target of 55 percent, although some of this is due to a slow start, (i.e., no progress in the first year). Treatment of childhood pneumonia with antibiotics and ANC first and fourth visits lag slightly, between 52-54 percent. Progress for gender mainstreaming (milestone 8) has been much slower than planned and is now more than a year behind due to NGO budget constraints, political unrest and challenges related to internalization of gender sensitivity and practices by NGO and clinic staff.[57,58] Slow performance in nutrition, gender and adolescents is attributed to these areas being new to this iteration of the project; staff have been on a learning curve before advancing with partners and clinic staff.[59]

Coordination with select urban governance bodies to improve urban health governance to provide needed services has not yet been achieved; a draft memorandum of understanding has been shared with the Urban Primary Health Care Services Delivery Project for final comment and approval.[60,61] The reasons seem to be the lack of a bureaucratic process to move the effort forward and some lack of political will on the part of the GoB. Further discussions between USAID and GoB ministries could create a better understanding of how this might be improved.

NHSDP has been working in the Chittagong Hill Tracts and is exploring the potential to extend services through partnerships with other organizations already working in the region, such as UNDP.[62] Performance data from this region (Annex III)[63] indicate significant uptake of certain services, such as SBA deliveries, which would be important to validate through monitoring visits. Expansion of select services should have been completed by year two and therefore is overdue for several reasons: (1) relatively few NGOs are willing or able to work in these remote, hard-to-reach areas with local government approval, and (2) although funds were made available, details of the UNDP collaboration were to be developed in consultation with USAID.[64]

**NHSDP performance data:** NHSDP's IR 1 stipulates expansion of the client base, with total service contacts as a proxy indicator. The NHSDP database shows that the project conducted more than 32

[54] NHSDP, Couple-Years of Protection by Method & SBA Deliveries, November 22, 2015.

[55] Note from FP/Adolescent Sexual and Reproductive Health Advisor, November 23, 2015.

[56] NHSDP Year 3 Annual Performance Report, October 2015.

[57] NHSDP key informant and group interviews with NHSDP ESP unit staff.

[58] NHSDP Year 3 Annual Performance Report, October 2015.

[59] Phase 1 team key informant and group interviews with NHSDP ESP unit staff.

[60] NHSDP Milestone Tracking Sheet, October 2015.

[61] Phase 1 team key informant and group interviews with NHSDP staff.

[62] NHSDP Year 3 Annual Performance Report, October 2015.

[63] NHSDP, Health Delivery Service Distribution in Chittagong Division, December 7, 2015.

[64] NHSDP comments on draft Phase 1 report, February 1, 2016.

million service contacts (individual visits to NGO partner clinics) during its second year and 39 million in the third year. (See Annex III for more information on the MIS Access database and reporting procedures.)

**Poorest of the poor (POP) identification criteria:** NHSDP has five specific identification criteria for the poor and POP for rural and urban locations (Annex III). At least 35 percent of the selected service contacts in categories that achieved the target ratio were provided to the poor category during the project's first year; these reached 43.4 percent in July 2015. The target of 40 percent coverage of poor with service contacts was exceeded in year three by NHSDP-supported NGOs (Annex III). (NHSDP data did not allow the service contacts to be disaggregated by poor and POP categories for the life of the project.) Based on the aggregated data of the 25 NGOs, 58 percent of the clients are non-poor, 35 percent poor and 7 percent POP (Table 7). The percent of POP clients provided services by the NHSDP-supported NGOs ranges between 1 and 15 percent. This is because the definitions changed when DFID funding was negotiated. USAID had only been tracking poor clients; DFID wanted to separate the poor and POP.

**Table 7. NGO coverage of clients by economic status**

| Statistics | Poor, Excluding POP | POP | Non-Poor |
|---|---|---|---|
| Range | 20%–44% | 1%–15% | 45%–72% |
| Mean | 35% | 7% | 58% |
| Median | 36% | 6% | 59% |

*Source:* Computed from NHSDP data (October 2014–September 2015).

One of the NHSDP mandates is reaching a 40 percent target for service contacts who qualify as poor. The Phase 2 team found that, following the pro-poor system implementation, three types of categories of cards are provided to clients: the Least Advantages card for POP; Health Benefit card for the poor; and Family Care card for clients able to pay. Under this system, the poor receive subsidies, and POP are fully free from cost. For this reason, the pro-poor guideline has clear and well-defined criteria of the poor and POP; clinics are also collecting data separately for the subsidization of each category.

Reports are generated per indicator needs. USAID has a mandate of services to the poor only, so reports provided to USAID combine poor and POP data.

### Factors Affecting Performance

**Management and leadership**: Having a centralized project leadership emerged as a common theme during interviews as a factor that directly affected ESP unit performance in several ways:

- Leadership instability in the project, as evidenced by the change in DCOP/Service Delivery position three times in as many years, left critical gaps in coordination and information for monitoring service quality.
- The Phase 2 team found that adjustments to staffing and redefining of staff roles since Phase 1 had dramatically improved the management of the NHSDP team, resulting in increased productivity and communications.
- While the Phase 1 team found that subcontractor skills and resources had not been optimized to the project's benefit–particularly senior management roles such as the DCOP/Service Delivery, which was not provided sufficient access to in-depth project reporting information and resources to fulfill its senior project management and technical leadership role–the Phase 2 team found that the installment of the new DCOP/Service Delivery (shortly before the start of Phase 1) had resulted in increased access to information and resources at the time of Phase 2.

**Internal project coordination:** During Phase 1, interviews with numerous NHSDP staff revealed that the project's various units tended to operate independently rather than collaboratively,[65] which hindered the effective flow and usage of information for project implementation. The Phase 2 team, however, found that new leadership and adjustments to management techniques had greatly improved opinions of NHSDP staff about the status of project coordination. For example, the M&E unit regularly generates tremendous amounts of data, which the ESP unit is increasingly using to improve project performance. Through extensive discussions with both teams and verification of shared data, the Phase 2 team found that information sharing has greatly improved since the Phase 1 team's departure. Continued monitoring of the sharing and utilization process is needed between the ESP and M&E units.

**Staff retention/training:** The ability of clinics to recruit and retain staff who require specialized training, such as doctors and paramedics, was found to be a significant issue, as discussed by key informants and by staff during clinic visits. Several GoB key informants mentioned that this issue affects all players; this is confirmed by USAID.[66] A MOHFW official pointed to a lack of LAPM skills in SH clinics. In the SH network, training has been limited, and most clinic staff interviewed by the Phase 1 team had not received training from NHSDP due to rapid staff turnover.[67]

**Quality monitoring** is implemented by NGO monitoring officers; however, partners managing less than 10 clinics are not staffed with a monitoring officer. For this reason, the 2015 rationalization exercise established an ideal range of no less than 10 and no more than 30 clinics per NGO to maintain quality standards for the SH network.[68]

The Phase 2 team found that NHSDP clearly instructed NGOs that if they have five or more clinics, they must have monitoring officers, and they will continue quality monitoring and supervision visits by these officers. If they have less than five clinics also they will continue quality monitoring and supervision visits by the project director or project managers to maintain quality service delivery. They are also required to submit regular reports on the visits. Unfortunately, there was not enough time to verify that these requirements are adhered to.

**Manuals, guidelines and job aids:** Although a multitude of manuals were found at the clinic level, some were from predecessor projects with differing guidance, which could be confusing for providers, and the manuals available appeared to be substantial in size and not easy for quick reference. In one case, the Phase 1 team saw a reference binder created by copying or tearing out the most useful pages from various sources for easier use.

Phase 2 found that, according to a USAID deliverable, NHSDP developed clinic management guidelines in English and Bangla and distributed them to all NGOs, and 376 clinic managers received orientation on those guidelines. A Bangla translation of the guidelines was later completed and sent to the NGOs for implementation in the field.

**Gender:** Key informants interviewed in Phase 1 showed limited understanding of gender's relevance to the project. Most think gender is about women and girls only, missing the role men play in decision-making at the household and community levels. Clinic staff seemed much more aware and attentive to meeting the needs of women and girls facing gender-based violence, although they reported that most

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[65] NHSDP comments on draft Phase 1 report, February 1, 2016.

[66] USAID NHSDP COR comments on draft Phase 1 report, February 1, 2016.

[67] USAID/Bangladesh commented that NHSDP has trained key members of NGOs to serve as trainers, and their job is to cascade the training to the clinics. For example, PD trains all clinic managers at a monthly meeting in clinical services, then the clinic managers train their staff in their staff meetings on a weekly/monthly basis.

[68] NHSDP Rationalization Workshop Year 3, August 19–20, 2015.

patients who are victims do not typically pursue filing cases against perpetrators. In a country where gender-based violence is pervasive, this awareness is a step in the right direction.

**Urban health coordination:** A lack of effective coordination mechanisms between municipal and city corporations and the MOHFW due to a lack of clarity on jurisdictional authority and related limited funding for urban public health has led to service duplication and low utilization in some urban clinics. Phase 1 interviews with local government and health officials confirmed the considerable lack of coordination among service providers. However, the 2013 Urban Health Survey observed that NGOs are the major providers in slum areas and are making significant contributions in urban health improvement. On the initiative of the development partners supporting urban health activities (ADB, DFID, SIDA, EU, etc.), an urban health strategy has been developed to address the long-standing issues. MOHFW recently conducted a review to identify the gaps in ESP service delivery in urban areas and made recommendations. Given that more than half of NHSDP-supported clinics–205 of 388–are located in urban areas, this is a significant issue for both USAID and DFID. NHSDP is playing a key role in advocating improved coordination between the Ministry of Local Government, Rural Development and Cooperatives and the MOHFW.

NHSDP is a key partner of the National Tuberculosis Program and the urban TB control program, and its contribution is significant in terms of case detection and patient management.

**Community service providers (CSPs):** There are 7,321 CSPs serving 388 static SH clinics and 777 service promoters working in both rural and urban areas. The present terms of reference list 28 tasks for CSPs, many of which require documentation. Data on the total number of patients receiving CSP services were not available. CSPs receive an honorarium of less than Taka 1,000 monthly. Phase 1 field visits to SH clinics revealed that CSPs are also eligible to receive a commission for bringing clients to the clinics. This commission comes from revenue generated from selected services offered to non-poor and poor (not POP) clients. For instance, if laboratory or imaging services for a C-section are performed, the CSP receives a certain percentage of the fees charged. The compensation level varies by clinic. NGOs determine the fee based on the total package. Both the honorarium and a commission are part of the pay. This compensatory arrangement encourages the CSPs to identify and refer clients who will pay for services. However, clinic managers stated that reaching out to the POP patients offers no commission to the CSPs as POP are not charged for services. Such an incentive arrangement can have a perverse economic incentive whereby CSPs are encouraged to bring clients that are expected to pay and not to bring POP into SH clinics. The poor pay of CSPs, combined with a wide range of responsibilities, can affect accountability and delivery of services and requires a reconsideration of the current salary structures and adjustments to better match the current economy.

**Role of BCC:** The Phase 1 team evaluated the role of BCC in the following project components:

- **The ANGEL Initiative** is an excellent venue for addressing adolescents and young adults. BCC studies and strategies should be an important component of this initiative to inform the planning and evaluation of its activities. This initiative is operated under the service-delivery component by the FP/adolescents sexual and reproductive health advisor, who was not involved in the project's BCC strategy design process.
- **Service delivery** to ensure consistency of messages and inclusion in the clinical management guidelines and job aids used by the providers in every client-provider contact opportunity: A review of the latest draft of the project's clinical management guidelines showed that there is not enough consideration of all messages listed in the BCC strategy for different audiences during different types of service contacts that SH clinics provide.
- **Quality assurance:** NHSDP invested in strengthening providers' skills and competencies required for client satisfaction and effective client-provider interaction through continuous

assessment of their skills and knowledge, interactive training on IPC/C skills and information and technologies that are related to services provided, and equipping them with job aids.

- The project's **social marketing component**, which is currently limited to pharmacy outlets, is neither coordinated with nor informed by the BCC strategy. The business initiative specialist was not involved in the BCC strategy development nor aware of its components. On the other hand, the BCC strategy did not consider social marketing as an important component to package, position and market SH services and portray the competency and friendly attitudes of service providers.

Interviews with the BCC team and review of the project's annual plans and reports revealed that the role of BCC and marketing baseline, formative and operational studies in informing the design, implementation and evaluation processes of the BCC strategy, activities and materials is unclear. Most of the studies conducted are limited to field-testing the BC materials before finalization and production to ensure clarity, accuracy and appropriateness. In addition to field testing the BCC materials, the NHSDP BCC team used relevant studies done under the previous SSFP and other projects to inform the development process of BCC materials and activities.

According to the NHSDP third annual report, increased community satisfaction with SH clinic services has not yet been adequately measured; this is planned for year four. The Phase 2 team found that NHSDP has implemented a number of interventions to address quality from the start of the project. Quality assurance systems in place from earlier project cycles were continued and improved across the SH network. During the past year (starting from around the time the Phase 1 team was on the ground), the quality management and supervision system has been extensively reviewed, revised and improved. This is an ongoing process, documented in quarterly reports for the second and third quarters of year four. Quality services are being ensured (see Annex II: Quality Monitoring and Supervision Guidelines).

It should be noted that client satisfaction is recognized globally as a difficult thing to define and measure. There are no universal standards for how to approach this issue. NHSDP has approached this from varied perspectives (e.g., client exit interviews, mystery client, focus groups, standing item on the agenda of SHCSGs). The assumption is that client satisfaction is not necessarily an indicator of quality or of successful service provision. The SH network continues to meet or exceed nearly all its service performance indicators. There appears to be a link between what NHSDP is doing with regards to establishing for-profit, women-friendly pharmacies and what it is doing in terms of BCC, and they are closely connected and coordinated in terms of branding and promotional activities.

The core indicators that USAID requires the project to report on are largely focused on service statistics. Quality measurements were not built into the core reporting requirements. NHSDP is working to improve the ability to measure and report on quality.

**Knowledge, attitudes and practices and other client studies**: A knowledge, attitudes and practices study was not done in NHSDP or in predecessor projects. However, the project designed and conducted a mystery client study to assess the provider behavior and quality of counseling based on client satisfaction. The study results show that more than 75 percent of respondents found overall clinic services to be satisfactory or good; and more than 60 percent found counselling satisfactory or good. While the majority of clients are satisfied, there is plenty of room for improvement (for example, addressing clients' long waiting time, increasing the client-provider contact time and improving the waiting room educational activities).

Within its quality improvement activities, NHSDP asked the clinic managers to conduct regular exit interviews of SH clients (10 interviews per clinic per month) to assess quality aspects of services provided, as a part of quality monitoring and supervision. Overall satisfaction of clients interviewed is

about 90 percent. This endeavor by facility clinic managers could lead to *positive skew bias* with more satisfactory responses compared to unsatisfactory.

Although the purposes of mystery client assessments and exit interviews are similar, there was limited coordination between the service-delivery and BCC project components responsible for the two, respectively, in terms of their design, implementation timing, and how their outcomes will be used in informing quality assurance activities. This is another example of the limited coordination between project components and shows how BCC is not envisioned as an integral crosscutting approach. Further, there are no similar baseline data to compare the results of these two studies to assess impact.

The project's BCC strategy is a comprehensive and well-designed document to inform BCC strategies and activities for providing information, promotion and education and for stimulating positive behaviors among project beneficiaries. However, the strategy did not consider social marketing as an important component to package, position and market SH services and portray the competency and friendly attitudes of service providers.

Interviews with government officials, project management, clinic staff, and NGO-SH project managers and a review of the major results of the mystery client and exit interview studies indicated that the service providers' friendly attitudes and competencies are the main points of difference that distinguish the market niche for SH services versus services provided by the government and private sectors.

Pathfinder headquarters[69] is reluctant to accept the idea of including marketing approaches within the strategy and asked the team to focus mainly on community engagement and mobilization through the role of BCC in providing information and promoting healthy behaviors and care-seeking practices.

The Social Marketing Company subcontract agreement was terminated in October 2015. The Social Marketing Company was responsible for designing initiatives to increase the program income of an NGO/clinic through profits earned by establishing a network of profitable pharmacy outlets under the SH umbrella with standardized product offerings, prices and service guidelines, common signage, and advertising and promotion to create awareness and generate more customers. Currently, the new business initiative specialist recently recruited by the project is working on updating and executing the Social Marketing Company plan. The specialist came from the Social Marketing Company and is considered a source of continuity for the pharmacy initiative. He reports to the DCOP and is not part of the BCC team. He was not involved in the BCC strategy development process and is not aware of its finalization or its major components.

The delay of a couple of NHSDP subs in fulfilling their plans and deliverables, limited room for subs' engagement with other project components in planning and implementation, and the types and frequency of the required reports submitted to Pathfinder and USAID make quantitative reporting a priority of the project management with less focus on qualitative outcomes, such as innovative ideas, best practices and lessons learned.

Because they were driven by the numerical indicators, the project management limited use of the subcontractors' skills and resources and placed an emphasis on IRs and their numerical milestones as the major driving force for the project activities' planning and implementation. As a result, there was limited room for innovations and creativity in exploring non-traditional options to improve quality and increase the SH clinics' revenue to ensure sustainability beyond the life of the project.

The project is on track for the eight milestones of IR 2. However, field visits to clinics and interviews conducted with project directors and clinic managers and staff revealed the following:

[69] According to the Phase 1 team's discussions with the BCC teams

- Field visits to five clinics showed that some counselors have not attended any IPC/C training (either by the respective NGO or the project) despite being in their position for more than five years. In some clinics, as the counseling responsibility is not clearly assigned, more than one person is assigned as a counselor or the counselor is assigned by the clinical manager to do other duties. The team found that other counselor duties are not well defined; assisting the clinic manager with administrative support is the broader role, along with data entry (that does not leave enough time for counseling) and assisting in the pharmacy. Availability of the same counselor would strengthen the client-provider relationship and client loyalty to services provided.
- The TVs/DVDs in the waiting area of visited SH clinics are not used regularly to display the health messages that NHSDP produced, or obtained from BCC communities of practice, and disseminated. At the five clinics that the Phase 1 team visited, the TVs/DVDs either have technical problems or are used to display commercial or entertainment programs. Waiting for services is an excellent opportunity to expose the SH clients to educational and awareness-raising messages.
- Clinics still use the old SSFP brand and not the NHSDP brand on some of their materials, such as the ambulance and posters.

However, revisions of the training plans and interviews with NGO and clinic staff show that the project has made extensive efforts and investment in developing guidelines/protocols and in conducting training programs, mainly for clinic staff, either directly or through training trainers from project staff of each NGO to cascade training to the clinic staff.

The magnitude and content of the clinical, technical and organizational training, coaching and supervision received by clinic staff and NGOs from the project, along with the cumulative experience built over years through former similar projects, have prepared a solid ground and increased readiness among these NGOs to be more receptive and effective in the future in planning and implementing interventions to ensure sustainability and more coverage.

### ESP Management

The ESP unit's technical assistance approach has been challenging to implement because the clinics for each NGO are in different parts of the country, and each technical lead is responsible for supporting all ESP services, including in areas where they are not the technical lead.[70]

The revised clinic-monitoring checklist was found to be useful in assessing SH clinic quality and was one of the tools that the Phase 1 team used. Clinic data, however, were found not to be accurate due to data entry and other errors and reports of misclassification of clients[71] related to the project's performance-based incentive system, among other reasons. Examples include instances of misclassification of clients who are not POP or poor yet received free or low-cost services, and of some POP being misclassified as non-poor and being charged for services. Project staff are working to correct this problem (whether intentional or by misunderstanding) by identifying and addressing these discrepancies during monitoring visits. Effectiveness of the updated clinic guidelines could not be assessed because they were in the process of being distributed during Phase 1; however, the Phase 1

[70] Phase 1 key informant and group interviews with NHSDP staff, October–November 2015.

[71] Information on this was gathered during interviews with the project and in the review of documents. While sometimes described as "fake clients" in project documents, including the rationalization workshop presentation, it may be better described as misclassification of clients, and it is still clearly problematic. ESP staff were found to be skeptical of data reported by the NGOs and said they were working on rectifying this issue with them. *Sources*: NHSDP Rationalization Workshop Year 3, August 19-20, 2015; Phase 1 interviews with NHSDP staff.

team was given the updated clinic guidelines, which clearly define the POP and poor (see Annex IV for the Poor and POP Guidelines–Bangladesh).

## EVALUATION QUESTION 3: GIVEN THE REVISIONS TO NHSDP'S SOW SINCE THE CONTRACT WAS AWARDED DUE TO INCREASE IN TOTAL FUNDING, ASSESS PROJECT-LEVEL PERFORMANCE ISSUES, IDENTIFY DEFICIENCIES AND PROPOSE STRATEGIES FOR IMPROVEMENT, TAKING INTO CONSIDERATION THE LIMITED TIMEFRAME FOR IMPLEMENTATION.

The Phase 1 team found that the rationalization in site selection of health service provision by NGOs, government and the private sector, particularly in the urban areas, is a concern of government policy makers and can be addressed jointly. The limited coordination across the health sector supports significant information-gathering but does not eliminate oversupply of services in some areas and limited services in others. NHSDP clinic sites were initially assigned in areas where the GoB had weak infrastructure and could not post staff; this decision was made mostly for distribution of government services (FP and Expanded Program on Immunization (EPI)).

To address a lack of coordination and planning between the GoB, NGOs, private health service providers and development partners, an inter-ministerial committee of eight ministries to support and expand NHSDP health services has been created. NHSDP is mandated to ensure strengthened partnerships and coordination with GoB health authorities and other USAID-supported projects (IR 1.2). The Phase 2 team found that the MOHFW formulated the Inter-Ministerial USAID-DFID NHSDP Advisory Committee to leverage existing project resources and enhance its closer collaboration with other ministries and USAID-funded NGOs. The committee will provide strategic direction to providing services to underserved populations, which other ministries address.

Under the MOHFW's leadership and ownership, eight ministries are NHSDP Advisory Committee members: Ministry of Local Government, Ministry of Women and Child Affairs (MOWCA), Ministry of Social Welfare (MOSW), Ministry of Information, Ministry of Disaster and Rehabilitation, Ministry of Youth, and Ministry of Hill Tracts. In addition to the ministries, 12 international and national NGOs are also members.

This committee creates ownership and strong bonds with the eight ministries and GoB departments, led by the MOHFW. It is creating ownership through the following collaborative activities:

- Publicizing the NHSDP serial drama "Enechi Surjer Hashi" through the Directorate of Mass Communication of the Ministry of Information, through mobile vans at the community level.
- Ministries are working with the NHSDP to celebrate international and national days, such as World Population Day, Women's Health Day and Safe Motherhood Day.
- The committee contributed to publicizing SH services through the Information, Education, and Motivation Unit of the MOHFW Directorate General of Family Planning (DGFP). TV scrolls nationwide suggest the benefits of receiving care from SH side-by-side with public facilities.
- The committee advises on the creation of linkages with district and upazila-level offices of the respective eight ministries to encourage their involvement in the local planning process to leverage resources.

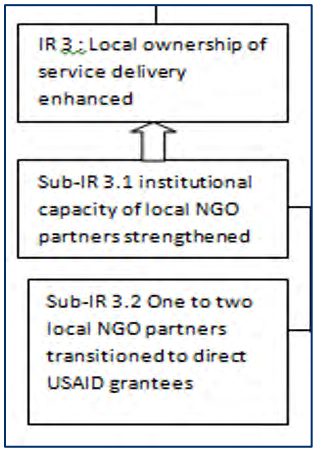
NHSDP benefits from this advisory committee in the following ways:

- **Gateway platform:** This committee serves as a gateway platform to increase collaboration and leverage existing resources of other ministries for service-related benefits.
  As these ministries are mandated to provide benefit packages related to health services for people with special needs, the SH clinics can ensure these services to the beneficiaries.

- **Increase in coverage:** The coverage of the NHSDP network increases by providing services to those populations that receive allowances, for example, pregnant or lactating mothers or the mentally or physically disabled who receive allowances from the MOWCA and the MOSW. A letter of collaboration was signed with the MOSW and with the Directorate of Youth to provide services.
- **Enhancing credibility:** The committee enhances the credibility of the NHSDP with other ministries and creates an environment of greater ownership of SH clinic services.
- **Facilitating the approval process:** The committee facilitates approval for the processes of the SH network countrywide (District Technical Committee, comprehensive emergency obstetric care (EmOC), lab, model women-friendly pharmacy, etc.) and sustainable supply logistics (FP, EPI vaccines, iron-folic acid, vitamin A, anti-helminthic).

## EVALUATION QUESTION 4: WHAT SUCCESSES (BEST PRACTICES) AND SHORTCOMINGS (LESSONS LEARNED) HAS NHSDP HAD REGARDING BUILDING/STRENGTHENING NGO CAPACITY?

**Figure 3. IR 3**




After reviewing multiple NHSDP documents and interviewing NHSDP staff, NGO project directors and boards, government officials, and others, the Phase 1 team found that the institutional capacity of local NGO partners had been strengthened (sub-IR 3.1). These activities were reported in NHSDP's various documents.

NHSDP's initial NGO baseline capacity assessments were a major achievement. With extensive technical support from Pathfinder headquarters, NHSDP's institutional strengthening unit initiated the multifaceted assessments. Starting with an in-depth desk review, NHSDP combined data from previous assessments.[72] The institutional strengthening unit also conducted nine NGO focus group discussions to identify issues and developed a SWOT tool for self-assessment of the 25 NGOs. These best practices and tools supported the compilation of NGOs' baseline status. The institutional strengthening unit reviewed and analyzed the results and shared the report with the NHSDP senior management team, the NGO Council and USAID. The findings of this very intensive capacity-assessment phase were synthesized to establish a numerical and narrative baseline status of the capacity of the 25 NGOs (Table 8). Scoring from the baseline assessment was presented in a May 25, 2013 meeting to the NGO Council (see Figure 4 for a summary and Table 14 in Annex III for details per NGO).

[72] SDP MOCAT End-line (2007), SFP Baseline (2011), SSFP Institutional Strengthening Plan for 10 NGOs (2012), Pre-Award Assessment of NGOs (2012), and NHSDP and SSFP's Baseline Capacity Score (2012).

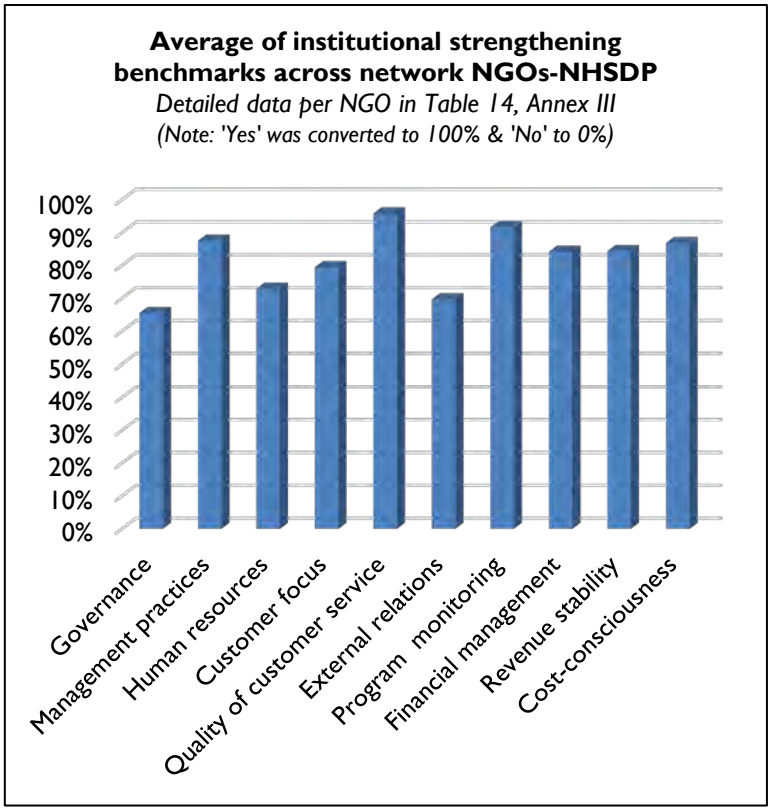
**Table 8. MOCAT scoring**

Baseline Position of NGOs
(Adapted MOCAT Score 2013)

| NGOs | Classification | MOCAT Score | NGOs | Classification | MOCAT Score |
|---|---|---|---|---|---|
| 1. PSTC | Expanding | 2.33 | 14. VFWA | Emerging | 1.78 |
| 2. Swanirvar | Expanding | 2.24 | 15. Kanchan | Emerging | 1.76 |
| 3. VPKA | Expanding | 2.22 | 16. SSKS | Emerging | 1.71 |
| 4. FDSR | Expanding | 2.20 | 17. Proshanti | Emerging | 1.70 |
| 5. JTS | Expanding | 2.20 | 18. Tilottama | Emerging | 1.67 |
| 6. BAMANEH | Expanding | 2.20 | 19. Shimantik | Emerging | 1.67 |
| 7. SGS | Expanding | 2.15 | 20. UPGMS | Emerging | 1.63 |
| 8. Bandhan | Expanding | 2.04 | 21. IMAGE | Emerging | 1.62 |
| 9. CWFD | Expanding | 2.04 | 22. SUS | Emerging | 1.57 |
| 10. Nishkriti | Emerging | 1.96 | 23. CRC | Emerging | 1.52 |
| 11. PKS | Emerging | 1.91 | 24. PSF | Emerging | 1.27 |
| 12. SOPIRET | Emerging | 1.91 | 25. KAJUS | Emerging | 1.25 |
| 13. PSKS | Emerging | 1.80 | 26. SUPPS | Emerging | 1.04 |

USAID | NGO Health Service Delivery Project

**Figure 4. Averages of institutional strengthening benchmarks across NGOs**




This major successful assessment phase took place early in the first year, with individual NGO road maps dated June 2013. The 10 major areas of the road maps included: governance, management practices, human resources (HR), customer focus, service quality (or quality of customer service), external relations, programming and monitoring financial management, revenue stability, and cost consciousness. The Phase 1 team's review found that the road maps for each NGO contained some specific and different needs; however, many of the capacity gaps identified were similar across the 25 NGOs. Many NGO road maps noted the need for NHSDP technical assistance to meet benchmarks for completion in FY 2013-2014. After the road maps were developed, NHSDP conducted an additional assessment using an adapted Modified Organizational Capacity Assessment Tool (MOCAT) methodology to identify more in-depth NGO needs and reported out in 80-page MOCAT assessments/plans. Technical assistance to NGOs was planned as individual and group training, technical assistance, mentoring and phone support. The NGO road maps were to evolve based on additional information from the first annual MOCAT in 2014.

An internal document, "Summary of Institutional Strengthening Benchmarks," provides data on the status of NGOs' capacity-development activities at 2.5 years (September 23, 2015), using road map benchmarks (Annex III, Table 15).

The Phase 2 team found that, based on the results of the NGO baseline analyses, institutional strengthening benchmarks were developed for each of the SH NGOs. The purpose of these benchmarks was to provide a tangible way to measure NGO institutional strengthening progress, as well as to identify areas where project assistance would be required across most NGOs. A set of benchmarks for the network was developed based on the results of the baseline analysis, and then from that set, benchmarks appropriate to the individual needs of each NGO were assigned to them as part of their institutional strengthening road maps. These benchmarks were then updated as part of a July–August 2015 exercise to review progress and ensure alignment between benchmarks and priority project outcomes, as well as to reflect shifts in the budget as a result of contract modifications. Technical assistance related to these benchmarks was then mapped out as part of a project-wide integrated technical assistance plan, which reflected technical assistance targeted at both the NGO and clinic levels across all three NHSDP IRs.

The MOCAT assessment was conducted in the second year of the project. Initially, the plan was to conduct it every year; this timeline was changed to conduct the next one in the fifth year as the end-line MOCAT assessment to assess progress toward sustainability within the three pillars: institutional, programmatic and financial sustainability, including subcomponent areas. However, instead of the MOCAT, the NHSDP, with headquarters short-term technical assistance, developed an "Institutional Strengthening Verification/Validation Tool" for monitoring progress against institutional strengthening benchmarks of SH NGOs; the NHSDP has been implementing this tool on annual basis. The NHSDP institutional strengthening team is monitoring the progress of SH NGOs' capacity-building activities through a document review, periodic phone calls, records and reports against institutional strengthening benchmarks on a regular basis, and it provides technical assistance to the SH NGOs as needed. (See Annex II for the status of capacity-development activities.)

**Activities related to the team's recommendations**: In response to the Phase 1 team's recommendations, the Phase 2 team found that NHSDP had implemented a wide range of NGO capacity-building activities, including:

- Hiring a consulting firm to work on HR issues under the close supervision of the NHSDP institutional strengthening team
- Providing consistent technical assistance to SH NGOs to prepare a communication plan and document best practices
- Having SH NGO representatives regularly participate in GoB coordination meetings
- Placing increased emphasis on fundraising initiatives
- Fulfilling the male/female ratio requirement in the executive committee and NGO management
- Forming functional institutional strengthening teams at 24 SH NGOs
- Having the SH NGOs take initiatives to increase the numbers of new customers
- Conducting 24 governance, leadership and management refresher orientations for the executive committee members of the 24 SH NGOs and 24 leadership and management orientations for the NGO management team, project management team, promising clinic managers and administrative assistants of the NGOs
- Conducting an orientation on succession plan guidelines, best practices guidelines, stakeholder feedback mechanism, etc.
- Providing technical assistance on regular basis for capacity-development activities

NHSDP training was to be one of the major sources of capacity development support to NGOs. The Phase 1 team reviewed training data from various sources. Some courses included capacity development related to the road maps' 10 areas presented above; reportedly finance and administrative manager meetings and other trainings included capacity development.

Capacity-development training support demonstrated some weakness, such as differences between the number of trainings planned and provided. The amount and specific types of capacity-development training and relationship to the needs of a specific NGO's capacity were difficult to establish (Annex III).

The Phase 2 team found that:

- Most of the trainings related to capacity building were merged with other trainings to reduce time and costs. Although the training topic headings were different, NHSDP incorporated all contents/topics of the capacity-building training carefully, and this has been reflected in the training schedule. (See Annex III.)
- All 24 SH NGOs have opened three files for documenting activities related to capacity-building: one for all correspondence, one for institutional strengthening benchmark achievements, and one for documenting governance, leadership and management follow-up achievements. In addition, the NHSDP institutional strengthening team is maintaining the records and documents of capacity-building activities and support provided to SH NGOs that emphasize the tracking and documentation of IR 3 activities.

In an extensive documentation review, the Phase 1 team did not find significant NHSDP support for NMC development, although the Phase 2 team learned that this approach had been revised (see below). Phase 1 found that NHSDP's sustainability approach, as reported in the first annual report, was to directly "support NGOs to develop pharmacies, to conduct baseline assessments, to develop a transition plan for the two NGOs IR 3.2 and to organize three meetings of the NMC." The report provides extensive information on NHSDP's direct IR 3 activities with individual NGOs but no mention of coordinating the NMC. The second year's work plan defines 19 capacity-building activities for IR 3.1 and 10 for IR 3.2 but no activities for NMC development. The second annual report continues to describe capacity-development activities in detail for individual NGOs (3.1) and for two "transition" NGOs (3.2), but no NHSDP support to the NMC to build a vehicle for NGO sustainability at the project's end.

NGOs discussed the need for a mechanism to support sustainability. The NHSDP's opinion was that the "Bangladeshis could not form a council." In Phase 1 team meetings with NHSDP leadership, it was said that "Councils are difficult and political." USAID has more recently stated that it was "trying to look more holistically at sustainability beyond USAID support to NGOs." It was not clear to the Phase 1 team why NHSDP remained in the central position of technical assistance when NMC was defined as the sustainability option. After 20 years of USAID support to flagship health programs reportedly seeking sustainability, the NMC was not supported as a viable option. USAID and Pathfinder mutually agreed to remove the NMC as a requirement.

Upon review, the Phase 2 team found that the NMC approach has been revised. NHSDP stated that USAID is seeking something more than activation/development of the NMC as previously defined, and that they envision a broader and deeper role for an "apex body" and/or "umbrella organization" for the existing loose network of SH NGOs. A local consultant is currently being contracted to review and make recommendations for an apex, and this process is being closely coordinated with USAID.

The milestones related to the direct transition of up to two NGOs to USAID funding (sub-IR 3.2) were successfully met within the first six months. To assess the actions and consequences of the efforts, the Phase 1 team interviewed NHSDP, Pathfinder headquarters, and NGO staff and reviewed the after-action review report prepared as a Pathfinder headquarters in-depth review of the process. Some details

provided by NGOs, NHSDP and Pathfinder headquarters staff and the written report vary slightly, but information on the actions, lessons learned and eventual outcomes are essentially the same.

At the start of this effort, there was rapid project action and close collaboration between NHSDP, Pathfinder headquarters and USAID to identify one or two NGOs for eventual transition to direct USAID awards within the first six months of an award. Six of the larger NGOs were initially identified as potential candidates, partially due to their large number of clinics and services. Swanirvar and PSTC were selected, using organizational capacity assessment and pre-award assessment methodologies. The second assessment tool used was the non-partner assessment survey (a tool used by USAID); its methodology is focused on assessment of the NGO as an entity, not only the health project within the NGO.

To contribute to the success of the two NGOs in receiving direct USAID funding, after their selection, NHSDP and Pathfinder headquarters technical assistance, mentoring and coaching was intensified to address identified gaps and to strengthen the NGOs' capacities. This assistance was provided for the remainder of 2013 and into 2014. It was focused not only on the NGO's health staff but also involved their boards and executive levels. The NGOs were put through a simulated pre-award assessment process in May 2014 to strengthen their capacities to successfully compete in the actual USAID pre-award process. In August 2014, a month-long, intensive, hands-on mentoring session on proposal preparation was done with the NGO practicing its response to mock RFA and technical assistance feedback. Upon the RFA's release in late 2014, the two NGOs submitted their initial proposals with the assistance of NHSDP and Pathfinder headquarters. During proposal preparation, USAID conducted its own formal non-partner assessment survey assessment with the two NGOs.

Several weaknesses were recognized by NHSDP and the NGOs as the process advanced. In the process of questions and requests for further information from USAID, the NGOs' lack of familiarity with USAID's processes allowed them to assume that this was a definite, positive sign of USAID's interest and commitment to fund their proposal, and they responded to questions and met deadlines. Swanirvar was eliminated after the first round of proposals. In addition, during these crucial months, several major changes in the second NGO (PSTC) and NHSDP took place. A new executive director assumed the post at PSTC and reportedly changed the communications internally in PSTC and with NHSDP and Pathfinder headquarters, although he was familiar with the transition process, having served on the executive committee during the past year of the assessment and proposal process. The NGOs later discussed the issues of non-alignment within their organizations, roles and responsibilities of staff and boards, decision-making authority, and misunderstandings of the expectations of Pathfinder and USAID. Unfortunately, at the same time, there were major issues with the Swanirvar board, with significant internal conflicts that hampered unified decision-making. Within PSTC, the new executive director's takeover of the proposal process during its final stages of preparation, excluding the input of staff and other board members and the support from NHSDP, negatively affected the proposal quality.

With the timing critical, NGO staff struggled to more effectively engage their board to proceed with the transition process. During this crucial time, NGOs conceded that additional NHSDP support would have been valuable. The Pathfinder headquarters after-action report provides extensive Pathfinder headquarters and NHSDP internal review and documentation of the strengths and weakness of the process. Pathfinder shared this report with USAID.

In discussions with the Phase 1 team, the PSTC NGO staff reflected that the break in communications with NHSDP and Pathfinder headquarters was unfortunate but was due to executive decisions within the NGO. In addition, at this crucial time, with the delay of the release of the RFA and loss of the director of NHSDP's institutional strengthening unit, the NGOs' need for consistent support from NHSDP throughout the transition process was not fully met. However, the NGOs were generally positive, reflecting that they had successfully learned a great deal in the transition process, were

stronger internally, and that later a full analysis could prompt NGO leadership to recognize changes that can be made in the future for more successful outcomes. Generally, the NGOs recognized that the support from NHSDP and Pathfinder was effective, supportive and collegial. Finally, as a result of not receiving direct USAID funding, the NGOs experienced some difficult issues with restructuring budgets and the intense reporting requirements that resulted from returning to direct NHSDP funding. With the deletion of IR 3.2 in Amendment 9 in 2015, the direct transition of NGOs to USAID funding was cancelled.

**Needs defined by NGOs:** Discussions and e-questionnaires sent to solicit opinions of NGOs provided insights into their collaboration with NHSDP. NGOs were appreciative of the first year's assessments of capacity-building needs, the resulting road maps, and the training and technical assistance provided. On a Likert scale, NGOs rated NHSDP support effectiveness at 3.14 out of 5. When asked about their initial needs in 2013 in the road map's 10 areas, NGOs defined needs in all road map areas. Their responses to the Phase 1 team's e-questionnaire (Annex III) in terms of areas of support still needed, the NGOs responded that their primary capacity-development needs at midpoint were in implementing road maps, ambulance and vehicle support, staff salary and benefits, sustainability strategies and training support, but responses included a number of other support needs. When requested to identify challenges to strengthening their NGO's institutional capacity, responses varied among NGOs but included lack of knowledge to develop policies/plans, funding constraints, retention of staff/HR, strong collaboration with the GoB, and links with educational institutions, among others.

## EVALUATION QUESTION 5: WHAT SUCCESSES (BEST PRACTICES) AND SHORTCOMINGS (LESSONS LEARNED) HAS NHSDP HAD REGARDING DEMAND CREATION FOR SERVICE UTILIZATION AT NHSDP CLINICS?

Promoting and sustaining optimal healthy behavior across SH communities, clients, service providers and partners is a crucial NHSDP component that should cut across its different strategies and activities on different levels. Behavior change and marketing (BC&M) through BCC, community mobilization, social marketing and knowledge management should be appreciated and envisioned as integral components of the project's overarching strategy.

BC&M contributes to the four project dimensions of performance, as follows:

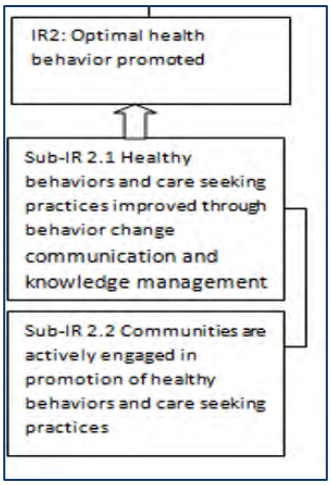
1. ***Coverage and uptake:*** Through community engagement, generating demand, marketing SH brand and quality, increasing service uptake and promoting healthy practices among SH clients and communities
2. ***Quality:*** Through increasing the effectiveness of the client-provider interaction, ensuring client satisfaction and establishing a culture of quality across different services provided
3. ***Equity:*** Through creating supportive social norms and attitudes that are conducive to delay marriage and childbearing, support reproductive and sexual health services provided to adolescents and young adults, and address gender inequalities;
4. **Institutional strengthening:** Through advocacy, policy review and establishing supportive organizational behaviors toward innovative approaches for sustainability.

NHSDP's current BCC component is led by a team of three specialized staff seconded from the BCCP. BCCP has extensive experience in a full range of services and technical know-how in BCC program design, development, implementation and M&E to foster positive health-seeking behaviors among the people of Bangladesh, especially the poor.

A community mobilization advisor (CARE position) was moved from the service delivery team to the BCC team to lead the community-based activities, which was recognized by the project management as an integral BCC component. Most of the BCC team members have cumulative experience in this project due to their involvement in the predecessor NGO Service Delivery Program and SSFP.

The BCC team has accomplished significant results under IR 2 and its sub-results and milestones, such as finalization of a comprehensive BCC strategy in consultation with MOHFW, partners, community members and stakeholders; eight new and adapted versions of BCC materials developed, produced and distributed, along with TV commercials and BCC material user guidelines; and 1,088 clinic managers and service promoters trained on IPC/C and BCC messages while counseling on ESP interventions. More than 75 percent of clients found overall clinic services satisfactory or good, and more than 60 percent found IPC/C services satisfactory or good (per the mystery client study). Street drama was developed, and 900,000 brochures were distributed to all SH clinics, communities and NGOs to raise household knowledge and health-seeking behaviors on exclusive breastfeeding. More than 90 percent of SH catchment area communities are linked with SH clinics through SHCSGs. An emergency transportation plan template especially for pregnant women at the time of delivery was developed and shared with service promoters, and the red flag initiative was introduced to SH networks in year three.

**Figure 5. IR 2**




However, a review of the BCC strategy, project reports and plans, and interviews with BCC and other project teams, NGOs staff and partners revealed that the project's vision of BCC roles and importance are limited mainly to its contribution to the project's IR 2: Optimal Healthy Behavior Promoted and its two sub-results.

There is slim appreciation and understanding that BCC's role should be a crosscutting integrated approach that complements and contributes effectively to other project components, with no effective programmatic and organizational platforms to operationalize this concept.

The NHSDP IR 2 envisioned an empowered and enlightened community having household-level knowledge to practice model health behavior, facilitated by the SH service-delivery network. This network was specifically envisaged to promote improved healthy behaviors and care-seeking practices through BCC/knowledge management and by actively engaging communities in the promotion of healthy behaviors and care-seeking practices. To attain these objectives, the Phase 2 team found that the project has emphasized key interventions, as follows: generating demand through BCC campaigns, building capacity of clinic staff in IPC/C, promoting media advocacy, blending mass media with IPC based on the local context, building capacity of the SHCSG members to contribute to better community mobilization, and adapting CARE's Community Support System model in the NHSDP community-strengthening effort.

The Phase 2 team found that service promoters and CSPs are working in the community on a variety of supportive activities. As result of these community mobilization and BCC campaigns, the service contacts in SH clinics have contributed to an increase of 12 percent in clientele going to satellite clinics compared to static clinics (when comparing clinics in 2013 and 2015) according to the NHSDP clinic monitoring data. Results show that approximately 75 percent of clients are served by CSP/satellite clinics versus 25 percent at static clinics. The Phase 2 team found that many of these activities have resulted in increasing the customer flow at the service-delivery sites. Key activities have created a direct impact on customers coming to the clinics and changing their health-seeking behavior in an increased number. These statistics are collected monthly, fluctuate from month to month, and are reported to USAID quarterly.

The BCC and community mobilization not only reflect results of service data, but health information through BCC and community mobilization has an impact on people's practices. Not only does it bring clients to service-delivery sites, it also promotes preventable health practices in their households with

the information that the service providers provide at the community level through communication materials and counseling at the clinic and community levels.

To further strengthen the delivery of quality health services, NHSDP conducted a mystery client clinic exercise/survey in clinics across the country (see question 2, above). NHSDP considered the following specific objectives in the exercise:

- Understand the behavior of the clinic staff displayed before the customers.
- Make clinics "poor-friendly."
- Share observation on the spot to undertake appropriate corrective measures.
- Learn by their own experience and internalize understanding.
- Determine certain service-delivery standards.
- Learn from their life skills.

The Phase 2 team found the mystery client concept to be a strong and effective research technique that serves as a performance improvement tool. It helps to monitor and, in certain circumstances, evaluate service-delivery programs, health facilities and providers, by providing information on good practices that may be overlooked during routine clinic activities. Because the mystery clients act as another set of eyes to assess and contribute to improving the quality of services, they serve the interests of both clients and the program by highlighting the ways that the facility can serve its target audience. Mystery client information is fed back to the clinic so that it can improve its service provision. It is expected that the exercise will be able to explore the real situation of how counselors and service providers are handling different types of customers in their clinics. Based on the visit findings, NGOs should be able to take corrective measures to further improve service delivery and thereby increase customer flow.

Question 2, above, has more information on lessons learned and best practices related to question 5 for POP identification criteria, CSPs and the role of BCC.

## EVALUATION QUESTION 6: HOW HAS NHSDP STANDARDIZED SERVICE-DELIVERY MODELS, STRATEGIES AND TOOLS ACROSS THE SH NETWORK (NGOS AND CLINICS), AND HOW CAN THIS BE IMPROVED?

**ESP management**: On technical issues, NGOs reported that there is a real need for a mechanism that adequately coordinates across the many partners. With many silos in NHSDP's technical division, there are multiple different communications and actions of training and support. NGOs report that decisions are essentially made by NHSDP, not with NGOs as partners in service delivery. They say that guidelines are not based on reality and are often too complex. The required reporting is considered a very heavy burden on the staff.

Before allowing the clinics to expand as they wish, USAID noted that it is trying to rationalize services and improve standard quality.

See also questions 2 and 5, above, for more information on these areas as related to question 6:

- Performance on targets and milestones
- NHSDP performance data
- Factors affecting performance
- NGO capacity building as related to service delivery
- Knowledge, attitudes and practices and other client studies

## CROSSCUTTING THEMES

During Phase 1, the team uncovered several crosscutting themes relating to the evaluation questions, as follows:

### Management Issues Affecting NHSDP

**Organizational structure** (Questions 2, 4, 5, 6): NHSDP's organizational chart was changed several times with changes in the Deputy Chief of Party/Service Delivery position, director of ESP, and in the capacity development, BC&M and other units. The initial organizational chart placed the capacity development/institutional strengthening unit at the director level, with close links to service delivery, and allowed high-level links across NHSDP's technical and program areas. This positioning allowed the capacity development/institutional strengthening director to lead the training and capacity building task force and finalize the integrated training budget and calendar. Several institutional changes were made that moved the institutional strengthening unit under the responsibility of the finance and administration unit and changed links to service delivery, BCC and M&E units. Later NHSDP requested that the capacity development/institutional strengthening director position (within a unit of 4) be a lower senior manager position supervising one staff member. These changes were part of an overall attempt to address the funding crisis resulting from USAID not awarding transition grants to two large NGOs.[73] The changes in staffing, responsibilities, authorities and links with other divisions led to diminished potential for a strong capacity-development force. NHSDP organizational structure changes have also affected the ESP unit; staff changes have been frequent, affecting programming. In addition, staff turnover is a concern, and the division of responsibility between Pathfinder staff and partner organizations (CARE and BCCP) is not always optimal.

**NGOs' HR systems** are designed to support their organizations with an adequate supply of quality, stable HR for clinical services and program management. The need for sufficient qualified HR has been reported as a major issue in NHSDP 2013 road map assessments, has been discussed frequently by NGOs, and was confirmed in Phase 1 interviews. The Rapport Compensation Study and Retention Strategy (February 2014) provided information and recommendations to strengthen NGOs' HR systems. Pathfinder had substantial methodological concerns with the two Rapport reports. In year four, another HR study is planned. The HR section of the 2015 Benchmark Verification (see Annex III, table 17) reports that revised salary scales were implemented, HR policies were revised, and no tailored retention strategy was implemented. In Phase 1, NGO and clinic staff and directors repeatedly discussed salary issues as constraints on recruiting and retaining qualified staff. NGO staff discussed with the Phase 1 team their belief that salaries are fixed by NHSDP, with no flexibility, and stated they are considerably lower than salaries of other NGOs. USAID acknowledges that recruitment and retention of quality staff is a key issue but states that contract regulations allow for increases of no more than 5–10 percent and that this does not permit project salaries to keep pace with current market trends in Bangladesh. It was not clear to NGO staff interviewed–some of whom may have been new–that staff salaries are set by the NGOs and that they are able to use the performance-based grant bonuses to augment them. (See Annex VI for a summary of the Rapport HR studies.)

To move NGOs toward local ownership and sustainability without compromising the provision of quality services to the poor and underserved, the Phase 2 team found that the NHSDP strategically ties performance-based grants to four dimensions of NGO performance: service uptake and coverage, quality, equity and institutional strengthening (see NHSDP Performance-Based Grants Strategy, Annex III). NGOs increase service coverage of underserved populations through mapping exercises and

[73] According to the Phase 1 team, these changes were also a reflection of the limited priority of capacity development. Capacity development, BCC and other needed components that were poorly supported were reduced. Because the project was not exclusively service delivery, these components are needed.

expansion of essential FP and reproductive, maternal, newborn and child health services via static, satellite and mobile clinics. To generate demand for services, the project uses behavior change, community mobilization and social marketing initiatives. As a necessary element to increase demand for services, the project ensures high quality by reinforcing quality standards at every service-delivery level and through stressing service integration, youth-friendliness, non-discrimination and no stigmatization of the poor, and emphasis on women- and girl-centered approaches. To reach the poor and adolescents and youth–particularly young couples who are beginning child-rearing–the project uses BCC and community-mobilization strategies to address norms around early marriage and child-bearing as well as gender-based violence. To bring NGOs closer to long-term sustainability, the project strengthens NGO capacity through tailored technical assistance in leadership, governance, administrative systems, financial planning and HR through a range of methodologies, including training, mentorship and coaching, and cross-NGO learning opportunities.

**Planning systems** (Questions 4, 5): To develop sustainability of results and impact, NGO planning systems could be more long-term beyond the life of the project. Due to USAID's funding cycle, budgets are approved annually; this situation can negatively affect more long-term planning toward sustainability. In addition, NGOs discussed with the Phase 1 team their need for more autonomy in planning and developing their own systems toward sustainability.

(Questions 1, 2, 4, 5, 6): The Phase 1 team reviewed **reporting systems** for their quality and use for decision-making. NHSDP has moved to simplify reporting of service statistics for indicators that USAID requires. A one-page format for customer registration ("customer record sheet") with key clinical and cost data has been rolled out. As of April 2016, all clinics are using the new format, from which clinic-level service data are entered digitally into a single MIS database. Data entry operators are hired at the clinic level for this purpose. This database also captures service data from CSPs in the field and from satellite clinics. The consolidated MIS reduces some of the paperwork that clinic staff used to spend time on. However, the new MIS does not cover all reporting requirements. There are paper-based registers that must be completed for reporting to the government (EPI, FP). Some additional reporting requirements, for NHSDP purposes, are related to project milestones and to indicators included in the project M&E plan (but not required for routine reporting to USAID). Nevertheless, since the new MIS was fully implemented in April, NGO and clinic staff have given a good deal of positive feedback to NHSDP indicating considerable improvement in reporting systems. Each NGO has at least one M&E officer (or designated point person) who is the lead person for managing data collection and reporting to NHSDP. M&E officers receive ongoing training and support from NHSDP's M&E team. This includes group training–for example, through quarterly meetings of all M&E officers–and on-the-job training in the field. The NHSDP M&E team has been strengthened in 2016 with two additional staff so that more frequent and regular field visits are undertaken. Clinic managers and other staff have also been trained to support reporting and data analysis at the clinic level.

**Oversight systems:** NHSDP oversight of such a large and complex project requires quality systems to support the project's proper functioning and success. In discussions with NHSDP, the chief of party, and the DCOP for Finance and Administration attempted to provide detailed data and information from their oversight of areas and issues, i.e., capacity development, BC&M, cost recovery and M&E. The team noted that the chief of party's lengthy presentation provided extensive clinical services information; the DCOP for Administration and Operations made a presentation during the Phase 1 team's overview meeting. Due to high turnover in the capacity development team, NHSDP relied heavily on Pathfinder headquarters technical assistance to provide information to the Phase 1 team on NHSDP's capacity-building history, assessments, major activities/benchmarks and data. Pathfinder headquarters provided valuable information.

USAID oversight and issues of concern, such as the need for clear NHSDP reporting, more comprehensive capacity-development progress, and more effective processes for BCC approaches and

activities to support NHSDP overall programming, were discussed with USAID. Frequent transitions in USAID staffing have affected oversight. To date, there have been five Contracting Officers involved in the contract and three Contracting Officer's Representatives (CORs). The present COR was assigned as the alternate in January 2015 and as the COR in February 2015.

The full extent of guidance and oversight by USAID to NHSDP on its project management and technical, capacity development and other systems could not be reviewed in depth by the Phase 1 team, in part due to all the transitions. During the Phase 2 team's work, it was found that many of these issues were resolved.

**Logistics** (Questions 2, 4): The Phase 1 team was not able to assess the logistics system in depth. Project directors and clinic staff discussed the basic equipment in their clinics and the delays in replacement of mattresses, equipment and other materials. Supplies for cleaning equipment and facilities were generally available. Clinic visits revealed that clinical equipment was basic, often dated, and in moderate to poor repair. The staff were using aged office desks, chairs and computers, many purchased years before under previous projects. NGOs are responsible for identifying what they need and including that in their budget. NHSDP manages the procurement to ensure alignment with contract terms, following the provision that if the equipment value exceeds the threshold in the CFR, USAID approval is needed. Some equipment is centrally purchased by NHSDP; however, equipment that is part of an NGO's clinic management requirement can be budgeted and managed by the NGO. Clinic staff may need to be advised by their NGO, reinforced by NHSDP staff, that the NGO can purchase needed equipment.

**Service expansion** (Questions 2, 4, 6): Network expansion was achieved, in part, by adding 67 new clinics to ensure that the project met its overall targets once the two NGOs left the network in year three. Because the two NGOs did not graduate to receive USAID approval for direct funding (detailed below), the project has struggled to accommodate the cost of sustaining them and the new clinics, cutting funding back in other areas, such as project sub-partner staff and agreements.

NHSDP added 67 clinics since the start of the project (January 1, 2013 to September 30, 2015), including 33 Comprehensive Emergency Obstetric and Newborn Care (CEmONC) clinics. In its second year, the project added 18 new clinics–nine EmONC and nine CEmONC (see Table 9 and Annex III). In year three, no new clinics were added, but one vital clinic was upgraded to EmONC, and five CEmONCs were downgraded to vital clinics.[74] During that year, the project focused on efficiency, rationalization and standardization of staffing patterns of clinics versus expansion. According to Phase 1 interviews with NHSDP staff, "Currently, there is no plan for upgrading clinics due to the (project's) lack of funds to do so."

[74] Clinic upgrades and downgrades were made based on the August 2015 rationalization workshop, which was followed by annual plan and budget negotiations with the NGOs. The ESP unit shared its frustration in its attempts to coordinate with the finance unit to ensure that the project did not make high capital investments in low-performing clinics. It was unclear if funds had been expended yet based on information gathered by the Phase 1 team. *Sources:* Year 3 Annual Report, Year 4 Work Plan, key informant interviews.

**Table 9. NHSDP service expansion, January 1, 2013 to September 30, 2015**

| Project Year | Baseline[a] | Year 1 | | Year 2[b] | | Year 3 | | Midterm |
|---|---|---|---|---|---|---|---|---|
| Clinic type | Number of clinics | Total | Annual change | Total | Annual change | Total | Annual change | Change since project start |
| Vital | 277 | 275 | -2 | 278 | 3 | 316 | 42 | 43 |
| EMOC-B | 28 | 10 | -18 | 19 | 9 | 19 | 0 | -9 |
| EMOC-C | 20 | 42 | 22 | 51 | 9 | 53 | 2 | 33 |
| **Total** | **325** | **327** | **2** | **348** | **21** | **392** | 44 | **67** |

a. *Source*: Technical Proposal. b. *Source*: NHSDP, clinics by level and project year, December 9, 2015.
c. *Note:* At the beginning of year four, four vital clinics were downgraded to fixed satellite spots, leaving a total of 388 clinics.

This iteration of the project was designed to add focused services for unmarried and married adolescents and youth and additional nutrition services in line with the GoB's, and to mainstream gender to make services more accessible to women and girls and gender-equitable, including an emphasis on joint decision-making among couples and involving men to increase family access to ESP services. As discussed below, progress for these new areas has been slow for various reasons.

Referral networks need a follow-up mechanism to ensure referrals for poor patients. Vital clinics are reportedly not referring clients, and some only provide referrals in certain circumstances. Also, if patients with four ANC visits do not return for their checkups, they are often "lost" from SH, particularly if they go to other towns to deliver, for example, where their parents or other relatives live, more often in rural areas.[75] As a result, potential referral opportunities for continued care, including ANC follow-up, SBA delivery, and essential newborn care/postnatal care and postpartum FP, are missed.[76] USAID reports progress in this area on recent monitoring visits[77] with clinics maintaining a list of pregnant women with their estimated date of delivery and their phone numbers. The clinics have begun calling them to check on their delivery and recognized that this is an opportunity to increase SBA (where there are trained personnel), essential newborn care, postnatal care and postpartum FP.

[75] *Note*: Data were not available on how often this occurs.

[76] Phase 1 interviews with NHSDP staff.

[77] USAID/Bangladesh COR comments on Phase 1 draft report, February 1, 2016.

# IV. CONCLUSIONS AND LESSONS LEARNED

1. **What have been the successes and limitations of the project's cost-recovery component?**
   - USAID-established targets for cost recovery and targeting the poor and POP are on track. The project's efforts to identify, monitor and analyze information on the POP were improved (i.e., number visiting/time period, type of service used, POP and non-POP characteristics).
   - The majority of implementing NGO partners have been associated with earlier USAID projects, and the partner NGOs lack adequate support and initiatives to expand their services and develop innovative financing.
   - A sense of security prevails, whereby the NGOs believe USAID shall continue their assistance. The NGOs have become passive in their effort to attain sustainability through innovative financing, including seeking funds from alternate development partners or collaborating with the government, and they could benefit from additional training and mentoring.

2. **What have been the successes and limitations of network expansion, especially for key ESP services: FP/RH, ANC, delivery, child health and nutrition?**
   - There was an in-built bias in locating the SH clinics where NGOs have operated in the past, without assessing the shifts in supply (providers) and demand (clients) factors. Thus, there is an oversupply of services in some areas while other locations are underserved. NHSDP conducted an extensive "rationalization exercise" of distribution of clinic services during project year three and is following up to address some of the uneven distribution.
   - The SH network's recognition, infrastructure and mix of services are significant.
   - NHSDP's current centralized management style is driven mainly by the IRs and their numerical milestones, leaving limited room for innovation and creativity in exploring non-traditional options to improve service quality.
   - To be successful, a complex health project needs strong, streamlined, operational management systems and effective, appropriate organizational structures that function.

3. **What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding building/strengthening NGO capacity?**
   - NHSDP made significant efforts to initially assess the capacity of NGOs with multiple tools and analyses that provided individual road maps for action. Training, technical assistance and institutional support were provided, some of which was planned and linked to the road maps; the Phase 1 team did not find that other inputs were clearly tied to the capacity-development assessments, road maps, or established needs of the NGOs. NGOs' governance, finance and administration seemed to benefit most from the inputs with training and review, updating and improvement in the functioning of governing boards, increased training and improved systems in finance and administration reported. Measuring progress of the NGOs' capacities was more difficult to track and compare because the tools used differed. Cross-network capacity-development support declined somewhat during years two and three as so much of the project's capacity development resources were focused on the transition process.
   - A program that depends on collaboration with independent NGOs with different dynamics, contexts and structures must be ready from inception with feasible options and plans for NGOs' technical, organizational and financial sustainability, informed by a participatory strategic planning process for building consensus among NGOs.

- Building NGOs' capacity to meet *only* USAID and contractor requirements does not prepare them to function with independence and to successfully contract in the future with public and private agencies in the health sector.
- The NMC's role provides great advantages as a valuable forum for NGOs to share their goals, skills, talents, lessons learned, models and tools. It is also a forum for a unified, strong alliance of NGOs to interact, collaborate and negotiate with other NGOs, the GoB, donors and other Bangladeshi institutions.
- NHSDP, Pathfinder and USAID dedicated extensive effort to develop up to two NGOs with capabilities to receive direct USAID support. NHSDP successfully met its indicators. The intent to identify and prepare one or two NGOs for direct USAID funding was successful in building NGO capacity and received a high level of effort by NGOs, NHSDP, Pathfinder headquarters and USAID. The NGOs' skills and awareness were strengthened, and NHSDP support was effective in building the NGOs' capacity, although no award was made. In addition to direct funding, USAID plans for sustainability of NGOs could have included NHSDP preparing other NGOs to seek funding and institutional support from other donors and strengthening their links to the health systems of the GoB, city corporations, other NGOs and the private health sector.
- In considering the potential for an accreditation system (see text box under section VI. Recommendations), the Phase 1 team found that NHSDP has developed multiple mechanisms, tools and processes that are meant to provide standards and to measure NGO performance and quality improvement.

**4. What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding demand creation for service utilization at NHSDP clinics?**

- NHSDP's concentrated decision-making and leadership style, derived mainly from the focus on IRs and their numerical milestones, has prevented effective use of the expertise and skills of project staff, subcontractors and partners. Units work independently and in isolation. Having a lot of data does not always mean it will be useful.
- Ensuring implementation of the project's minimum quality standards—established in the 2015 rationalization[78]—is essential to improving service quality across the network.
- **BCC and marketing:** NHSDP has developed a comprehensive BCC strategy that includes community mobilization and knowledge management strategies and activities for providing information, promotion, education, and stimulating positive health-seeking behaviors among project beneficiaries. There is meager appreciation and understanding that the role of BCC should be a crosscutting, integrated approach that complements and contributes effectively to other project components; there are no effective programmatic and organizational platforms to operationalize this concept.

**5. How has NHSDP standardized service-delivery models, strategies and tools across the SH network (NGOs and clinics), and how can this be improved?**

- The NHSDP efforts are well appreciated by GoB because the project's objectives, goals and success complement the GoB's overall goal of providing quality ESP services, particularly to the poor.
- CSPs impart a key role in creating awareness and bringing clients to SH clinics.

[78] NHSDP Rationalization Workshop Year 3, August 19-20, 2015.

# V. RECOMMENDATIONS

The following proposed recommendations relate to the evaluation question findings reported in section IV, above. Priority (P), short-term (ST) recommendations that can be accomplished in the remaining time of the project, and long-term (LT) recommendations for future USAID designs are marked as such.

## 1. WHAT HAVE BEEN THE SUCCESSES AND LIMITATIONS OF THE PROJECT'S COST-RECOVERY COMPONENT?

**Enhanced Sustainability of ESP Delivery through Innovative Financing**[79]

(P) **Cross-subsidization:** NHSDP should use the commissioned Brandeis University study and other evidence-based information to objectively strategize price adjustments of its services. The Abt studies should also be used to address pricing, as well as alternate reimbursement models that address cost recovery while targeting the poor. NHSDP should consider assessing the potential of charging or changing the prices for some services provided to the non-poor at satellite clinics, recognizing that all charges to the public must be in alignment with GoB policies.

(ST) **Price discrimination:** NHSDP and the NGOs should research and then set higher targets for their pharmacies to increase revenue. Increasing the type and number of drugs, expanding service hours and promoting community awareness of their presence are needed. NHSDP and the NGOs should undertake a cost-benefit analysis of additional services that could be offered in clinics to increase revenues. This analysis should include an assessment of local market demand and alternate service providers' quality and price information.

(ST) **Subcontracting:** NHSDP should assist NGOs individually and as networks to position themselves to partner with the GoB in its health financing protection scheme. NHSDP should strengthen and motivate more partner NGOs to enroll in DSF pilots. Subcontracting services to the government or other service providers, or enhancing revenue generation from its pharmacies or laboratory facilities are a few options that could expand financing beyond current levels that depend heavily on project and client funding.

(LT) **Community and private sector:** NHSDP should review and standardize compensation, including reimbursements for CSPs and service promoters bringing clients to clinics. NHSDP should explore the potential of community support and private sector groups to contribute support for services to the POP.

(ST) Reporting on cost recovery at the NGO level would contribute to assessing best practices to support in the remaining life of the project.

(ST) Cost recovery and local investment (including the GoB) could help increase sustainability of NHSDP initiatives. USAID should continue discussions with the MOHFW to develop opportunities to expand investment in Bangladeshi health services.

(LT) Future NHSDP-type health service delivery projects should explore the possibility of partnering with NGOs as well as with the for-profit private sector. There are Bangladeshi corporations and businesses that acknowledge and would welcome social business activities that provide services to the community and concurrently are financially sustainable.

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[79] Price discrimination is recommended primarily for cost recovery without adversely affecting the very poor. Standardization should be pursued when price discrimination can lead to such perverse effect as reselling of a service or product (e.g., drugs purchased by a group at lower price are sold at a higher price elsewhere).

## 2. WHAT HAVE BEEN THE SUCCESSES AND LIMITATIONS OF NETWORK EXPANSION, ESPECIALLY FOR KEY ESP SERVICES: FP/RH, ANC, DELIVERY, CHILD HEALTH AND NUTRITION?

(ST, LT) By expanding the BCC strategy development with careful consideration of the mandate and activities of the other project components, NHSDP could inform the BCC planning process, align BCC activities with the other project components, harmonize BCC messages across SH facilities and communities, and maximize its integration within the different project components.

(ST, LT) Given the magnitude of work and infrastructure established in the NHSDP and its predecessors, USAID should consider network sustainability as a backbone for the next project, with emphasis on: (a) participatory strategic planning with NGOs to develop solid corporate systems and create viable organizational structures, (b) evidence-informed BCC and social marketing strategies and plans and (c) collaborative win-win partnerships with MOHFW and the private sector.

(P, LT) Strengthening partnerships with the GoB can be enhanced through information-sharing and lessons learned from NHSDP activities. While designing a post-NHSDP project, location and service-delivery options should be discussed intensively with the government as well as development partners and NGOs. If warranted, feasibility studies can be undertaken collectively by different stakeholders, and not singly by USAID.

(ST, LT) Service quality needs to be improved across the network in areas such as staff retention, training capacity, intensified monitoring using cross-functional teams (technical/M&E/grants), implementation of quality standards,[80] governance capacity, referral tracking of the poor/POP, improved inter-unit collaboration, and improved environment and infection control at facilities, as detailed in section IV, above.

(LT) Special focus in both the design and implementation phases of an NHSDP-type project is essential to effectively serve the POP. Disaggregated monitoring and reporting could be used to assure that the POP category is being adequately served.[81]

**Knowledge, attitudes and practices:** A well-developed, high-quality knowledge, attitudes and practices study is a key foundational component of BCC and marketing programs that is used to inform and guide the planning process and later to assess program progress and impact. Formative, operational and communication research is required by NHSDP (and/or its successor) to inform its planning and evaluation of BCC activities and materials. In addition, this information would validate the appropriateness of NHSDP's BCC interventions to the various audiences to be reached.

(P) Fielding the mystery client assessments and exit interviews on a regular basis will contribute effectively in monitoring the impact of BCC activities over the life of the project.

(ST) Interviews with the project staff and SH clinic managers and results of the e-questionnaire completed by the project directors reveal the importance of and need for strengthening the project's marketing component and expanding it beyond marketing the pharmacy outlets.

(ST) NHSDP should go beyond building technical skills and individual capacity of clinics and NGOs to developing solid NGO systems and creating viable organizational structures for effective transition and long-term sustainability.

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[80] NHSDP Rationalization Workshop Year 3, August 19-20, 2015.

[81] USAID noted that "The POP came into the indicators in Year 2, when DFID funds were added. This is a big reason why the data cannot be disaggregated."

(LT) The potential of expanding the SH network's market share in service provision in their catchment areas is promising, if more strategic marketing plans and activities are there to build customer loyalty among clients from adolescence and to increase market value of the SH brand and position the network's services to the appropriate market segments that cannot afford private sector services and are looking for quality services with affordable cost. The more customers the outlets serve, the more profits they will generate, which in turn will contribute to cross-subsidizing services in clinics that serve mainly those who are not able to pay.

(ST, LT) USAID should consider the frequency and types of reports required.

(ST) Improved cohesiveness and integration among different project components would align activities, maximize the impact of each individual intervention and rationalize the use of project resources.

(ST) A clear USAID vision of its future health project and the role of NGOs in it is needed to define the capacity and sustainability to be achieved. NHSDP can use the time remaining in the contract to test models.

## 3. GIVEN THE REVISIONS TO NHSDP'S SCOPE OF WORK SINCE THE CONTRACT WAS AWARDED DUE TO INCREASE IN TOTAL FUNDING, ASSESS PROJECT-LEVEL PERFORMANCE ISSUES, IDENTIFY DEFICIENCIES AND PROPOSE STRATEGIES FOR IMPROVEMENT, TAKING INTO CONSIDERATION LIMITED TIMEFRAME FOR IMPLEMENTATION.

(P, ST) **Improve Performance**

- Intensify monitoring of C-section delivery services in CEmONC clinics using the World Health Organization's most recent statement (2015) and forthcoming guidance on the Robson classification system.[82]
- Strengthen mother-child health service integration to improve the project's performance in essential newborn care/postnatal care, including postpartum FP. For example, develop and test innovative ways of engaging young girls and women in peer support groups, based on global best practices research,[83] that would bring them in for more services, such as ANC checkups including birth planning and referrals for SBA delivery near natal homes if needed.
- Since the project's adolescent work is in its early stages, progress in this area will require vigilance. Adults typically take over unless they, together with the adolescents, are trained and empowered to be part of the decision-making. This process could include creating youth-friendly spaces, adjusting clinic hours to better meet adolescent schedules, i.e., after-school hours, and reaching out to out-of-school youth.

(P, ST) **Elevate Service Quality**

- Recalibrate SH salaries to be more competitive with the GoB to stem the loss of HR trained by the project, examining the possibility of using contract amendments.
- Continue to upgrade NHSDP training capacity. Given the relatively short time remaining on the project, consider contracting a training organization to plan and implement an effective training plan to help individual NGOs and the NGO network achieve goals within the project's duration.
- Intensify monitoring of service quality using regional cross-functional teams (technical/M&E/ grants) to build NGO capacities, increase effectiveness and efficiency of project monitoring and

[82] http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf

[83] http://www.popcouncil.org/research/adolescent-girls-empowerment

encourage sharing of lessons learned and promising practices. Strengthen project staff capacity for monitoring and capacity-building technical roles.

- NGOs should comply with standards established through the 2015 rationalization, and NHSDP should conduct a follow-on exercise to streamline resource utilization by geographic location to eliminate service duplication.
- USAID should add technical capacity in governance to the project (Pathfinder and subs) to guide and strengthen its own and the NGOs' abilities to avert resource leakage and misuse.
- Establish interagency and network service referral tracking to ensure services to poor, particularly to POP clients.
- Improve the collaboration between the technical and BC&M units to intensify SH's community-mobilization activities, develop quality BCC materials and market the program to various client segments.
- Improve facilities' environment and functionality by mapping patient flow to reduce clinic bottlenecks and wait times, and reinforce infection control in all levels of clinics, as unsanitary conditions were noted in some clinics visited.[84]
- Hold more regularly scheduled meetings with SH clinics, with the participation of all parties (within and outside of NHSDP), to share information and experiences and explore areas for increased intervention and improvement.

(P, ST) **Advance Understanding of the Relevance of Gender**

- NHSDP should expand its understanding of the relevance of gender to the project and its results framework with all stakeholders, from the MOHFW to communities, including all project staff.
- The project should reinforce linkages to local, national and international campaigns–community-level dialogues and campaigns to prevent of child marriage, gender violence, etc.–to further support and expand adolescent and youth programming and activities.
- NHSDP should actively encourage innovation in programming to involve men and boys in SH clinic services and in the community activities, in addition to women and girls.
- As the project's work with adolescents is at an early stage, further expand programming for adolescents/youth, including their involvement in SH governance, i.e., inclusion in SHCSGs to ensure their needs are heard and met.

(P, ST) **Facilitate Urban Health**

- USAID and DFID should work to ensure strengthened collaboration at the policy level between its supported USAID/project and the ministries involved.
- USAID and DFID should provide joint leadership in developing a mechanism that cuts out duplication of services and improves efficiency of service delivery. For example, geographic concentration of similar services in some areas resulted in overcrowding of some clinics and low use of others; in some instances, donors such as the Asian Development Bank handed over clinic infrastructure after completion to the local partners, making relocation for these clinics practically impossible without exploring other innovative solutions; and there is competition between NGO and GoB facilities for clients seeking similar services, resulting in non-functioning referral systems.

[84] As shared with the project and in the out-briefing.

(P, ST, LT) **Pilots for Sustainability**

- The NHSDP should actively pilot co-monitoring of SH clinics with the GoB in different areas, especially in hard-to-reach areas and small municipalities, with the goal of being endorsed, recommended and even accredited once a clinic meets an agreed-upon quality standard, as the entry point into the primary health care system.
- As a result of the joint monitoring described above, the GoB would become more vested in improving the network's quality and in strengthening its own linkages to it, and could simultaneously strengthen its own local technical capacities, as is done on other USAID projects.
- Strong leadership and consistent technical assistance, training, tools, and support and clear documentation of progress are needed in the final project years to prepare NGOs to provide high-quality, expanded services and to build their sustainability results. Due to the high volume of work and multiple duties assigned to each staff member in the clinic, NHSDP and the NGOs should consider developing user-friendly job aids, in addition to the current protocols/guidelines for different types of service providers on the key topics and skills.

(LT) **Accreditation:** Given that NGOs have been trained and are currently using NHSDP standards and measuring performance and quality, improving these may be more productive than beginning a new, external accreditation system that could increase the burden on NHSDP and NGOs, as the system costs could be high and the new program could absorb considerable staff time. When there is a need for additional measurement of NGOs, accreditation could be reconsidered, but this should be as part of a broader GoB accreditation process. However, if GoB accreditation is pursued over a longer-term horizon, the SH network would be able to attract more qualified skilled staff, particularly doctors and paramedics; reduce turnover of scarce skilled staff; and become more attractive to potential investors (public and private).

**Accreditation systems** are external evaluation mechanisms that assess the performance of compliance with predefined explicitly written standards and encourage continuous improvement of quality. The Phase 1 team did not do an extensive analysis of the opportunity to develop an accreditation system. The team did find, however, that NHSDP has tools and processes to establish standards and measure performance internally, with an emphasis on improving quality. An external accreditation program for NHSDP has not yet been developed, and costs have not yet been estimated.

### Planning for Future Investments

- (P, ST) USAID should plan for sustainability by allowing time to develop a realistic transition plan, including costing, in collaboration with the GoB and other partners and stakeholders.
- (LT) USAID should plan future investments based on a decentralized approach, i.e., regional hubs, for stronger collaboration with local government, other partners and stakeholders and cost-effective monitoring.

### Strengthened Partnerships and Coordination with GoB Authorities and other USAID-Supported Projects

(ST) USAID should direct NHSDP to more effectively collaborate with the GoB and other USAID-supported projects for comprehensive mapping, rationalization and referral of services, especially in urban areas. USAID should monitor NHSDP's response to ensure that this strengthens coordination and referrals across NHSDP NGOs, other NGOs, the GoB, city corporations and other health services. In addition to the Inter-Ministerial Advisory Committee, NHSDP should strengthen partnerships at all levels of the health system.

(ST) NHSDP and its NGOs should actively collaborate with the community clinics and community health workers on outreach, referrals and follow-up in rural communities. This process would support the GoB's provision of ESP services in rural areas, primarily through its network of more than 13,000

community clinics with paid community health workers and a system of electronic reporting of services provided.

- Building an effective council (or a similar type of organization) will require strong NHSDP, Pathfinder, and external technical expertise and awareness of the dynamics of Bangladeshi institutions and culture. Capacity-development strategy review and revision could serve as a starting point. Expert external technical assistance with capacity expertise and awareness of the social and institutional constraints of councils/networks in Bangladesh will be needed to move this commitment forward. The Phase 1 team identified several pilots and initiatives in the public sector that could be leveraged to collaborate more closely with GoB/MOHFW health structures, service-delivery systems for referrals, closer collaboration on EPI, maternal and child health, TB, integration on MIS reporting systems, and collaborative outreach services to communities.

(LT) Strengthening partnerships with the GoB can be enhanced through information-sharing and lessons learned from NHSDP activities. While designing a post-NHSDP project, location and service-delivery options should be discussed intensively with the government, development partners and NGOs. If warranted, feasibility studies can be undertaken collectively by different stakeholders, and not singly by USAID.

### Human Resources

(P) To develop and maintain HR capacity, a major renewed effort should be made by NHSDP and the NGOs to assess and address HR issues. The planned HR study and other assessments should be carefully crafted to assure accurate information focused on NGO and NHSDP needs. The study should address the full range of HR issues (job descriptions, hiring, training, supportive supervision, salary, compensation and benefits, performance evaluation, promotion, etc.), and its findings should be shared widely. A structured, comprehensive HR policy, strategy and action plan should be developed and implemented to assure the high-quality, more stable and dedicated workforce needed.

### Management

(LT) USAID should consider the frequency and types of reports required from the project to go beyond the numerically focused report to reflect the innovation, integration between different activities, lessons learned and best practices toward achieving the project's goals and objectives.

## 4. WHAT SUCCESSES (BEST PRACTICES) AND SHORTCOMINGS (LESSONS LEARNED) HAS NHSDP HAD REGARDING BUILDING/STRENGTHENING NGO CAPACITY?

### NGO Network Sustainability

- (LT) USAID and NHSDP should explore and work toward establishing a viable and effective platform/network to glue the NGOs together beyond the life of the Project that supports the technical and cost recovery sustainability of SH clinic services to fulfill the project goals and objectives This viable platform/network would be a strong foundation for SH successor.
- (P, LT) NHSDP should go beyond building technical skills and individual capacity of clinics and NGOs to developing solid NGOs systems and creating viable organizational structures for effective transition and long-term sustainability.

(P) **Planning systems** are critically needed to support capacity development across NHSDP. Discussions with the project's key staff did not demonstrate a clear, supportive vision of the importance of NGO capacity development, BC&M and other areas in NHSDP's overall plan and its future role in NHSDP.

(P, ST) **Institutional capacity of NGOs improved:** In the next months, USAID and NHSDP should conduct high-level, in-depth discussions to make clear decisions on the future focus of capacity building across project components and partners. These discussions should serve as the basis to reorient efforts in the remaining duration of the project to achieve priority short-term capacity-development actions and to plan for long-term stability and sustainability of NGOs and for a future project. Strong, competent, senior-level capacity staff within the capacity development unit in-country would provide opportunities needed to provide oversight for capacity-building to function as a major component of the NHSDP. Highly qualified senior staff with appropriate qualifications in BC&M and ESP are also needed to guide and oversee development in those units.

(P, ST) USAID should direct NHSDP to rapidly commit high-level NHSDP, Pathfinder and external, expert technical assistance and additional level of effort, working in close partnership with the NGOs to rapidly build more NGO capacity. Areas of emphasis to be considered in annual road maps include current key road map areas: tailored retention strategies, external relations, proposal development, revenue stability, strategy development and increasing the female membership on governing boards. In addition, increasing the sharing, interchange and integration of NGOs with the GoB, city corporations, other NGOs and private sector health programs, would greatly benefit the project NGOs in terms of observing other systems, strengthening their systems and linking their clients to other services needed.

(LT) In consultation with USAID, NHSDP should seek opportunities to collaborate with the GoB and the many other actors in the health sector in the remaining years of the project. This collaboration will help prepare the NGOs with stronger systems and skills, in line with Bangladesh's other actors in the health sector, to progress toward sustainable programs after the end of the project. Increasing NHSDP operational links of its planning, monitoring and reporting systems with those of GoB, other donors and private sector would also strengthen NGOs skills to present their capacities and submit proposals to other sources in the health sector for support.

(ST, LT) NHSDP could develop pilot efforts to link and support NGOs, integrating them more closely to city corporations. This process can offer urban-based NGO opportunities to grow and contribute to an urban network of service delivery. New discussions could be pursued with the GoB on integrating, and at least partially supporting, a select group of high-quality NGOs that USAID support has developed. USAID can also carry out in-depth internal discussions to clearly define the mission's plan for support to NGOs after 20 years of similar projects. The mission can define phases of decreasing USAID support after the NGO reaches adequate capacity, with the remaining support potentially supplemented by other sources. USAID can alternatively define a plan for indefinite funding support at a certain level to a group of NGOs for service delivery to the poor and POP.

(LT) Generating the right type of data regarding service utilization is essential for effective decision-making and management of this large and complex project. In-house capacity and willingness of the NGOs and NHSDP project management are essential to reach the POP more effectively and to report on their usage of SH clinics.

(LT) **Direct transition of NGOs to USAID funding:** USAID should conduct in-depth internal discussions to recommit to developing the capacity of the 25 NGOs toward a newly defined and measurable status of financial and institutional sustainability. The remaining project time should be rededicated to refinement of models of collaboration with the GoB, city corporations, NGOs and others to support a cohesive integrated health services system. Project capacity-building should be intensified, with NGO and apex leadership supported by NHSDP and external technical assistance experts. NGO capacity development should not only seek funding from USAID but rather attract collaboration and support from multiple sources. In addition to direct funding, USAID plans for NGO sustainability could have included NHSDP preparing other NGOs to seek funding and institutional

support from other donors and strengthening their links to the health systems of the GoB, city corporations, other NGOs and the private health sector.

### Apex Development

(ST, LT) Building an effective apex organization will require a strong NHSDP, Pathfinder and external technical expertise and awareness of the dynamics of Bangladeshi institutions and culture. Capacity development strategy review and revision could serve as a starting point. Expert external technical assistance with capacity expertise and awareness of the social and institutional constraints of councils/networks in Bangladesh will be needed to move this commitment forward. The Phase I team identified several pilots and initiatives in the public sector that could be leveraged to collaborate more closely with GoB/MOHFW health structures, service-delivery systems for referrals, closer collaboration on EPI, maternal and child health, TB, integration on MIS reporting systems, and collaborative outreach services to communities.

(P) In the next four months, aggressive internal USAID policy and technical discussions should take place around a determined commitment to support a strong apex (or a similar type of organization) during the remainder of this project and beyond. This process would commit NHSDP to develop the organization to actively facilitate interchange, cooperation, support, communications and visibility across the SH NGOs and with the public and private health sector. USAID should solicit market research from these organizations into the design of the future USAID health project.

(P) In the next six months, USAID should direct NHSDP to more closely engage an activated apex and individual and groups of NGOs and work to link them with the MOHFW and urban health systems to be more sustainable. The apex, the NGOs and NHSDP should also actively explore the current GoB health care finance and other models, city corporation models of financing of NGOs for service delivery, the Asian Development Bank's funding of urban health services, models of support by the UN and other donors, and Bangladeshi sources for appropriate changes during the current project and for the design of a future health project.

(P, LT) **Service attitude/quality:** The SH network is known for its positive service attitude and could potentially draw in more clients if it were also known for its high-quality services. The program's ability to attract and retain qualified HR is integrally linked to its ability to deliver high-quality services. A regionalized cross-functional team (technical/M&E/grants) approach to building NGO capacity, instead of crisscrossing the country to monitor individual NGOs, would increase efficiency and effectiveness of these efforts.

(P, LT) **BCC/social marketing:** USAID should consider the BCC and social marketing as an integral crosscutting component in the NHSDP successor program(s). Social marketing along with the BCC strategy will contribute to the NHSDP cost-recovery objective through attracting new and different types of clients to services. The existing organizational structure and BCC strategy do not support coordination and integration between BCC and social marketing to work together in a synchronized way. Social marketing is an important component to package, position and market SH services and to portray the competency and friendly attitudes of service providers to increase the market share of SH service network. These dimensions could be considered by the service marketing specialist within the marketing plan to promote the pharmacy outlets and any other income-generating activities considering the available project resources and timeframe, in collaboration with the BCC and other project components.

> As stated by the CEO of one of the key project partners "…there is a need for establishing more effective process to appreciate, consider and integrate BCC approaches and activities in different project components."

(P, LT) Capitalize on the current SH services and respective markets. These can be categorized from a marketing viewpoint as three RH/FP major market segments (that include all the SH-provided services). NHSDP's marketing strategy and plans can address these segments through three marketing objectives:

- ***Preparing the RH/FP market*** (initiators): Marketing and service activities are indicated—targeted toward adolescents and young people (ages 15–24) who are either married or unmarried but have no children, with an intensified focus on adolescents (age 15–19)—to make this demographic a project priority.[85] The ANGEL model could be, among others, an important intervention for this market segment to promote gender equity, healthy lifestyles and practices. Marketing these ideas and services at early stages of life through SH facility- and community-based BCC/marketing activities will build customer loyalty to SH services at later life stages.
- ***Capture the FP market (spacers):*** It is recommended that marketing and service activities be targeted toward young married women, men and couples with one child to increase their knowledge; improve attitudes toward ANC, nutrition, breastfeeding, child health and modern FP methods; address side effects, misconceptions and discontinuation; and increase successful use of modern contraceptives for birth-spacing.
- ***Maintain the FP market (limiters):*** It is recommended that marketing and service activities be targeted toward married couples with two or more children to promote the use of LAPM.

## 5. WHAT SUCCESSES (BEST PRACTICES) AND SHORTCOMINGS (LESSONS LEARNED) HAS NHSDP HAD REGARDING DEMAND CREATION FOR SERVICE UTILIZATION AT NHSDP CLINICS?

- (ST, LT) USAID and NHSDP should conduct in-depth discussions around the importance of developing a multi-phase, evidence-based, action-oriented marketing strategy for SH services and successor programs through building upon the brand recognition and successes that SH and their predecessors have achieved over the past decades, with clear market segmentation and approaches for each market segment.
- (ST) Social marketing and the BCC strategy should be developed to contribute to the NHSDP cost-recovery objective by positioning SH services for different market segments and increasing the visibility of the successes of the SH clinics and their SHCSGs, which will attract new and different types of clients to services. USAID should consider BCC and social marketing as an integral crosscutting component in NHSDP successor programs.
- (LT) Strategic social marketing should be developed that can change the perception that SH services are only for the poor (which makes those who are able and willing to pay reluctant to get services from SH clinics), increase the market value of the Smiling Sun brand, and make it easier to get support and sponsorships from the private sector and other partners. Any social marketing strategies and plans should be designed in a scalable way to accommodate new services for different market segments in the future.
- (LT) As the existing BCC strategy did not consider social marketing as an important component to package, position and market SH services and to portray the competency and friendly attitudes of service providers to increase the market share of SH service network, these dimensions could be considered by the service marketing specialist within the marketing plan to promote the pharmacy outlets and any other income-generating activities, considering the available project resources and timeframe, in collaboration with the BCC and other project components.

[85] This is because of the sheer size of this age demographic at 31 percent (2014), with 41 percent in the lowest wealth quintile, and about half (48 percent) with no education beginning early childbearing (BDHS 2014).

- (P) Innovations to improve quality, coupled with innovations to increase utilization of services, should be developed to increase the SH clinics' revenue to ensure sustainability beyond the life of the project.
- (P) In-house capacity and willingness of the NGOs and NHSDP project management are essential to reach the POP more effectively and to report on their usage of SH clinics. Improved compensation to the CSP and concurrently greater accountability are necessary. CSP's role in reaching out to meet the POP needs be strengthened. A greater role of community leaders in creating awareness and overseeing SH clinic activities should be pursued.
- (P) The BCC team should consider including potential clients of SH clinics in other BCC and social marketing relevant studies and not limiting the studies to current clients.
- (LT) Ensuring implementation of the project's minimum quality standards—established in the 2015 rationalization[86]—is essential to improving service quality across the network. The SH network is known for its positive service attitude and could potentially draw in more clients if it were also known for its high-quality services. A regionalized cross-functional team (technical/M&E/grants) approach to building NGO capacity, instead of crisscrossing the country to monitor individual NGOs, would increase efficiency and effectiveness of these efforts.
- (P) NHSDP should reconsider the current brand tagline and develop an evidence-informed umbrella tagline for SH clinics with promise/benefit (tagline) to each of the identified market segments.
- (P) **GoB**: The project should explore further participation in GoB-promoted DSF schemes and its social health protection schemes under the Health Care Finance Strategy 2012–2032. NHSDP can take advantage of its reputation with the GoB in developing stronger relationships with various units of the MOHFW and other stakeholders.

## 6. HOW HAS NHSDP STANDARDIZED SERVICE-DELIVERY MODELS, STRATEGIES AND TOOLS ACROSS THE SH NETWORK (NGOS AND CLINICS), AND HOW CAN THIS BE IMPROVED?

**Behavior Change and Marketing Are Leading Crosscutting Project Components**

- (P) NHSDP should provide a significant reorientation for the key project staff on the importance and role of BC&M as a crosscutting integrated approach and its implications on strategic directions and sustainability of the SH services, and ensure this understanding is cascaded to different levels of the project.
- (P) NHSDP should align its BCC and marketing components in one unit, BC&M, that reports to the DCOP.
- (ST) USAID and NHSDP should provide support and reallocate resources to designing and fielding operational and impact assessment marketing studies to inform the design and evaluation of different BC&M activities and materials for the rest of the project, given the available resources and timeframe.

## CROSSCUTTING RECOMMENDATIONS

(P) **Vision:** A clear vision is needed to develop NGO capacity development, BC&M and other areas within NHSDP's overall plan and NHSDP's future role in these areas and their sustainability in the NGOs in the remaining life of the project. Additional technical assistance and full staffing are also needed

[86] NHSDP Rationalization Workshop Year 3, August 19-20, 2015.

to develop a careful plan and specific steps to move NGOs toward implementation of NHSDP programming goals.

(P, ST) **Participatory management platform:** USAID and NHSDP should conduct high-level, in-depth discussions to develop a management structure and platform that ensure integration between different project components and allow effective participation of the project partners (Pathfinder, CARE and BCCP) in planning, management and evaluation of their assigned technical roles within the project's objectives and framework. USAID should consider the frequency and types of reports required to give room for the project to go beyond the numerically focused report to reflect the innovation, integration between different activities, lessons learned and best practices toward achieving project goals and objectives.

(ST) **Logistics:** Orient project directors and clinic staff to the logistics system to be able to purchase needed and appropriate clinic equipment and supplies and to negotiate with their NGO and NHSDP to replace equipment and supplies that are essential for managing NHSDP systems on a timely basis.

(LT) **Improving project support to NGOs:** Given NHSDP's pride about its collaboration with NGOs and other partners, input from NGOs provides opportunities for NHSDP to strengthen its working relationship with partner NGOs and will help to restructure future NHSDP support to them.

(LT) **Information-sharing/discussion:** It is suggested that opportunity for discussion and sharing information between the partners be increased to allow learning and improved project performance.

(LT) **USAID oversight and reporting:** The need for future, active, in-depth USAID oversight would help ensure that not only contractual requirements are met but that NHSDP has strengthened, innovative, high-quality clinical, BC&M and capacity-building activities and services, strong management systems, and that the 25 NGOs and the NMC develop in-depth institutional capacity. This process could include refinement of reporting systems that are more integrated with the MOHFW, increased technical assistance to NGOs to develop proposals and to conduct outreach to public and private sectors for added support, and models to support analysis of service costs. Increased USAID oversight can stimulate NHSDP to implement creative innovations, pilots and changes in approaches in the final two years that will be valuable for the development of future health projects. USAID should carefully consider its required reporting needs (deliverables) before including them in the contract and consider that the Agency can always ask the contractors for ad hoc data and requests, so as not to overburden the project.

(LT) **Accreditation:** In the design of a future health program, USAID can consider supporting the use of an external accreditation program, if research/literature supports its benefits and an analysis of its feasibility and costs are done in the context of Bangladesh.

# ANNEX I. EVALUATION STATEMENT OF WORK

Assignment #: **129** [*assigned by GH Pro*]
**Global Health Program Cycle Improvement Project–GH Pro**
**Contract No. AID-OAA-C-14-00067**

**EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK**

Date of Submission: 06-29-15
Last update: 10-09-15

## I. TITLE: BANGLADESH NGO HEALTH SERVICE DELIVERY PROJECT (NHSDP)

## II. REQUESTER/CLIENT

■ USAID Country or Regional Mission
Mission/Division: Bangladesh / OPHNE

## III. FUNDING ACCOUNT SOURCE(S): (CLICK ON BOX(ES) TO INDICATE SOURCE OF PAYMENT FOR THIS ASSIGNMENT)

| | | |
|---|---|---|
| ☐ 3.1.1 HIV | ☐ 3.1.4 PIOET | ■ 3.1.7 FP/RH |
| ☐ 3.1.2 TB | ☐ 3.1.5 Other public health threats | ☐ 3.1.8 WSSH |
| ☐ 3.1.3 Malaria | ■ 3.1.6 MCH | ☐ 3.1.9 Nutrition |
| | | ☐ 3.2.0 Other (specify): |

## IV. COST ESTIMATE:

Note: GH Pro will provide a final budget based on this statement of work.

## V. PERFORMANCE PERIOD

Expected Start Date (on or about): October 13, 2015
Anticipated End Date (on or about): January 29, 2016

## VI. LOCATION(S) OF ASSIGNMENT: (INDICATE WHERE WORK WILL BE PERFORMED)

Dhaka, Sylhet, Chittagong, other cities in Bangladesh as needed

## VII. TYPE OF ANALYTIC ACTIVITY (CHECK THE BOX TO INDICATE THE TYPE OF ANALYTIC ACTIVITY)

EVALUATION:

■ **Performance Evaluation** (*Check timing of data collection*)
■ Midterm ☐ Endline ☐ Other (specify):

*Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision-making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.*

☐ **Impact Evaluation** (*Check timing(s) of data collection*)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
*Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.*

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**
*Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.*

☐ **Costing and/or Economic Analysis**
*Costing and economic analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.*

☐ **Other Analytic Activity** (Specify)

**PEPFAR EVALUATIONS** *(PEPFAR Evaluation Standards of Practice 2014)*
***Note***: If PEPFAR-funded, check the box for type of evaluation

☐ **Process Evaluation** (*Check timing of data collection*)
☐ Midterm ☐ Endline ☐ Other (specify):
*Process evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, and management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)*

☐ **Outcome Evaluation**
*Outcome evaluation determines if and by how much intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)*

☐ **Impact Evaluation** (*Check timing(s) of data collection*)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
*Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.*

☐ **Economic Evaluation** (PEPFAR)
*Economic evaluation identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?*

## VIII. BACKGROUND

If an evaluation, project/program being evaluated:

| | |
|---|---|
| Project/Activity Title: | NGO Health Service Delivery Project (NHSDP) |
| Award/Contract Number: | AID-388-C-13-00002 |
| Award/Contract Dates: | December 9, 2012–December 9, 2017 |
| Project/Activity Funding: | $82,746,497 ($53,866,280 from USAID and $28,880,217 from DFID). |
| Implementing Organization(s): | Pathfinder International-led consortium |
| Project/Activity AOR/COR: | Miranda Beckman |

### A.1. Country Context[87]

Bangladesh has shown remarkable achievements in reducing child and maternal mortality in the last two decades. In 2011, Bangladesh had surpassed the MDG 4 target (reducing the under-5 mortality rate by two-thirds) and is on track to achieve MDG 5 (reduce the maternal mortality ratio by three quarters). Progress on key indicators is listed in the table below.

**Table 1: Progress on key indicators in Bangladesh**

| Indicator | 2007 | 2011 | 2014 |
|---|---|---|---|
| Neonatal mortality rate (per 1,000 live births) | 37 | 32 | 28 |
| Infant mortality rate (per 1,000 live births) | 52 | 43 | 38 |
| Under-5 mortality rate (per 1,000 live births) | 65 | 53 | 46 |
| Total fertility rate (TFR) | 2.7 | 2.3 | 2.3 |
| Contraceptive prevalence rate (CPR) | 56 | 61 | 62 |
| Low height for age (stunted) | 43 | 31 | 36 |
| Low weight for height (wasted) | 17 | 16 | 14 |
| Percent of children <6 months exclusively breastfed | 43 | 64 | 55 |

Bangladesh greatly reduced the maternal mortality ratio, from 322 per 100,000 live births in 2001 to 194 in 2010.[88] The country is on track to reach the MDG target of 143. Some 79 percent of women receive at least one ANC visit, the majority from a medically trained provider (64 percent). However, only 31 percent received the recommended four or more ANC visits. Although still low, some 42 percent of deliveries are assisted by skilled provider, 37 percent of those in a facility. Most births still occur at home, attended by untrained providers. The majority of those who deliver in a facility are delivering in private sector facilities (22 percent), and there is cause for concern with the alarming rate of cesarean section deliveries in private facilities (80 percent). Increasing skilled birth attendance is a priority area of action for the national program. Postnatal care is increasing, yet only 34 percent of mothers and 32 percent of infants receive care from a medically trained provider within 48 hours of birth, and only six percent of newborns receive all the elements of essential newborn care.

While Bangladesh has had success in fertility reduction and contraceptive use, both the CPR and TFR are stagnating. Some 12 percent of the population still has an unmet need for contraceptives. Although 62 percent of couples want no more children, long acting reversible contraceptives and permanent method (LARC/PM) use remains limited (8 percent). Male involvement in FP is below the desired levels, but male sterilizations are increasing in some areas where quality services are offered. There is an opportunity to increase provider knowledge and skills, strengthen LARC/PM referral networks and improve facility readiness to provide LARC/PM with equipment, supplies and BCC materials.

[87] Unless otherwise noted, all references from the Bangladesh Demographic and Health Survey 2014: National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2015. *Bangladesh Demographic and Health Survey 2014: Key Indicators.* Dhaka, Bangladesh and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

[88] National Institute of Population Research and Training (NIPORT), MEASURE Evaluation, and icddr,b. 2012. *Bangladesh*

Bangladesh has recently made great strides in improving the nutritional status of children. However, rates of malnutrition are still high and contribute greatly to child deaths. Some 36 percent of children under 5 are stunted and 15 percent are acutely malnourished or wasted. Only 23 percent of children 6-23 months are fed with appropriate infant and young child feeding practices. About 24 percent of married women of reproductive age are undernourished and 42 percent of them are anemic. The government's effort to mainstream nutrition into service delivery has been slow.

Bangladesh has the sixth highest level of TB burden in the world. Although detection of smear-positive cases has increased over 70 percent with a 92 percent treatment success rate, overall only 53 percent of all forms of TB are notified in the country.[89] Stigma around care-seeking behavior and lack of notification system by private sector providers result in about half of cases going undetected. Despite recent increase in case detection and treatment, Bangladesh also has a high burden of drug-resistant TB. In coordination with the National TB Program, there is an opportunity for private sector providers to assist with the scale-up of the national response to TB.

The burden of poverty and cultural constraints falls disproportionately on women, with women representing only 26 percent of the workforce. The average age of marriage is very young (15.3 years[90]). Just over half of women contribute to household decision-making, and these women are more likely to use FP and receive antenatal or delivery care from a trained provider. Because unmarried adolescents are not included in national-level surveys, little is known about their reproductive health needs.

### A.2. USAID/Bangladesh NGO Health Service Delivery Project (NHSDP) Project History

NHSDP is USAID/Bangladesh's flagship clinical service delivery project. The project has evolved from several precursor programs initiated by the Government of Bangladesh (GoB) (the Health, Nutrition and Population Sector Program) and by USAID. Previous USAID investments include The Rural Service Delivery Project and the Urban Family Health Partnership followed by the NGO Service Delivery Program (NSDP). Under NSDP (2002–2006) USAID worked to improve technical and management capacity of Bangladeshi NGOs to deliver essential health services and maximize access to other funding sources. NSDP was a cooperative agreement awarded to Pathfinder.

Following NSDP, USAID designed the Smiling Sun Franchise Program (SSFP), a contract, awarded to Chemonics (2006–2012). SSFP was designed to move NGOs to financial independence, and had three objectives: (1) Establish a Smiling Sun Franchise network; (2) Increase cost recovery (goal: 70 percent cost recovery) while continuing service delivery to the poor; and (3) Increase client volume, coverage of the poor, range of services and quality of care. USAID determined the franchise model was not appropriate, and in an effort to reach the cost-recovery goal, services to the poor were neglected. The franchise model was discontinued in the third year of the project in favor of a network of NGOs operating clinics. Based on the SSFP experience, NHSDP was designed to better balance quality service delivery to the poor, cost recovery, and institutional strengthening.

### A.3. NHSDP Project Overview

NHSDP, implemented by a consortium of national and international partners led by Pathfinder International, supports the delivery of a primary health care ESP through the nationwide "Smiling Sun" or Surjer Hashi (SH) network of 26 local NGOs. NHSDP is presently comprised of 392 static clinics (53 ultra clinics[91] and 339 vital clinics), 8,838 satellite clinics, and 6,320 CSPs. NHSDP serves approximately 27 million people in Bangladesh (17 percent of the total population) through the SH NGOs and their clinics and service providers. This project has been designed to complement the GoB's efforts to maximize the reach to the poor and underserved populations in the country with quality services at low or no cost, while supporting the sustainability of local service-delivery organizations. In accordance with the USAID Forward (Local Solutions Development)

[89] WHO Global TB Report 2014

[90] National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

[91] Ultra clinics are 24/7 emergency obstetric care clinics, with an operating theater and capacity to do cesarean section deliveries. Vital clinics do preventive care only and do not have the capacity for delivery services.

procurement reform and GoB initiatives, NHSDP was designed to strengthen local ownership of service delivery through institutional strengthening interventions targeted at the SH network NGOs.

Expanded access to and use of the ESP resulting from NHSDP efforts should measurably improve health outcomes and contribute to decreasing fertility and maternal, infant and child mortality. Project implementation contributes to: the Global Health Initiative/Bangladesh Country Strategy and principle of women, girls and gender equality; USAID's Country Development Cooperation Strategy; and the GoB's Health, Population, and Nutrition Sector Development Program (HPNSDP). Specifically, activities will contribute to the Global Health Initiative/Bangladesh results framework and Country Development Cooperation Strategy Development Objective 3: "Health status improved" and will result in: (1) increased use of effective FP and RH services; (2) increased use of integrated, essential FP, health and nutrition services; and (3) strengthened health systems and governance.

DFID has provided supplementary funds to support current efforts and to strengthen the focus on FP and maternal health outcomes, with a specific focus on improved service delivery for the urban poor.

The total estimated cost of the contract is $82,746,497 ($53,866,280 from USAID and $28,880,217 from DFID).

### A.4. NHSDP Project Approach

NHSDP's strategy is to increase poor and vulnerable populations' uptake of the GoB's ESP. Specific priority components of the ESP include long-acting reversible contraceptives and permanent FP methods (LARC/PM), maternal health, nutrition, newborn care, and treatment for acute respiratory infections. To do so, NHSDP focuses on developing the capacity of the SH NGOs along four key dimensions of performance: coverage/uptake, quality, equity and institutional strengthening.

***Coverage and uptake:*** NSHDP is expanding coverage by mapping, service rationalization, and use of satellite clinics, mobile clinics and CSPs. Underserved areas and those suffering the worst health outcomes are areas of focus. BCC, community mobilization efforts, and social marketing initiatives are used to increase access to and use of services.

***Quality:*** Quality services are essential to client satisfaction, increasing and sustaining demand, and are more likely to achieve intended health outcomes. Ensuring that the SH brand continues to be equated with quality services is a priority.

***Equity:*** Further gains in health and development indicators require a concerted effort under to reach the poor, especially young women and girls, as well as new parents. DFID funding has enabled the project to focus on the urban poor. Innovative financing and cross-subsidization, combined with improvements in coverage and quality, will increase the proportion of poor clients.

***Institutional strengthening:*** Strong institutional capacity in terms of governance, management and leadership supports performance in the three other dimensions and is critical to NGOs' viability and overall sustainability.

The NHSDP expansion strategy will increase uptake of key reproductive/maternal health services (including FP, ANC, SBA and postnatal care) through (1) increasing demand for reproductive/maternal health services within existing program catchment areas, (2) increasing availability and accessibility of under-used and high-impact services, and (3) expanding the coverage of the SH network through upgrading current service delivery points under existing and new NGOs.

| | Urban Clinics | Rural Clinics | TOTAL |
|---|---|---|---|
| Vital Clinics | 154 | 163 | 317 |
| Ultra-B | 6 | 14 | 20 |
| Ultra-C | 45 | 10 | 55 |
| **TOTAL** | 205 | 187 | 392 |

To date, 62 new clinics have been added to the network. All basic ultra clinics will be upgraded to comprehensive ultra clinics, able to provide CEmONC services, and at least 15 new comprehensive clinics will be added to the network. NHSDP has strengthened capacity to reach the urban poor, including often overlooked sub-populations, through the roll-out of a cadre of urban CSPs. The project has designed interventions for adolescents and young married couples to improve healthy timing and spacing of pregnancies and LARC, and strengthened efforts related to improved referral systems through improving referrals among

other provider networks–including BRAC, Marie Stopes Bangladesh and Blue Star. Improving maternal and child health has been prioritized by training additional nurses and paramedics for provision of SBA, enabling safe home delivery for women who are unable or unwilling to travel to a clinic for institutional delivery services, and providing follow up within 48 hours for postnatal care, including referrals in case of postpartum complications. The project developed a community strategy to identify and link pregnant women to ANC early in their pregnancy to allow for the recommended four visits, and then ensuring a continuum of care for the mother and her child. CSPs play a crucial role in service contacts, counseling and referrals; data from the first two years of the project show that over 60 percent of service contacts were driven by CSPs.

Describe the theory of change of the project/program/intervention.

USAID/Bangladesh DO 3 strives to stabilize population and improve health and nutrition. Its development hypothesis is: "If all Bangladeshis have access to quality health services at an affordable cost and are aware of the benefits of using these services, they will use these services, leading to improved health outcomes. Strengthened health systems are integral to ensuring access to quality and sustainable service provision." NHSDP efforts should contribute to all IRs under DO3. Expanded access to and use of the ESP resulting from NHSDP efforts should measurably improve health outcomes and contribute to decreasing fertility and maternal, infant and child mortality.

Strategic or results framework for the project/program/intervention (*paste framework below*)

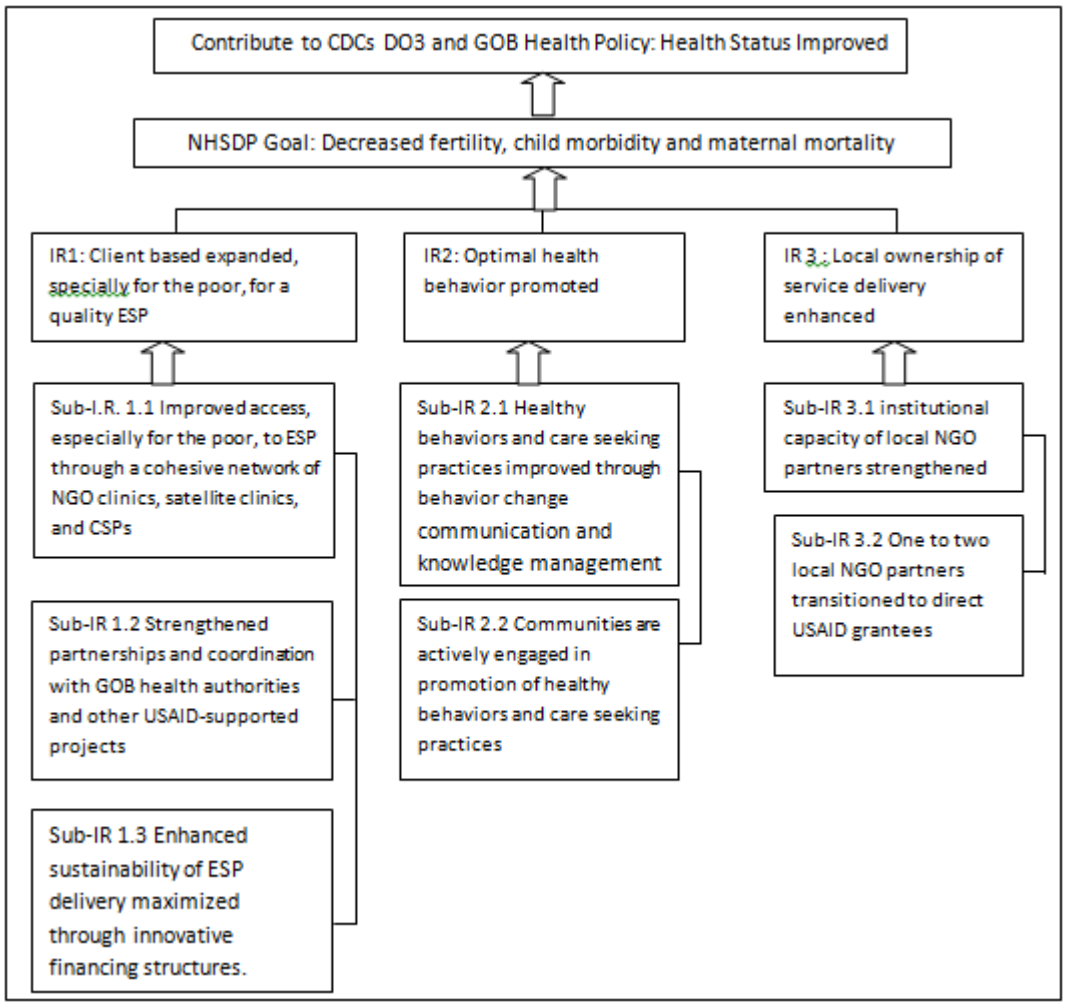
As illustrated in the results framework (Figure 1), the project is implemented through three IRs.

IR1: Expansion of client base especially for the poor to obtain quality ESP. This includes improved access, especially for the poor, to quality services through a cohesive network of NGOs, clinics and community service providers (CSPs); strengthened partnerships and coordination with GoB authorities and other USAID-supported projects; and enhanced sustainability of ESP delivery through innovative financing structures. As part of sustainability, it is expected that during the last year of the project, at least 40 percent of total activity operating costs are recovered through program income and other sources.

IR 2: Promote optimal healthy behavior. The project improves healthy behaviors and care-seeking practices through BCC by engaging communities to be actively engaged in promoting such activities.

IR 3: Enhanced local ownership of service delivery. The project strengthens the institutional capacity of local NGO partners and transitions two of the selected local NGO partners to direct USAID grantees.

**Figure A6: NHSDP results framework**




What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

| |
|---|
| The project has national coverage. The specific catchment areas were assigned under predecessor projects to meet gaps in the GoB primary health care system. |

## IX. SCOPE OF WORK

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

| |
|---|
| The purpose of the NHSDP performance evaluation is to assess the status of the project and provide suggestions for the selection, design and implementation of future projects. The performance evaluation will also assess the relevance and sustainability of the program. In particular, the evaluation results will inform USAID and other relevant stakeholders of how the clinical service delivery program can best be used to maximize public health results and educate the USAID/Bangladesh mission in guiding the design of future service delivery programs. The results of the evaluation will recommend possible options for USAID in adopting service-delivery models and cost-recovery schemes to move toward diverse funding and sustaining a reasonable balance of cost recovery and service delivery to the poor. |

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The audience for this midterm performance evaluation includes USAID/Bangladesh, the Global Health Bureau, the Asia Bureau, DFID, the GoB, relevant implementing partners and sub-grantees and, local NGOs, other bilateral and multilateral donors working for health and service delivery. Other stakeholders, include NHSDP management team members, NGO project personnel, NGO management advisory committee members, government personnel, other USAID supported implementing partners, other donors (DFID in particular) and other donor-funded similar project personnel, are also the intended audience (with any procurement-sensitive portions removed).

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

USAID intends to use the assessment findings as evidence base for follow-on design. Any procurement-sensitive recommendations should, therefore, not be made public. However, the findings and programmatic aspects of recommendations from the assessment will give feedback to Pathfinder and its partners to identify loopholes and shortages in inputs and processes and fine-tune implementation for rest of the project period. Therefore, the team should prepare both public and sensitive but unclassified (SBU) versions of the report (or the SBU section may be a separate, clearly marked, section in the report). USAID intends to arrange broader dissemination of the evaluation through a presentation to stakeholders, seminars and public websites. Such dissemination will help a broader range of stakeholders, including the GoB and donor partners, to look into the potential for growth of service delivery and health financing programs.

D. **Evaluation questions**: Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

| | **Evaluation Question** |
|---|---|
| | ***Note***:<br>a) The evaluators should keep in mind the context of NHSDP:<br>i. Service to the poor and underserved<br>ii. Cost recovery<br>iii. Sustainability<br>iv. Financing, as related to cost recovery and sustainability<br>b) All evaluation questions should result lead the evaluators to determine best practices and lessons learned that lead to recommendations for continued programming and planning for any possible follow-on project, with a focus on urban and rural context or geographic focus.<br>c) The mission is looking for recommendations of innovative approaches that can be rolled out or piloted. |
| | What have been the successes and limitations of the cost-recovery component of the project? Key issues to consider are:<br>• The cost-recovery target of the predecessor project was too high (70 percent) and resulted in NGOs neglecting to serve the poor (see SSFP midterm evaluation). This project has targets of 40 percent cost recovery and 40 percent of service contacts to the poor.<br>• Given the cost-recovery expectations, developing innovative and sustainable financing mechanisms is a key component of the project's work, including health financing pilots. |
| | What have been the successes and limitations of expansion of the network, especially for key ESP services: FP/RH, ANC, delivery, child health and nutrition? Key issues to consider are:<br>• Management of expansion<br>• Client volume<br>• Coverage of poor clients |

| | |
|---|---|
| | • Range of services and quality of services<br>• Referral networks for more complicated cases<br>• Addition of 62 clinics in the past three years<br>• Upgrade of some clinics from vital to ultra clinics<br>• Rational and viability of upgrading clinics<br>• Inclusion of key ESP components in services package |
| | Given the revisions to NHSDP's statement of work since the contract was awarded due to increase in total funding, assess project-level performance issues, identify deficiencies and propose strategies for improvement, taking into consideration limited timeframe for implementation. Key issues to consider are:<br>• Shortcomings and challenges in building NGO capacities<br>• Management-level challenges to execute field-level services and capacity building/on-the-job training by the technical team members<br>• Status of all partners' achievement per the approved workplan of NHSDP–strong and weak areas |
| | What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding building/strengthening NGO capacity? Key issues to consider are:<br>• Effectiveness of mechanisms put in place<br>• Processes to strengthen capacity of two local NGOs to receive direct funding from USAID<br>• NGO sustainability, including diversified sources of funding |
| | What successes (best practices) and shortcomings (lessons learned) has NHSDP had regarding demand creation for service utilization at NSHDP clinics? Key issues to consider are:<br>• Promotional and communication activities<br>• Demand-generation activities that could be supported in partnership with local government, other social services (i.e., education) and civil society for increasing use of health services |
| | How has NHSDP standardized service-delivery models, strategies and tools across the Sujer Hashi network (NGOs and clinics), and how can this be improved? Key issues to consider are:<br>• Standardization of activities across the 26 NGOs that make up the SH network is critical as USAID Bangladesh aims towards sustaining its service-delivery investment through this project. USAID's long-term vision is to develop a solid service-delivery model coming out of this project that the GoB would replicate and scale up as a purchaser of health services from NGOs and the private sector. The model will standardize key components of the service-delivery package offered through the NHSDP related to training materials, standard operating procedures, equipment, etc. The model will eventually be a signature package of USAID SH health services.<br>• Standardization of the five elements of the ESP across NGO clinics<br>• Standardization of standard operating procedures, materials, equipment, demand generation, quality of services<br>• Recommend changes in strategies and approaches for standardization of services across the network to be achieved in the short and long term given the remaining time frame under this project. |

E. **Methods**: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

■ **Document and Data Review** (*list of documents and data recommended for review)*

- Contract statement of work(s)
- Project M&E plan
- CDCS
- PAD
- NHSDP quarterly and annual reports
- NHSDP monthly service statistics reports
- Indicator Performance Tracking Table
- BCC materials

- Training manuals
- SSFP Midterm Assessment (2010) and Impact Reports (2012)
- NHSDP Baseline Information (2014)
- 2014 Bangladesh Demographic and Health Survey
- 2013 Bangladesh Urban Health Survey
- 2014 Bangladesh Health Facility Survey
- HPNSDP Midterm Assessment (2013)
- FANTA Nutrition Report
- NHSDP service quality checklists
- NHSDP Impact Evaluation Baseline tools

☐ **Secondary analysis of existing data** (*lists the data source and recommended analyses*)

| Data Source (*existing dataset*) | Description of data | Recommended analysis |
|---|---|---|
| | | |

■ **Key Informant Interviews** (*list categories of key informants, and purpose of inquiry*)

The team will hold consultations/interviews with a wide range of stakeholders. These stakeholders will include:

- NHSDP management team members
- NGO project personnel
- NGO management advisory committee members
- Government personnel
- Other USAID-supported implementing partners
- Other donors (DFID in particular) and other donor-funded similar project personnel

**Note**: Some of these interviews can be clustered into group interviews for efficiency, as long as the presence of another informant does not inhibit their response.

■ **Focus Group Discussions** (*list categories of groups, and purpose of inquiry*)

[OPTIONAL] Client exit interviews are recommended (see below) to gain information about the demand and use of services from users of the services. Focus group discussions can be conducted among community-based target beneficiaries that include non-users and users of the SH network clinic services, if the evaluators feel that their input is needed to answer the evaluation questions. If data from users of these services is sufficient, the focus group discussions are not needed.

■ **Group Interviews** (*list categories of groups, and purpose of inquiry*)

Key informants can be clustered into groups for efficiency. However, the participants within a group should be of equal status, and all participants should feel comfortable sharing their opinions freely. For example, it is recommended that management be interviewed separately from their staff.

■ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

Exit interviews may be conducted with clients during site visits at SH clinics. Each of these interviews/ discussions will be conducted to determine if the network is operating efficiently, offering high-quality services and meeting a need in the community. The exit interview can be a structured or semi-structured survey.

☐ **Facility or Service Assessment/Survey** (*list type of facility or service of interest, and purpose of inquiry*)

☐ **Verbal Autopsy** (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

☐ **Survey** (*describe content of the survey and target responders, and purpose of inquiry*)

■ **Observations** (*list types of sites or activities to be observed, and purpose of inquiry*)

| |
|---|
| Field visits will be made to observe NHSDP clinic sites and outreach satellite clinics. Visits will also be made to nearby facilities operated by GOB and other providers. Observations will be recorded using an observation checklists. |

☐ **Data Abstraction** (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

| |
|---|
| |

☐ **Case Study** (*describe the case, and issue of interest to be explored*)

| |
|---|
| |

☐ **Rapid Appraisal Methods** (ethnographic/participatory) (*list and describe methods, target participants, and purpose of inquiry*)

| |
|---|
| |

☐ **Other** (*list and describe other methods recommended for this evaluation, and purpose of inquiry*)

| |
|---|
| |

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ☐ No

List or describe case and counterfactual.

| Case | Counterfactual |
|---|---|
| | |

## X. HUMAN SUBJECT PROTECTION

| |
|---|
| The analytic team must develop protocols to ensure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information. |

## XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests and what data is to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

| |
|---|
| The evaluation team will analyze the information collected to establish credible answers to the questions and provide major trends and issues. This will require a thematic analysis of qualitative data, validated by trends of project-produced quantitative data (e.g., service statistics). Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.<br><br>Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist. |

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, MICS, HMIS data, etc.) will allow the team to triangulate findings to produce more robust evaluation results.

USAID requires that performance evaluations explore issues of gender; thus, the evaluation should examine gender issues within the context of the evaluation of NHSDP activities. The evaluation must collect and include gender-disaggregated data in the analysis of findings and conclusions and in making recommendations.

The evaluation report will describe analytic methods and statistical tests employed in this evaluation.

Methodological limitations and challenges for this evaluation are expected to include:

- Ensuring adequate representation of interview and rapid appraisal sources vis-à-vis the full scope of NHSDP activities and outcomes; and
- Taking systematic actions to counter any biases in (a) reporting by data collection sources and (b) interpretations of collected data by the evaluation team.

The methodology narrative should discuss the merits and limitations of the final evaluation methodology. The evaluation team will design appropriate tools for collecting data from various units of analysis. The tools will be shared with USAID during the evaluation and as part of the evaluation report.

## XII. ACTIVITIES

List the expected activities, such as team planning meeting, briefings, verification workshop with implementing partners and stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

**Document Review**
Prior to arrival in country, the team will review key documents on Bangladesh for context (DHS, Facility Survey, HPNSDP Midterm Report, National Population Policy, nutrition report (FANTA), MCH report). The team will also review program documents, including the technical proposal, M&E plans, quarterly progress reports, routine reports of project performance indicator data, annual work plans and annual reports, technical and training materials, and the evaluation reports (list and documents to be provided by the mission). This desk review will provide background information for the evaluation team, and will also be used as data input and evidence for the evaluation.

**Team Planning Meeting (TPM)**
The team will conduct a 4-day TPM upon arrival in Bangladesh and before starting the in-country portion of the assessment. During the TPM, the team will:

- Review and clarify any questions on the evaluation scope of work
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

The TPM outcomes will be shared with USAID/Bangladesh and the health and education team will participate in sections of the TPM. Discussions will also be held with other USAID offices such as OFDHA, DG and EG.
**Briefing and Debriefing Meetings**–Throughout the evaluation the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include the all evaluation team experts, but will be determined in consultation with the mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the team leader to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team leader and review the initial schedule and other management issues.
- **In-briefing with USAID**, as part of the TPM within two working days of internal team members' arrival in Bangladesh. This briefing may be broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM, when the evaluation team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-briefing will be the format and content of the evaluation report(s). The time and place for this in-briefing will be determined between the team leader and USAID prior to the TPM.
- **In-briefing with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the evaluation team.
- The team leader will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the team leader will share these during the routine briefing and in an email.
- A **final debriefing** between the evaluation team and USAID will be held at the end of the evaluation to present preliminary findings to USAID prior to preparing the draft report and before leaving Bangladesh. During this meeting a summary of the data will be presented, along with high-level findings and draft recommendations. For the debriefing, the evaluation team will prepare a **PowerPoint presentation** of the key findings, issues and recommendations; this PowerPoint will be distributed during the debriefing. **The evaluation team shall incorporate comments received from USAID during the debriefing in the evaluation report**. (***Note**: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **Stakeholders' debriefing/workshop** will be held with the project staff and other stakeholders identified by USAID to share and ground-truth top-line results (excluding any that are procurement sensitive). This will occur following the final debriefing with the mission, and prior to departing, and will not include any information that may be deemed sensitive by USAID.

**Fieldwork, Site Visits and Data Collection**–The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

**Evaluation/Analytic Report**–The evaluation/analytic team under the leadership of the team leader will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team leader will submit a draft evaluation report to GH Pro for review and formatting.
2. GH Pro will submit the draft report to USAID.
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro.
4. GH Pro will share USAID's comments and edits with the team leader, who will then do final edits, as needed, and resubmit to GH Pro.
5. GH Pro will review and reformat the final evaluation/analytic report, as needed, and resubmit to USAID for approval.
6. Once evaluation report is approved, GH Pro will reformat it for 508 compliance and post it to the DEC.

The evaluation report **excludes any procurement-sensitive and other SBU information**. This information will be submitted in a memo to USAID separately from the evaluation report.

## XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

| Deliverable/Product | Timelines and Deadlines (estimated) |
|---|---|
| ■ Launch briefing | October 19, 2015 |
| ■ Workplan with timeline | October 28, 2015 |
| ■ Analytic protocol with data collection tools | October 28, 2015 |
| ■ In-briefing with mission | October 25–28, 2015 |
| ■ In-briefing with NHSDP | October 26, 2015 |
| ■ Routine briefings | Weekly |
| ■ Out-briefing with mission or organizing business unit with PowerPoint presentation | November 29, 2015 |
| ■ Findings review workshop with stakeholders with PowerPoint presentation | November 30, 2015 |
| ■ Draft report | December 16, 2015 |
| ■ Final report | January 11, 2016 |
| ■ Raw data | January 11, 2016 |
| ☐ Dissemination activity | |
| ■ Report posted to the DEC | January 29, 2016 |
| ☐ Other (specify): | |

**Estimated USAID review time**
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 business days

## XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

**Evaluation team**: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with related methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

**Team Qualifications**: Please list technical areas of expertise required for this activity.

The evaluation team will consist of 3-4 key staff, including a team leader, plus a logistics/administrative assistant and 1-2 local evaluators. The team members should represent depth of knowledge related to health service delivery in Bangladesh; non-profit management, capacity building and financial sustainability; in-depth knowledge of financing schemes to subsidize service delivery to the poor; quality of care; behavior change and demand creation; MCH and FP. Below are position descriptions for five key staff, but during the recruitment process it is anticipated that some of these positions will be combined as consultants are identified that fit more than one profile.

The technical team members must all have significant international health program and evaluation experience. They should have some Bangladesh country or Asian regional experience, along with comparative experience in MCH-FP service delivery in other countries or regions of the world. At least two members of the technical experts must have Bangladesh experience, speak Bangla, and be familiar with the MCH-FP service delivery structure in urban and rural areas. The logistic/support person should have basic knowledge about interview

techniques and be able to provide translation services to other team members. All team members must have professional-level English speaking and writing skills.

**Team Leader**

This is an international consultant who will be selected from among the key staff, and will meet the requirements of both this and the other position. The team leader should have significant experience conducting project evaluations. The team leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other members of the team. The team leader will develop tools for the assessment and a design plan and share it with USAID/Bangladesh. The team leader will develop the outline for the draft report, present the report and after incorporating USAID Bangladesh staff comments if necessary, submit the final report to USAID/Bangladesh within the prescribed timeline.

**Skills/Experience:** The team leader should have:

- Advanced degree in health management, health finance, public health or related field
- At least 10 years working experience in the field of international health
- Knowledge of health systems and health issues in Bangladesh
- A good understanding of USAID project evaluation
- At least 5-8 years of experience in conducting/leading evaluations in the health sector
- Program planning and assessment/evaluation experience
- Experience leading a team for international health program evaluations or related assignments
- Excellent writing, communication and presentation skills
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation and consensus-building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report-writing experience
- Experience working in the region, and experience in Bangladesh is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation Policy
  - Results frameworks
  - Performance monitoring plans

In addition to the technical responsibilities outlined in the scope of work for the assignment, team leader responsibilities include:

**Preparations**

- Finalize and negotiate with USAID/Bangladesh the evaluation work plan.
- Establish assignment roles, responsibilities and tasks for each team member.
- Ensure that the logistics arrangements in the field are complete.

**Management**

- Facilitate the TPM or work with a facilitator to set the agenda and other elements.
- Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report.
- Manage the process of report writing.
- Manage team coordination meetings in the field.

- Coordinate the workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

**Communications**

- Handle conflict within the team.
- Serve as primary interface with the client and serve as the spokesperson for the team, as required.
- Debrief the client as the assignment progresses, and organize a final debriefing.
- Keep the GH Pro headquarters staff apprised of progress challenges, work changes, team travel plans in the field, and report preparation via phone conversation or email at least once a week.
- Serve as primary interface with GH Pro in submission of draft and final reports/deliverables to GH Pro.
- Make decisions about the safety and security of the team in consultation with the client and GH Pro headquarters.

**Direction**

- Assume technical direction lead as required in order to ensure quality and appropriateness of assignment and report content.

**Key Staff 1** Title: **Health System Strengthening and Health Financing Specialist**

Roles and responsibilities: Serve as a member of the evaluation team, and provide technical expertise on health systems strengthening and/or health financing, particularly as it relates to sustainable management and delivery of quality integrated services within the NGO sector. The specialist will determine if the distribution of the clinics and the distribution of the types of clinics are rational and viable as the service delivery landscape evolves. S/He will be able to effectively examine referral networks and links to other networks of service provision, including the private sector, BRAC and GoB systems using project and system data. The consultant will participate in team meetings, key informant interviews, group meetings, site visits and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. S/He will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID/Bangladesh or other stakeholders. S/He will communicate with the team leader and other consultants to produce written notes to incorporate in the report as required, addressing comments and feedback from USAID. S/He is required to make his/her contributions to the team leader within the timeline.

Qualifications:

- Minimum of 10 years of experience in public health in Bangladesh, with technical knowledge and experience of health systems strengthening/service integration.
- Strong background in MNCH, FP and nutrition, particularly commodities and services available in Bangladesh, with a focus on health systems strengthening, health service financing, costing, health insurance and quality improvement
- Knowledge of various financing schemes to subsidize service delivery to the poor
- An advanced degree in public health, health management, health administration, or related field
- Experience in design and implementation of health service delivery programs
- Good writing skills, with experience producing evaluation and/or technical reports

- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Proficient in English
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the region, and experience in Bangladesh is desirable.

**Key Staff 2** Title: **Non-profit organizational capacity development specialist**

Roles and responsibilities: This consultant will provide technical expertise to evaluate organizational capacity-strengthening and management activities. S/He will evaluate the performance of the NGOs and the network. The consultant will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. S/He will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID/Bangladesh or other stakeholders. S/He will communicate with the team leader and other consultants to produce written notes to incorporate in the report as required, addressing comments and feedback from USAID. S/He is required to make his/her contributions to the team leader within the timeline.

Qualifications:

- An advanced degree in public health, public administration, health care administration or related field
- Background and at least 10 years' experience in organizational capacity development/strengthening
- Significant knowledge and experience with transitioning health service organizations from single-donor funding to diversified funding and/or financial independence
- Deep understanding of management and financial capability requirements for NGOs to manage diverse funding streams
- Knowledge of various financing schemes to subsidize service delivery to the poor is desirable.
- Knowledgeable in capacity building assessment and evaluation methodologies
- Demonstrated success in improving administration and management of non-profit health services organizations in developing country settings
- At least five years managing MCH/FP programs
- Experience in design and implementation of health service delivery programs
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report-writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the region, and experience in Bangladesh is desirable.

**Key Staff 3** Title: **Marketing, communication and demand-creation specialist**

Roles and responsibilities: A consultant will be a team member with expertise in strategic communication, marketing and demand-generation for health services. This specialist will look at how the project and clinic personnel have engaged communities, and whether or not these activities have stimulated demand and/or resulted in increased service utilization. S/he will identify promising demand-generation activities that NGOs could support in partnership with local government, other social services (i.e., education) and civil society for increasing use of health services. The consultant will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. S/He will also participate in presenting the report to USAID or other stakeholders and be

responsible for addressing pertinent comments provided by USAID/Bangladesh or other stakeholders. S/He will communicate with the team leader and other consultants to produce written notes to incorporate in the report as required, addressing comments and feedback from USAID. S/He is required to make his/her contributions to the team leader within the timeline.

Qualifications:

- An advanced degree in public health, or related field
- At least 10 years of experience working with marketing, communication and demand creation programs in developing country settings
- Experience in social marketing and demand-generation for FP/RH and MCH services
- Experience and knowledgeable on evaluation methodologies related to marketing, communication and demand-creation
- At least five years managing MCH/FP programs
- Experience in design and implementation of health service delivery programs
- Experience working in private sector health service delivery
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report-writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the region, and experience in Bangladesh is desirable.

**Key Staff 4** Title: **Evaluation specialist**

Roles and responsibilities: The consultant will provide quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing. The consultant will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. S/He will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID/Bangladesh or other stakeholders. S/He will communicate with the team leader and other consultants to produce written notes to incorporate in the report as required, addressing comments and feedback from USAID. S/He is required to make his/her contributions to the team leader within the timeline.

Qualifications:

- At least five years of experience in USAID M&E procedures and implementation
- At least five years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills and experience in developing qualitative and quantitative evaluation tools
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data

- Must have excellent data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Good writing skills, with experience producing evaluation and/or technical reports
- Experience working on MCH/FP programs; USAID health project experience preferred
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report-writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the region, and experience in Bangladesh is desirable.

**Key Staff 5** Title: **MNCH-FP specialist**

Roles and responsibilities: Serve as a member of the evaluation team, providing expertise in MNCH and FP. S/He will focus on MNCH-FP activities within the project, and with NGOs and clinics. The consultant will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. S/He will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID/Bangladesh or other stakeholders. S/He will communicate with the team leader and other consultants to produce written notes to incorporate in the report as required, addressing comments and feedback from USAID. S/He is required to make his/her contributions to the team leader within the timeline.

Qualifications:

- An advanced degree in public health, or related field
- At least 10 years of experience working with MNCH and FP projects/programs in developing country settings
- Knowledge of MNCH and FP service delivery models, including NGO and private sector
- Experience in design and implementation of health service delivery projects/programs
- Experience working in private sector health service delivery
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report-writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the region, and experience in Bangladesh is desirable.

Other Staff titles with roles and responsibilities (include number of individuals needed):

**Logistics/administrative coordinator (national)** will support the team in all aspects of their work for carrying out this assignment. This includes making provision for workspace, copying, internet, local transport, including any travel outside of the capital, and meeting rooms as needed for the teams' internal consultations. The administrative coordinator will have a good command of English, written and verbal, and Bangla, and will have knowledge of key actors in the health sector and locations, including the GoB, donors and other stakeholders, including the private sector partners. S/he will be able to efficiently liaise with hotel staff, arrange car rentals through using approved mission or hotel cars and ensure cell phones, business center support, e.g., copying, internet and meeting space is available for the team. S/he will work under the guidance of the team leader to make preparations, arrange meetings including round table meetings, travel outside of Dhaka and

ensuring note-taking at required meetings. S/he will conduct administrative and support tasks as assigned and ensure the process moves forward smoothly. S/he will be attentive to team requirements and anticipate needs for computers, AV equipment or other last-minute requests as required. S/he will report to the team leader and liaise directly with GH Pro as required to satisfactorily complete assignments for support the team.

**Local evaluators** *(2 consultants)* to assist the evaluation team with data collection, analysis and data interpretation. They will have basic familiarity with health topics (FP and MCH), as well as experience conducting surveys, interviews and focus group discussion, both facilitating and note-taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The local evaluators will have a good command of English and Bangla. They will also assist the team and the logistics coordinator, as needed. They will report to the team leader.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes–If yes, specify who:
■ No

**Staffing Level of Effort (LOE) Matrix (Optional)**:
This optional LOE matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of effort in **days** for each evaluation/analytic team member

| | **Activity/Deliverable** | **Team Leader** | **Key Staff (3 people)** | **Local Evaluators** | **Local Logistics/ Administrative Coordinator** |
|---|---|---|---|---|---|
| | Number of persons ☐ | 1 | 3 | 2 | |
| 1 | Launch briefing | 0.5 | | | |
| 2 | Desk review | 5 | 5 | | |
| 3 | Preparation for team convening in country | | | | 2 |
| 4 | Travel to country | 2 | 2 | | |
| 5 | Team planning meeting | 4 | 4 | 4 | 4 |
| 6 | In-briefing with mission with preparation | 1 | 1 | 0.5 | 1 |
| 7 | In-briefing with project | 0.5 | 0.5 | 0.5 | 0.5 |
| 8 | Data collection quality assurance workshop *(protocol orientation for all involved in data collection)* | 2 | 2 | 2 | |
| 9 | Preparation/logistics for site visits | 0.5 | 0.5 | 1 | 2 |
| 10 | Data collection/site visits (including travel to sites) | 18 | 18 | 18 | 18 |
| 11 | Data analysis | 5 | 5 | 5 | 3 |
| 12 | Debriefing with mission with preparation | 1 | 1 | 1 | 1 |
| 13 | Stakeholder debriefing workshop with preparation | 1 | 1 | 1 | 1 |

| Activity/Deliverable | | Team Leader | Key Staff (3 people) | Local Evaluators | Local Logistics/ Administrative Coordinator |
|---|---|---|---|---|---|
| 14 | Depart country | 2 | 2 | | |
| 15 | Draft report(s) | 5 | 4 | 1 | 1 |
| 16 | GH Pro report quality control review and formatting | | | | |
| 17 | Submission of draft report(s) to mission | | | | |
| 18 | USAID report review | | | | |
| 19 | Revise report(s) per USAID comments | 3 | 2 | | |
| 20 | Finalize and submit report to USAID | | | | |
| | 508 compliance review | | | | |
| | Upload evaluation report(s) to the DEC | | | | |
| | **Subtotal LOE** | **50.5** | **48** | **34** | **33.5** |
| | **Total LOE (248-296 days)** | **50.5** | **96-144** | **68** | **33.5** |

If overseas, is a 6-day workweek permitted? ■ Yes ☐ No

**Travel anticipated**: List international and local travel anticipated by what team members.

All team members will be expected to travel to at least one or two sites outside Dhaka.

## XV. LOGISTICS

***Note***: Most evaluation/analytic teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access
Specify who will require Facility Access: _____
☐ Electronic County Clearance (ECC) (International travelers only)
☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____
☐ Travel-other than posting (specify): _____
☐ Other (specify): _____

## XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review scope of work and recommend revisions as needed.
- Provide technical assistance on methodology, as needed.
- Develop budget for analytic activity.
- Recruit and hire the evaluation team, with USAID point of contact approval.
- Arrange international travel and lodging for international consultants.
- Request for country clearance and/or facility access (if needed).
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight.

- Report production: If the report is public, then coordinate draft and finalization steps, editing/formatting, 508ing required in addition to submission to the DEC and posting on GH Pro website. If the report is internal, then copy edit/format for internal distribution.

## XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add others as appropriate.

**USAID Roles and Responsibilities**

**USAID** will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

**Before Field Work**

- Scope of work:
  - Develop scope of work.
  - Peer-review scope of work
  - Respond to queries about the scope of work and/or the assignment at large.
- Consultant conflict of interest: To avoid conflicts of interest or the appearance of one, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential conflict of interest with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents: Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local consultants: Assist with identification of potential local consultants, including contact information.
- Site visit preparations: Provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs.
- Lodgings and travel: Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

**During Field Work**

- Mission point of contact: Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team's work.
- Meeting space: Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- Meeting arrangements: Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate contact with implementing partners: Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

**After Field Work**

- Timely reviews: Provide timely review of draft/final reports and approval of deliverables.

## XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for the final report. (See *How-To Note: Preparing Evaluation Reports*)

The **evaluation/analytic final report** must follow USAID's *Criteria to Ensure the Quality of the Evaluation Report* (found in Appendix I of the USAID Evaluation Policy).

a. The report must not exceed **30 pages** (excluding executive summary, table of contents, acronym list and annexes).
b. The structure of the report should follow the evaluation report template, including branding found here or here.
c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
d. For additional guidance, please see the *How-To Note on preparing Evaluation Draft Reports* found here.

**Reporting Guidelines:** The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508-compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The preliminary findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Title page with photo
- Acknowledgements (1 page)
- Table of contents (1 page);
- Acronyms
- Executive summary: concisely state the project purpose and background, key evaluation questions, methods, most salient findings and recommendations (2-3 pages);
- Evaluation purpose and evaluation questions, including audience and synopsis of task (1-2 pages)
- Project background, including country context, development problem, USAID's response, design and implementation of NHSDP, and other relevant previous and current programming (1-4 pages)
- Evaluation methods and limitations (1-3 pages)
- Findings (10-15 pages)
- Conclusions, including best practices and lessons learned (2-3 pages)
- Recommendations (3-4 pages)
- Annexes
    - Annex I: Evaluation/Analytic Statement of Work
    - Annex II: Evaluation/Analytic Methods and Limitations
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviewed
        - Bibliography of Documents Reviewed
        - Databases
        - [etc.]
    - Annex V: Disclosure of Any Conflicts of Interest
    - Annex VI: Statement of Differences [if applicable]

The report format should be restricted to Microsoft products and 12-point type font should be used throughout the body of the report, with page margins one inch top/bottom and left/right.

**The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports.**

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The evaluation report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other SBU information will be submitted in a memo to USAID separately from the evaluation report.

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All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the program manager. All data will be in an unlocked, editable format.

## XIX. USAID CONTACTS

| | Primary Contact | Alternate Contact 1 | Alternate Contact 2 |
|---|---|---|---|
| Name: | Miranda Beckman | Ferdousi Begum | Brenda Doe |
| Title: | Health Officer | Project Management Specialist | Senior Family Planning Advisor |
| USAID Office/Mission | Bangladesh/OPHNE | Bangladesh/OPHNE | Bangladesh/OPHNE |
| Email: | mbeckman@usaid.gov | fbegum@usaid.gov | bdoe@usaid.gov |
| Telephone: | +88-02 5566-2560 | +880-2-5566-2658 | |

List other contacts who will be supporting the requesting team with technical support, such as reviewing scope of work and report [OPTIONAL]

| | Technical Support Contact 1 | Technical Support Contact 2 |
|---|---|---|
| Name: | | |
| Title: | Sr. Evaluation Advisor | |
| USAID Office/Mission | Division of Strategy, Analysis, Evaluation and Outreach<br>Office of Policy, Programs, and Planning (P3)<br>USAID/Bureau for Global Health | |
| Telephone: | 571-551-7144 | |

## XX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above.

# ANNEX II. EVALUATION METHODOLOGY, LIMITATIONS AND DATA COLLECTION INSTRUMENTS

## EVALUATION METHODOLOGY

The evaluation team used a mix of quantitative and qualitative methods of data collection. The team used structured questionnaires to generate quantitative and qualitative data from Pathfinder and the 25 NGOs and a sample of SH clinics. The team studied several national-level data sets, such as the 2010 Household Income Expenditure Survey and 2014 BDHS. Qualitative and quantitative data were generated from individual interviews. Quantitative information was derived from data sets maintained and formative research conducted by the project. The team also used findings from several other relevant organizations. Qualitative information was generated through individual interviews, group discussions, focus groups and field observations. To ensure collection of comparable information during field visits, the team drafted standard guides for data collection activities.

The selection of cities where NGO clinics were identified and visited was purposive. The two largest cities covered, Dhaka and Chittagong, have the highest number of NHSDP SH clinics. The third location included was Cox's Bazar, a midsize town in the Chittagong Hill Tracts. Adjacent semi-urban and rural locations were also covered. The sampling coverage ensured representation of densely populated urban locations as well as a relatively small town.

Since key informant interviews, group discussions and focus groups were major sources for validation of information available from the project, the evaluation team selected locations and interviewees with guidance from USAID/Bangladesh to minimize the possibility of bias and maximize the outcomes of the evaluation process.

A brief narrative on the specific data collection methods is outlined below (Table A1):

1. **Desk review:** The evaluation team conducted an extensive desk review of data and reports from USAID, NHSDP and the GoB, as well as materials from other development partners and independent research organizations. Please see Annex V. for a list of key documents.
2. **Key informant interviews:** The evaluation team conducted individual and group key informant interviews with 70 individuals, including key NHSDP staff from different units and task forces, NGO and clinic staff, relevant government officials from the DGHS and DGFP of the MOHFW, lead representatives of the project subcontractors and major partners, directors of urban city corporation health units and others. Please see Annex IV. for a full list of key informants. Information was solicited from key informant interviews, depending on the person's affiliation in the health sector and association with NHSDP.
3. **Clinic client exit interviews:** The evaluators conducted 56 exit interviews[92] with clients in the 14 SH urban and semi-urban clinics visited. Once the client received his/her service(s) at the clinic and was about to leave, the interviewer approached the client and conducted the interview within the clinic in a private room, with only the interviewer and interviewee present. These interviews were done to assess the provider behavior and the quality of counseling based on client satisfaction. A semi-structured questionnaire, consisting of both open and closed questions,

[92] Exit interviews depended on the pool of outpatients available during the evaluation team visit. If the number of patients was higher than the targeted coverage, the team used a systematic random sampling technique (e.g., every third patient was interviewed after receiving service). If the number of patients equaled or was less than the targeted coverage for the clinic, all were interviewed.

was administered by the interviewer and responses recorded. Assistance from the clinic manager was solicited to encourage clients to participate in the interview, and to provide the private room for the interview.

4. **Group discussions:** The team conducted group discussions with project directors and members of the executive committees of partner NGOs. The discussions were conducted outside the project's facilities/premises.
5. **Focus group discussions:** Focus group discussions were conducted with representatives from CSPs and SHCSGs. These groups related to the SH clinics visited in Dhaka (1), Chittagong (1) and Cox's Bazar (3). The discussions were held on the clinic premises. Separate discussions were conducted for men and women. Local evaluators were available to document the discussion and interpret so that participants could speak Bangla if they felt more comfortable.
6. **NGO and clinic field visits:** For NGO and clinic visits, the team purposively selected three major cities of the country–Dhaka, Chittagong and Cox's Bazar–due to time and security constraints. A sample of 14 clinics was visited that represented both rural and urban clinics. Clinic visits included pre-arranged and unannounced visits.[93]
7. **E-Questionnaire:** A detailed e-questionnaire was developed and sent to all SH project directors at the 25 NGOs to obtain their input and recommendations about programmatic components of NHSDP.
8. **Clinic survey:** The clinic survey was conducted to assess capacity and understand targeted clients/patients. Selection of clinics involved a multistage purposively selected sampling. The survey was limited to the three cities/towns and their adjacent areas (urban, peri-urban and rural). In these three locations, the local team identified the NHSDP partner NGOs with clinics there. In Cox's Bazar, one NGO was operating, in Chittagong city, three NGOs and in Dhaka more NGOs operate. In Dhaka, the team purposively selected clinics from a number of NGOs based on varied characteristics–size, location, etc. USAID suggested that the team survey one particular NGO clinic. Often the respondent was the clinic manager. If not available, the senior staff person available was interviewed. For some questions, relevant staff were questioned. The survey instrument developed included a checklist of available services, amenities, compliance with standards and protocols, staff training received and client demographics. The survey was administered to both urban, peri-urban and rural clinics in each of the three cities.

**Table A10: Survey data collection coverage**

| Method | | Dhaka | Chittagong | Cox's Bazar | Total |
|---|---|---|---|---|---|
| Group discussions | | 4 | 1 | 0[94] | 5 |
| Focus group discussions | | 1 | 1 | 3 | 5 |
| e-Questionnaire of NGOs | | Instrument sent to 25 NGOs; 11 responded | | | |
| Clinic survey | Urban | 3 | 6 | 2 | 11 |
| | Rural | 2 | | 1 | 3 |
| Exit interviews of clients | | 17 | 20 | 19 | 56 |

[93] The clinic visit was systematic. It was aimed at talking to key staff about service delivery, management, etc. The team used a checklist of functional medical equipment and infrastructural facilities.

[94] The reason that no group discussion was held at Cox's Bazar is that unlike Dhaka and Chittagong, Cox's Bazar has a single NHSDP partner NGO, Family Development Services & Research (FDSR). The team interviewed the FDSR project director in Cox's Bazar. The NGO's executive committee members reside either in Dhaka or Chittagong, so the team interviewed FDSR executive members in group discussions in one of the two cities.

The instruments that were used for data collection are provided below. For quantitative data, the researcher asked structured questions. For qualitative data, the talking points served as guidelines for discussion and debate, with probing for clarity where necessary. Data from client exit interviews were entered and coded in Excel, then imported and analyzed in STATA, a data and statistical analysis software program. The data collected from the e-questionnaire were also entered and coded in Excel, and a comparative study of responses was made.

In studying the determinants that play a role in selection of health service providers, besides the analysis of primary data collected in the evaluation, comparison with secondary data was also made, including 2010 Household Income Expenditure Survey data and NHSDP Exit Interview Survey data.

## EVALUATION LIMITATIONS

- The selection of cities where NGO clinics were identified and visited was purposive due to time and security constraints on travel, especially of the three international consultants. Best efforts were made to cover both urban areas with NGOs with the high numbers of NHSDP SH clinics as well as adjacent semi-urban and rural areas with SH clinics of smaller NGOs.
- Positive response bias could exist among clients of the SH clinics who participated in the exit interviews when the clinic managers encouraged them to participate; they may have felt a responsibility to respond positively. Interviewees may also have had concerns that their responses may affect their future access to care.
- A limitation could be the proportionately larger number of focus group discussions done in Chittagong. This was because of the availability there of all four local team members, while, in other locations, the local team member numbers were smaller.
- The low response rate—the total number of NGOs that responded to the e-questionnaire was less than half (11/25=44 percent)–is a limitation. The results reported by the NGOs that have completed the e-questionnaire may be different compared to the NGOs that did not respond (raising the possibility of a non-response bias).
- The language issue in interviews and discussions is another potential limitation.
- Ensuring adequate representation of interviews and rapid appraisal sources vis-à-vis the full scope of NHSDP activities and outcomes is a limitation.
- The evaluation team was not engaged in primary data collection from any statistically designed sample of beneficiaries, providers or facilities. Rather, it depended on the secondary data

  assessments conducted by the project.

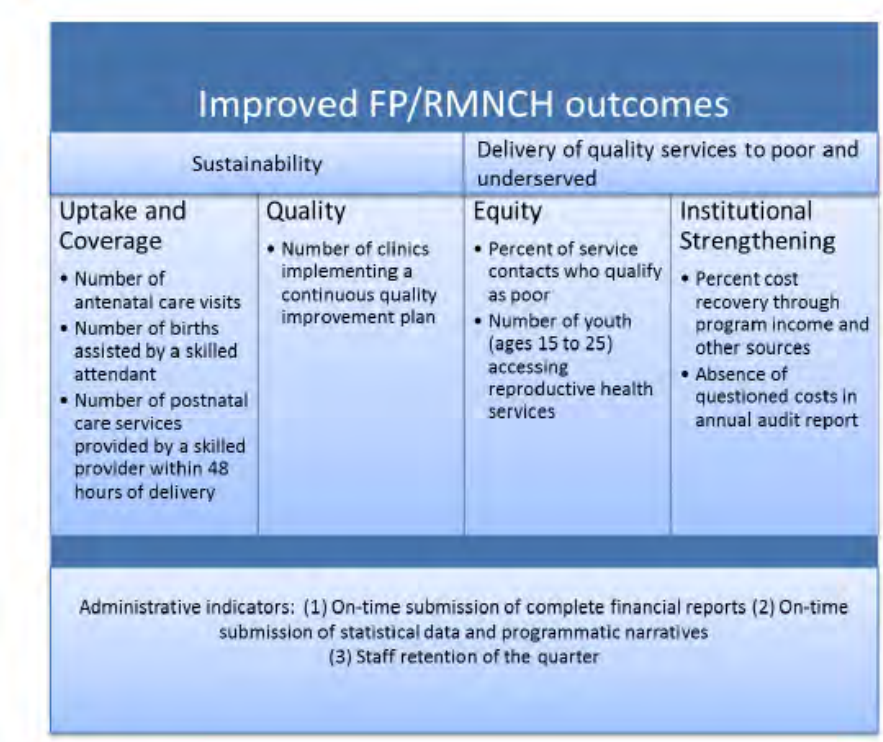
## NHSDP/Surjer Hashi Network
## Quality Monitoring and Supervision Process Instructions

1. **Quality monitoring and supervision** is the primary responsibility of **NGO monitoring officers**. Larger NGOs have up to three monitoring officers, with most NGOs having one. For the smallest NGOs, the role of monitoring officer is assigned to someone who may also have other responsibilities (e.g., the project director).
2. Monitoring officers will conduct **quality monitoring and supervision visits every six months** in each of their respective SH clinics. Visits normally require two days, using the quality monitoring and supervision guideline and checklist. The checklist results in quality scores for various aspects of clinic services. It also identifies areas for improvement, which are compiled in an action plan.
3. Quality monitoring and supervision visits should be planned based on the project year, with six-month periods from October–March (first and second quarters) and from April–September (third and fourth quarters).
    a. **QMS visits should be spread out over both the quarters in each six-month period**, not all conducted in one quarter.
    b. **At least 40 percent should be visited during the first quarter** (quarters one and three) of each six-month period so that there is not an unnecessary rush to complete all clinics in the second quarter (Q2 and Q4) of the period.
    c. In the **quarterly PBG report on continuous quality improvement** there is a standard of at least 40 percent quality monitoring and supervision visits conducted by NGOs to calculate the continuous quality improvement percentage.
4. After each quality monitoring and supervision visit, an **action plan will be developed by the monitoring officer**, according to the format in the guidelines.
    a. The action plan **must be signed by the project director** (since he/she is ultimately responsible for clinic performance) and sent to the respective clinic manager **within 10 days of the visit**.
    b. The action plan must clearly show the visit date, as well as the period for which the review was done (the previous six months).
    c. The action plan must be kept by the clinic manager, for **follow-up actions and review at any time** by NHSDP/USAID/DFID staff when visiting any clinic.
5. **A bar diagram** of each quality monitoring and supervision score will be made by the monitoring officer and sent to the clinic manager **within 15 days of each visit**.
    a. This diagram must be properly labeled with the **visit date and period** covered by the review.
    b. The diagram should be **posted by the clinic manager** on the bulletin board in the clinic for review by any visitors.
6. Every six (6) months, by the end of March and again by the end of September, **each NGO must compile a quality monitoring and supervision report that includes all the clinics monitored in that six-month period**.
    a. This compiled report, with clear labeling of the time frame, must be submitted to NHSDP's quality assurance specialist (Dr. Farhana Shams Shumi).
7. **Peer quality monitoring review visits** will be conducted during each six-month period by teams of monitoring officers to validate the most recent quality monitoring and supervision visit report in selected clinics. This will normally be a one-day visit.
    a. At least **one clinic from each NGO will have peer review** every six months; in the case of larger NGOs, more than one clinic may be reviewed.
    b. **NHSDP will provide technical support** for the peer reviews, including at least one staff member to accompany each review.

## NHSDP PERFORMANCE-BASED GRANTS STRATEGY

To move NGOs toward local ownership and sustainability without compromising provision of quality services to the poor and underserved, NHSDP strategically ties performance-based grants to four dimensions of NGO performance: service uptake and coverage, quality, equity, and institutional strengthening (see Figure A1). NGOs increase service coverage of underserved populations through mapping exercises, and expansion of essential FP/RMNCH services via static, satellite and mobile clinics. To generate demand for services, the project uses behavior change, community mobilization and social marketing initiatives. As a necessary element to increase demand for services, the project ensures high quality by reinforcing quality standards at every service-delivery level and through stressing service integration, youth-friendliness, non-discrimination and stigmatization of the poor, and emphasis on women- and girl-centered approaches. To reach the poor and adolescents and youth—particularly young couples who are beginning child-rearing—the project uses behavior change and community mobilization strategies to address norms around early marriage and child-bearing as well as gender-based violence. To bring NGOs closer to long-term sustainability, the project strengthens NGO capacity through tailored technical assistance on leadership, governance, administrative systems, financial planning and HR through a range of methodologies including training, mentorship and coaching, and cross-NGO learning opportunities.

**Figure A7. Strategy for improved NGO performance: Indicators incentivized through performance-based grants**




** Indicators for performance-based grants have evolved over the course of implementation to match project priorities and in response to feedback from NGOs.*

## IMPLEMENTATION

In the first nine months of NHSDP implementation, the project collaborated with NGOs to identify capacity-building priorities and benchmarks and initiated activities to expand access to quality services (such as community mapping, strengthening of community groups designed to connect community members with satellite clinics, and clinical trainings for providers) and promote improved healthy behaviors (such as training of community health workers on interpersonal communication and information dissemination). During this time, NHSDP financed NGOs through standard cost-reimbursable grants and established a foundation and design for the performance-based grants mechanism. Namely, the NHSDP team collaborated with USAID to select a set of incentivized indictors that best emphasized project focus areas. These indicators form the basis of the performance-based grants mechanism, in that high performance in those focus areas would result in financial incentives paid to the NGOs. Following design of the mechanism, preparation for performance-based grants included releasing a request for applications from NGOs to participate in the mechanism,[95] establishing a technical committee to review applications, an orientation to the indicators and terms and conditions of performance-based grants, and a negotiation process in which NHSDP and NGO staff discussed budgets and negotiated performance targets. USAID approved the issuance of all 26 performance-based grants, and their implementation began in October 2013, the second year of NHSDP.

Incentives are paid to NGOs annually based on performance against eight indicators (see Figure A2). For every target met, NGOs receive a bonus payment equal to one percent of their total annual budget. If all eight targets are achieved, NGOs receive an additional 2 percent bonus, so the total reward is 10 percent of their total annual budget. In addition, the project identified three administrative indicators. For each administrative target not met, the NGO is penalized by one percent of its quarterly funding from NHSDP. Thus, the NHSDP performance-based grants mechanism uses a "carrot and stick" approach. The project supports NGO capacity to reach these performance targets through a range of methodologies—including training, remote and on-site mentorship and coaching, and opportunities for cross-network learning. These methodologies target NGO capacity related to leadership, governance and management; grants management and financial reporting; and staff retention. This assistance is typically provided to NGO project directors, finance and administration managers, and management and information systems officers—who are then supported to cascade that learning throughout their organizations to ensure that all staff benefit from relevant efforts.

To monitor each grant, NHSDP employs management information system routine reports, supportive supervision and monitoring visits, and a third-party data quality assurance process to validate all submitted performance-based grant data. Additionally, to begin to understand how and why performance-based grants impact the performance of NGO and clinic staff, Pathfinder conducted semi-structured interviews with 19 staff from seven clinics, and 36 staff from 10 NGOs in March 2016.

On an annual basis, NHSDP assessed performance-based grants indicators, alongside NGO performance in other areas, to ensure indicators were appropriately calibrated and were continuing to incentivize desired behavior. Indicators were revised based on these assessments, NGO input and evolving project priorities.

Additionally, in year two, the contract was modified and DFID was added as a donor. This modification resulted in a significant increase in targets for certain performance payments, and thus increased the

[95] To be eligible, NGOs must be: registered Bangladeshi local NGOs with an NGO Affairs Bureau and Social Welfare Registration; principally located in Bangladesh; current Surjer Hashi Network NGOs; strongly linked to community in which implementation is proposed; and must have a constitution and financial management system.

challenge NGOs faced to meet their targets. At the time of this writing, NHSDP is in its fourth year of implementation and third year of performance-based grants implementation.

## FINDINGS

Quantitative and qualitative findings suggest that performance-based grants contributed to improvements from a systems, service-delivery and morale perspective.[96] With regard to systems improvements, the administrative indicators and the potential to incur a penalty if these indicators were not met contributed to on-time and more accurate monthly reports from NGOs. During the first nine months of NHSDP implementation, an average of 3.8 NGOs submitted monthly reports on time. In the first two years of performance-based grant implementation, all NGO reports were submitted on time. The project has also seen significant improvement in the quality of the submitted reports, as errors have decreased over time.

Regarding service delivery, all NGOs met at least one performance indicator target in the first two years of performance-based grant implementation, making them eligible for a performance payment. In the first year, US $702,509 was paid to NGOs and in year two, US $529,146 was paid.[97] Illustrative of improved performance, the number of ANC visits provided by project-supported clinics increased from 915,546 in the first year of NHSDP to 1,684,300 in the third year,[98] and the number of SBA-assisted deliveries increased from 17,663 in year one to 34,988 in year three. Further, the percent of services provided to those who qualify as poor increased from 35 percent in year one to 41 percent in year three.

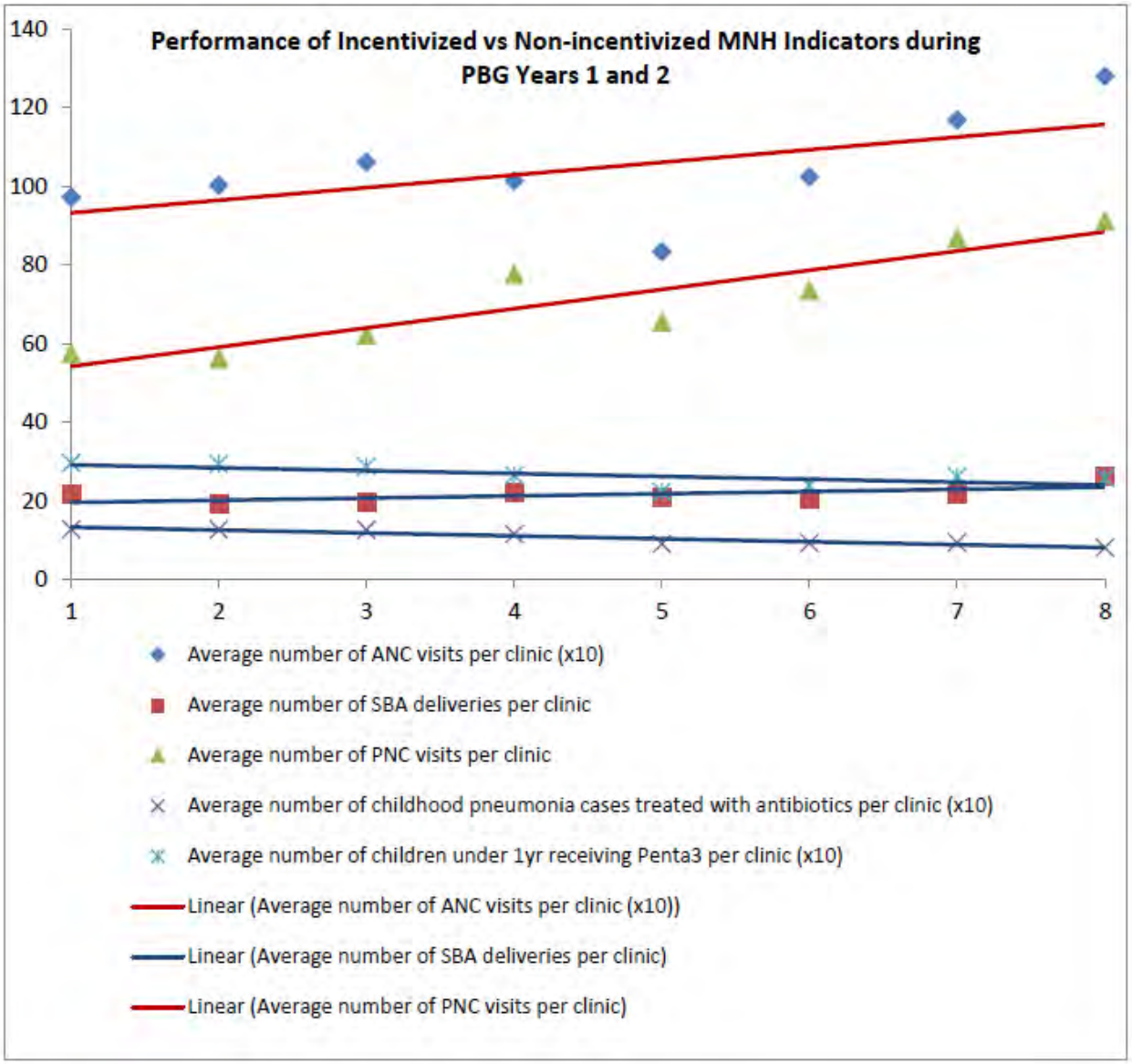
When compared to non-incentivized indicators, data suggest that incentivized indicators performed better. As depicted in Figure A2, the incentivized indicators (number of ANC visits, SBA deliveries, and number of postnatal care visits) increase more over time, while non-incentivized indicators (number of childhood pneumonia cases treated with antibiotics per clinic, and the number of children under 1 year receiving Penta3 per clinic) appear to be stagnant or decreasing. These results suggest that performance-based grants may contribute to further improved performance, when paired with other capacity-building activities.

[96] At the time of this writing, project data are available for years one through three of NHSDP, and years one and two of performance-based grant implementation.

[97] The project estimates that the modified indicators and increased targets led to decreased performance pay in year two.

[98] With the inclusion of DFID on the contract, the target for ANC visits increased significantly.

**Figure A8. Performance of incentivized vs. non-incentivized maternal and newborn health indicators in years one and two of performance-based grant implementation**




**Increased pride, accountability and autonomy leading to locally developed solutions:** All staff expressed feeling positively impacted by the performance-based grants because of the recognition, pride and material goods the grants brought with them. As a clinic counselor and an NGO finance and administrative manager explain:

> *"There is a formal acknowledgement that the target was achieved and I feel proud."*
>
> *"All are committed to achieving the target and it's not just in terms of the money. It's also an ownership, the staff person feels an accomplishment for what she did."*

The sense of ownership is reflected in interviews with staff from all levels. From NGO directors to clinic paramedics, staff demonstrated comprehension of and commitment to meeting their targeted performance. As one clinic paramedic states: "We are constantly monitoring [how] we are lagging behind and we are constantly thinking about what we still have to achieve." Interestingly, this increased

sense of ownership and commitment influenced clinic staff members, as local experts, to actively seek context-appropriate solutions to staff turnover and barriers to uptake or equity. For example, some clinics created a pool of candidates, composed of previous applicants for positions with high turnover, to expedite the hiring process should there be a new resignation. In addition, other clinics employ part-time doctors to meet level-of-effort targets. Further, clinic counselors and managers explain how they changed their practices to ensure they are meeting targets for service uptake:

> *"We are more proactive on follow-up visits for ANC and PNC. Previously, we waited for the clients to come. If a client came to the clinic, we provided her with the service. Now, we track the expectant mothers and do active follow-up to encourage them to come in for the services like ANC and PNC."*

> *"We try to provide services in a way that will better satisfy the customers so that [our] customer base will increase."*

This finding suggests that an ancillary benefit of pay-for-performance mechanisms may be locally developed modifications and solutions to service delivery and barriers to coverage. Further, such initiatives offer implementers an opportunity to work with incentive recipients to learn from these efforts to adapt and respond to contextual challenges in real time.

## KEY INFORMANT INTERVIEW

**SS CLINIC MANAGER/STAFF INTERVIEW**

Date: _____Name of the clinic manager: _____Contact No:_____

NGO name: _____Clinic name and ID: _____

Clinic address: _____

Clinic Type: Vital/BEmOC/CEmONC_____

| | Poor | Non-Poor | Total |
|---|---|---|---|
| 1) Number of clients served in past one month | | | |
| 2) Revenue earned (Taka) | | | |

| 3) Services Provided by the Clinic | Please tick |
|---|---|
| General health care | |
| Adoption of family planning method | |
| Vaccination | |
| Antenatal care | |
| Physical examination (Lab service) | |
| Child health care | |
| Health care services for women | |
| Counseling | |
| Postnatal care | |
| Family planning/Reproductive health counseling | |
| Care about side effects of family planning method | |
| Others | |

**4) Facilities of the Clinic**

| Facilities | Required number | Available Yes/No/ or number? | Functional Yes/No |
|---|---|---|---|
| OPD | | | |
| Waiting room | | | |
| Consultation room | | | |
| Delivery/labor room | | | |
| Pharmacy/dispensary | | | |
| Pathology/laboratory | | | |
| Radiology/X-ray | | | |
| Operation theater | | | |
| Post-operating room | | | |

| | | | |
|---|---|---|---|
| Doctors room | | | |
| Nurse room | | | |
| Medical record/store room | | | |
| Ambulance | | | |
| Ultrasound machine | | | |
| ECG machine | | | |
| Others | | | |
| General | | | |
| Generator | | | |

**5) Clinic Staff**

| Clinic Staff | Required | Available |
|---|---|---|
| M.B.B.S Doctor | | |
| Paramedic | | |
| Counselor | | |
| Lab test/technician | | |
| Administrative staff | | |
| Other support staff | | |

**Cost Recovery, Pricing, Quality, Sustainability**

6) Cost recovery and targeting the poor are two objectives of NHSDP. What are your thoughts on meeting these two objectives?

- _____

7) How many CSPs are operating under this clinic?

- _____

8) How effective are the CSPs in: (i) awareness creation; (ii) bringing clients to SS clinics; (iii) other?

- _____

**Service Charges (Prices) of Health Clinics**

9) Is the current pricing strategy effective in:

(i) reaching the poor:

(ii) competing with other providers:

(iii) cost-recovery effort:

10) What specific changes you would recommend to enhance cost recovery, increase utilization (more patients)?

_____

11) In your opinion what is the potential for other revenue-generating activities? Drug stores/pharmacies? Laboratory facilities?

_____

**Capacity building of NGOs through NHSDP**

| 12 | Types of training given to clinic staff (e.g., clinical training, MIS building) | Training provided to: | Frequency of training provided |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

13) Are there any other forms of capacity-building activities that you undertake?

14) Did the clinic staff receive any kind of training from government and others? If so, what kind of training?

**Public-Private Partnership**

15) MOHFW provides free FP commodities. What other types of assistance do you receive from the government?

**Sustainability of the Clinics Beyond NHSDP?**

How can you envision the sustainability of these clinics and the project? What are the potentials and what are the main challenges?

Are government-run community clinics your competitors or do they complement your services?

How do people perceive Smiling Sun services? What do you think about the quality of services? What is the most important component of the quality that clients care about?

Who are the main clients of Smiling Sun clinics and community-based activities?

**Service Delivery Questions**

What technical support have you received from NHSDP in delivering quality services through your network at clinic and community levels?

What has worked well?

What have been the major challenges?

What suggestions do you have to address challenges/improve support for your organization and its network in delivering quality services?

Have any of you been able to try new innovative ways of delivering services through your network during this project (since 2013)? If yes, please share specific examples.

**Quality and Availability of Services**

The basket of services is limited to primary care and limited curative care. Is increasing.

Location, type of service offered, competition in the area. Pricing strategy. Basket of services. Role of CSPs.

Availability of brand drugs

Availability of skilled medical personnel: physicians, SBA, others

Provider attitude

**POOR SALARIES, STAFF TURNOVER**

## Group Discussion/Focus Group Discussion

**Introduction (evaluation team and NGO representatives)**
- Purpose of the midterm evaluation
- Purpose of the meeting

**Introductory questions for the NGO representatives**
Tell us about your NGO. Year established.
Your NGO's health and non-health programs implemented.
Your NGO's coverage across the country. Since when is your NGO involved with NHSDP? Number of Smiling Sun (SS) clinics you manage.

**Cost Recovery, Pricing, Quality, Sustainability**
The NSHDP was to develop a project wide Sustainability Plan to explore diverse methods to recover costs (third party payers, cross-subsidization, etc. to help recover costs). How the NHSDP helped your NGOs to develop methods to be able to sustain the clinics' quality services? Has your NGO developed any such plans? Please describe.

Cost recovery and targeting the poor are the double objectives of NHSDP. Your thoughts in meeting the two objectives.

**Service Charges (Prices) of Health Clinics**
Is the current pricing strategy effective in: (i) reaching the poor; (ii) competing with other providers; (iii) cost-recovery effort? What specific changes you would recommend to enhance cost recovery, increase utilization (more patients), increase income from diverse sources?

**Quality and Availability of Services**
There were documented issues with NGO constraints in using their income to provide care. Has generally this issue been resolved?

The basket of services is focused on primary care and limited curative care.

An increase in the volume of patients (enhanced capacity utilization) is one key determinant in cost recovery. What are the key factors in determining selection of SS clinics: (i) location; (ii) brand; (iii) access to other health facilities; (iv) relative prices of services with competing facilities; (iv) role of CSPs; (v) other?

A study on SS clinics suggests that availability of brand drugs is a major factor to attract clients. Do you agree or disagree? Are there disruptions in the supply of drugs to the clinics?

Is there high turnover of medical staff in your clinics? Are poor salaries the main factor? Other factors?

**Capacity Building of NGOs**

1. NHSDP has conducted an extensive capacity-development assessment of the NGOs and provided training and other support. What areas have been strengthened the most in the NGOs? What areas are still in need of strengthening?
2. NHSDP developed a training needs assessment and an integrated training plan. Please discuss the training and follow-on support NHSDP provided to NGO staff. What is still needed by the NGOs?
3. What capacity-building needs do the NGOs have in tracking performance, financial systems, other reporting? Please describe.
4. Revised Management Guidelines were developed by NHSDP to help strengthen NGOs' capacity. Do you have the Revised Management Guidelines in Bengali in all your clinics? Please describe how staff is using them.
5. The NHSDP MIS system has been developed and introduced to the NGOs. What kind of capacity development is needed for NGOs to effectively use this new MIS system? How does this MIS system integrate with the HMIS system of the GoB/MOHFW?

**Public-Private Partnership**
MOHFW provides free FP commodities. What other types of assistance you receive from the government? Training of staff?

**Sustainability of NGO partners and their activities beyond NHSDP**

1. How do people perceive Smiling Sun services? What do you think about the quality of services? What is the most important component of the quality that clients care about?
2. Who are the main clients of Smiling Sun clinics and community-based activities?
3. How can you envision the sustainability of this project? What are the potentials and what are the main challenges?

**Service Delivery Questions**

- What technical support have you received from NHSDP in delivering quality services through your network at clinic and community levels?
    - What has worked well?
    - What have been the major challenges?
    - What suggestions do you have to address challenges/improve support for your organization and its network in delivering quality services?
- How effective are the Community Service Providers in: (i) awareness creation; (ii) bringing clients to SS clinics; (iii) other?
- Have any of you been able to try new innovative ways of delivering services through your network during this project (since 2013)? If yes, please share specific examples.

## E-SURVEY

NGO Health Service Delivery Project (NHSDP)
Midterm Evaluation

- Purpose of the evaluation

This midterm performance evaluation's focuses on: what the NHSDP has achieved; how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other issues related to its program design, management and operational decision-making. The evaluation will provide information to USAID, DFID and other relevant organizations for any changes needed in the current project and to support the development of the next project.

- Purpose of this questionnaire

The purpose of this questionnaire is to give each NGO the opportunity to participate in this midterm evaluation exercise and to provide a platform for the NHSDP project director in each NGO to introduce his/her organization, present and discuss areas of success and challenges of different project components and share best practices and lessons learned.

Your participation is highly appreciated and all received answers will be anonymous and strictly confidential. Please know that you have right not to answer the questionnaire or any of its question. Please send reply to: di@dataint.com

Service Delivery Quality
What technical/clinical support has NHSDP provided to improve quality health services in your NGO's Surjer Hashi (SH) project…..at the ANC, PNC clinic and community levels? Please describe.
(NHSDP technical services related to health service quality)

- Family planning ☐
- Nutrition–IYCF ☐
- Counseling ☐
- Delivery ☐
- EPI ☐
- Other ☐

List three major supports that your NGO provides to Surjer Hashi clinic teams and facilities.

Do you have full staffing?
Yes ☐ No ☐
List three issues that your NGO encounters in recruiting and retaining skilled medical staff, physicians, paramedics, lab technicians, skilled birth attendants for its SH program

How does your NGO evaluate the quality of its health services provided through SH?

What has worked well in your SH program? What are your successes?

What would make your SH services even better?

What are your major challenges in service delivery?

What new innovative approaches of delivering health services have your SH project tried?

I. Cost Recovery, Pricing, Quality, Sustainability

1. Did the NHSDP help you with your NGO plan for cost recovery? ☐
   If yes, describe. If no, why not.

2. What support did NHSDP provide to help your NGOs to develop the Sustainability Plan? Implement the plan? Please describe.

3. What is your SH project's percent of cost recovery?

4. What percent of your SH project cost recovery is from C-sections? ----------%

5. What are the charges for C-section in your SH project? ----------taka

6. What percent of your clients are

- POP? -------%
- Poor ---------%
- Able to pay ----------%

7. What specific changes would you recommend to enhance cost recovery?
    - Increase utilization (more patients): Yes ☐ No ☐
    - Increase income from diverse sources? Yes ☐ No ☐
    - Other … please explain

Are there constraints with your NGO getting access to its funds? Please explain.

II. Capacity building of NGOs

III. What kind of capacity-building support has NHSDP provided to your NGO? Please describe.

6. Did your NGO develop a road map based on the assessment? Yes ☐ No ☐

7. If yes, in your road map what major areas did your NGO need to strengthen? Please tick all that apply:

Governance
Management practices
Monitoring and evaluation
Program management
Human resources
Finance and administration
External relations
Other, please describe

8. On a scale of 1-5 how effective is the NHSDP support to your NGO (the areas ticked) for capacity development?
Not good Very good
☐ 1-------☐ 2-------☐ 3-------☐ 4------☐ 5

9. What areas of support does your NGO still need? Please describe.

10. What challenges do you have to strengthen your NGO's institutional management? Please describe.

11. NSHSDP has developed Revised Management Guidelines.
    - Does your SH program have the Revised NHSDP Management Guidelines in Bengali in all your clinics?
        Yes ☐ No ☐ but we have in _____%
    - Does your staff use them regularly?
        Yes ☐ please describe
        No ☐ why not?

IV. Sustainability of NGO SH programs

1. How do people perceive Surjer Hashi services? Tick one or more.
   - Excellent services with high quality ☐
   - Don't know–no studies were done to know how people perceive Surjer Hashi services ☐
   - Services for poor, so other people are not willing to use, or do not use SH services ☐
   - Services are too limited ☐
   - Providers are not always available ☐
   - Other (please explain) ☐

2. Do you think the Surjer Hashi program needs a strong marketing campaign?

   Yes ☐ How would a campaign help?

   No ☐ Why not?

3. What do you think about the level of quality of Surjer Hashi services?
   - Excellent ☐
   - Good ☐
   - Acceptable ☐
   - Not good ☐
   - Other (please explain) ☐

4. What is the most important component of "quality" that you think clients care about?
   - Providers' attitude and skills ☐
   - Affordable price☐
   - Good variety of services ☐
   - Accessibility ☐
   - Short waiting time ☐
   - Providers spend more time with the clients ☐
   - Other (please explain) ☐

5. What makes Surjer Hashi different from similar services provided by the government or other provider?
   - Providers' attitude and skills ☐
   - Affordable price ☐
   - Good variety of services ☐
   - Accessibility ☐
   - Short waiting time ☐
   - Providers spend more time with the clients ☐
   - Other (please explain) ☐

6. Who are the main clients of Surjer Hashi clinics' and community-based activities?
   - Young adults and adolescents ☐
   - Newly married couples with no children ☐
   - Married with one child ☐
   - Married with two children or more ☐
   - Other (please describe) ☐

## CLINIC SURVEY

# Surjer Hashi Clinic Monitoring Check List

Date: _____ Name of the visitor: _____

NGO name: _____Clinic name and ID: _____

Clinic address: _____

Clinic Type: Vital / Basic EmOC / CEmONC_____

| Sl. | Subject | Y | N |
|---|---|---|---|
| 1. | **Signage and branding** | | |
| | a. Are Clinic signboards clearly visible?<br>b. Is arrow marks appropriately placed?<br>c. USAID and DFID logo properly placed?<br>d. USAID and DFID logo properly visible?<br>**e.** Do you ever ask any one whether s/he noticed any direction signage? | | |
| 2. | **Reception:** | | |
| | f. Do you have housekeeping plan for cleanliness?<br>g. Does clinic have separate waiting space for men and women?<br>h. Is toilet Clean and functional/ with soap/ running water?<br>i. Is there any Breast feeding corner?<br>j. Is there any Nutrition corner<br>k. Is there any ORT corner?<br>l. Does clinic have DOTS corner for TB? | | |
| 3. | **Infection prevention** | | |
| | a. Are doctors trained on infection prevention?<br>b. Are paramedics trained on infection prevention?<br>c. Is autoclave available & functional?<br>d. Is chorine solution prepared every day following guideline?<br>**e.** Are 4 color buckets available? Used for waste disposal? | | |
| 4. | **Family Planning** | | |
| | a. No. of total FP customer served last month_____.<br><br>b. No. of total FP customer served for:<br>Pill_____Condom_____ECP____<br>Inj____IUD_____Implant_____<br>Tubectomy_____Vasectomy_____ | | |

| Sl. | Subject | Y | N |
|---|---|---|---|
| 5. | **FP compliance** | | |
| | a. have all staff received FP compliance training in last year?<br>b. Has clinic received any monitoring visits last year?<br>d. Do you maintain 5 FP compliance files?<br>e. What are the components of 5 FP compliance files?<br>1.<br>2.<br>3.<br>4.<br>5.<br>e. Do providers have & use tools like Tiahrt poster, flip charts, counseling cards, etc. ?<br>f. Have any targets, goals, or quotas related to the number of births, number of FP clients, or clients for a particular FP method been set at clinic, satellite or individual provider level?<br>If targets are not met, what action/s have you taken? describe<br>_____<br>_____<br>_____<br>_____<br>_____<br><br>g. Do you provide any incentives/financial rewards to FP clients for accepting an FP method?<br>h. Have you ever noted counselor /paramedic to influence customers for specific method?<br>i. Describe in bullet points what are the pre-requisite for Permanent method?<br><br>1.<br>2.<br>3.<br>4. | | |

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| Sl. | Subject | Y | N | | Sl. | Subject | Y | N |
|---|---|---|---|---|---|---|---|---|
| 5. | **FP compliance( continued):** | | | | 7. | **Child health** | | |
| | j. If any client comes for abortion or MR-related services, what do you do?<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br><br>k. State that this statement is correct: If a client doesn't accept FP method, s/he can be denied other health services. | | | | | a. Number of children served last month: Total _____under 5:_____ IMCI_____Pneumonia with antibiotics_____ ENC within 72 hours of delivery_____<br>b. What do you understand by ENC service? Describe<br>_____<br>_____<br>_____<br>_____<br>c. Paramedic/MO in clinic<br>Total no. ____No. trained in IMCI_____<br>d. Do your clinic/s have IMCI chart booklet? | | |
| 6. | **Maternal health** | | | | 8. | **Nutrition** | | |
| | a. ANC patients served last month: Total _____ ANC 4 _____<br>b. How do you record ANC 4 visit?<br>_____<br>_____<br>_____<br>_____<br>_____<br><br>c. Do you provide all six packages of ANC?<br>d. Number of paramedic trained on SD___<br>e. Total no. of delivery performed in your EmOC clinic_____no. of normal_____ No. of C/S_____<br>f. If no. of normal delivery is less compared to C/S, describe the reasons:<br>_____<br>_____<br>_____<br>_____<br><br>g. No. PNC services provided within 48 hours of delivery last month: Total_____ in the facility_____ at home_____ | | | | | a. No. of staff received training on IYCF _____Basic Nutrition:_____<br>b. No. functional logistics available height scale_____height tape_____ MUAC tape_____ 250 ml bowl & spoon_____dummydoll:_____ __ dummy breast_____ Weighing machine for baby_____ and adult:_____<br>c. No. of mothers counseled on IYCF last month_____<br>d. No. of clients provided with IFA tablets last month: Total_____ Pregnant _____ Lactating_____Adolescent_____<br>e. No. of GMP sessions held in Static_____ Satellite_____ | | |
| | | | | | 9. | **Gender** | | |
| | | | | | | a. No. of staff received all trainings SAA_____GBV_____<br>b. Do you offer choice of services?<br>c. Do you provide accurate information?<br>d. Do you maintain privacy and confidentiality?<br>e. Are GBV files confidentially maintained? | | |

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| Sl. | Subject | Y | N | Sl. | Subject | Y | N |
|---|---|---|---|---|---|---|---|
| 9. | **Gender continued** | | | 12. | **Reporting for poor** | | |
| | k. No. of GBV client served_____<br>l. Do You refer GBV client?<br>If yes, give no that were referred_____<br>m. Do you discuss SAA issues in monthly meetings? | | | | a. how does the clinic identify poor customers?<br>_____<br>_____<br>_____<br>_____<br>b. Describe Criteria for poor<br>_____<br>_____<br>_____<br>_____<br>c. Describe Criteria for poorest of poor<br>_____<br>_____<br>_____<br>_____<br>d. Is the list of poor families identified from the satellites and communities available?<br>e. Do you use any special cards for serving poor families? | | |
| 10. | **TB** | | | 13. | **Monthly meetings** | | |
| | a. No. of staff received training on TB:<br>DOTS_____ Lab:_____<br>ACSM:_____<br>b. No. of TB patient diagnosed<br>All forms _____Child (0-14yrs) TB case_____<br>c. Number of TB patients under DOTS:_____<br>d. No. of patient referred for diagnosis( if non TB clinic)_____ | | | | a. Do you conduct monthly meeting on regularly?<br>b. Do you maintain meeting register?<br>c. What thematic areas you routinely discussed in monthly meeting?<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ | | |
| 11. | **Community Mobilization** | | | 14. | **Monthly reporting** | | |
| | a. Number of meetings SHCSG (Satellite level) held in last month_____<br>b. Quarterly meeting of advisory committee of SH clinic held in last quarter.<br>c. Are minutes of quarterly meetings available?<br>d. Does SH clinic have community action Plan?<br>e. No. of Community Meetings conducted by SHCSG at community level in last month_____ and in previous month_____<br>f. No. of SP Trained on Community Mobilization Process_____/number of SP not yet trained_____<br>g, No. of CSP and SHCSG leaders trained on Community Mobilization _____the number of CSP and SHCSG are not yet trained_____<br>h. Is there any linkage developed or MoU signed with any development partners in Municipality/City Corporation to support poorest of the poor?<br>i. Have any health services provided through opening a new satellite for the hard to reach or most vulnerable community in Municipality/City Corporation?<br>j. if yes, who are they _____ | | | | a. No. of total female patient served_____<br>b. No. of total female service contacts_____<br>c. No. of total male patient served_____<br>d. No. of total male service contacts:_____<br>e. No of total patients served in previous day_____<br>f. Total patient served in the previous month:_____ | | |



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| Sl. | Subject | Y | N | Sl. | Subject | Y | N |
|---|---|---|---|---|---|---|---|
| 14. | **Monthly reporting continued** | | | 16. | **CSP** | | |
| | a. How much subsidy they are you giving for poor and POP_____<br>b. Do you main any referral slip if poor patients are referred from satellites?<br>c. If any patient who is not in the list of poor patients of that clinic catchments area, do you record signature of at least two persons (e.g. CM & any other staff in the clinic) who verified him/her as poor? | | | | a. How many household a CSP is responsible for?<br>b. What training CSP/s received from NHSDP?<br>c. What is the average number of customer s/he refers per month?<br>FP:_____ANC:_____<br>SD:_____ CH_____<br>TB: _____GBV_____ | | |
| 15. | **Clinic Manager** | | | 17. | **Satellite:** | | |
| | a. Does the clinic have a monthly work plan?<br>b. Do you have a plan for increasing the number of customer?<br>c. Does the clinic have any special initiatives/services for adolescents and youth?<br>d. Does the CM has a monthly satellite/ field visit plan?<br>e. Is there evidence of attendance in meetings with local Govt officials on health and FP?<br>f. Does the clinic have a work plan developed in consultation with government?<br>g. Does the clinic manager participate in local level planning of govt?<br>h. Are monthly performance reports submitting to relevant govt. Authorities? | | | | a. Is the signage easily visible?<br>b. Is banner being properly placed?<br>c. Is the spot clean?<br>d. Does the service provider follow proper disposal of wastes?<br>e. Are all logistics /materials for providing services available?<br>f. Number of customers on that day:<br>g. Do paramedics behave well to the clients? | | |
| | | | | 18. | **Pharmacy** | | |
| | | | | | a. Describe location of the pharmacy<br>_____<br>_____<br>_____<br>_____<br>_____<br>b. Sales person male/female_____<br>c. Do you maintain medicine stock register?<br>a. How do you track expiry of medicines and supplies?<br>b. Are SMC products available? | | |

## EXIT INTERVIEWS

**Customer Satisfaction Study within Surjer Hashi Community Network**
**Respondent: Interviews**

**Data Supplier Declaration**
I confirm that respondent's name and address were unknown to me until the interview starts. I know that the information given to me in the interview must be kept confidential.
Signed _____ Date _____

Salam/Adab. My name is ……. I am part of an evaluation team looking at the effectiveness of Surjer Hashi clinics. As a part of this research we have randomly selected you among the service recipients of this health care center. Your opinion is very important for our research. The information you give will be kept strictly confidential and will be used for research purpose only. I hope you will agree to participate in this interview. **YOU HAVE THE RIGHT NOT TO ANSWER OR STOP THE INTERVEIW AT ANY TIME.**

| No. | Questions and Filters | Coding Categories | Code |
|---|---|---|---|
| Q1. | Record the socioeconomic condition of the respondent by checking the service receipt. | Above poor | 1 |
| | | Poor | 2 |
| | | Poorest of the poor | 3 |
| Q2. | Record name and location ID of clinic | | |
| Q3. | Sex of respondent | Male | 1 |
| | | Female | 2 |
| Q4. | Age of patient | | |

| | Questions | Coding Categories | Code | Today | Last three months |
|---|---|---|---|---|---|
| Q5. | What are the services you have taken from this SH clinic today?<br><br>The health care services you or your family members have received in the past three months? | General health care | 01 | | |
| | | Family planning method | 02 | | |
| | | Vaccination | 03 | | |
| | | Antenatal care | 04 | | |
| | | Postnatal care | 05 | | |
| | | Reproductive health care | 06 | | |
| | | Family planning/Reproductive health counselling | 07 | | |
| | | Care about side effects of family planning method | 08 | | |
| | | Health care services for women | 09 | | |
| | | Counselling (Advice) | 10 | | |
| | | Child health care | 11 | | |
| | | Physical health check-up (Lab service) | 12 | | |
| | | Others (Specify) | | | |
| Q6. | Rank top three reasons for selecting this health care center? [Single response] | Close proximity | 01 | | |
| | | Less costly | 02 | | |
| | | Reputation of the health care center | 03 | | |
| | | Service provider is familiar to me | 04 | | |
| | | Availability of better care | 05 | | |
| | | Referred by some other service provider | 06 | | |
| | | Recommended by a friend | 07 | | |
| | | This is the only health care center in the area | 08 | | |

| | | | | | |
|---|---|---|---|---|---|
| | | Have good experience with this health care center | 09 | | |
| | | This is better than any other health care center | 10 | | |
| | | Service provider's behaviour and the staff is well and satisfactory | 11 | | |
| | | This health care center is neat and clean | 12 | | |
| | | Others (Specify) | | | |
| | | Not willing to mention | 99 | | |

| | | | | | |
|---|---|---|---|---|---|
| Q7. | From who have you received service in this SH clinic today? Response can be multiple] | M.B.B.S Doctor | 01 | | |
| | | Paramedic | 02 | | |
| | | Counselor | 03 | | |
| | | Others (Specify) | | | |

| | **Questions** | **Code** |
|---|---|---|
| Q8. | How much time (in minutes) did it take to reach this service provider? | |
| Q9. | How long (in minutes) did you have to wait at provider to be examined? | |
| Q10. | How much time (in minutes) did the provider spend with the client? | |

| | **Questions** | **Coding Categories** | **Code** |
|---|---|---|---|
| Q11. | Did you notice any queue system in the clinic? | 1. Yes<br>2. No<br>3. Not applicable | |
| Q12. | Do you think the queue was maintained properly? | 1. Yes<br>2. No<br>3. Not applicable | |

| Q13. | Services | Highly Satisfied | Moderately Satisfied | Satisfied | Not Satisfied | Not applicable |
|---|---|---|---|---|---|---|
| | Location of clinic | | | | | |
| | Operating hours of clinic | | | | | |
| | Presence of service provider | | | | | |
| | Behaviour of clinic staff | | | | | |
| | Waiting time before service provided | | | | | |
| | Time spent during service provided | | | | | |
| | Quality of services provided | | | | | |
| | Service charge | | | | | |

| | |
|---|---|
| Q14. | Do you have any complaints about this clinic? |
| Q15. | Do you want to make any suggestions for improvements? |

# ANNEX III. DATA COLLECTED

**Table A11. Couple-years of protection by method and SBA deliveries**

| Method | Baseline-2012 (SSFP achievement) | | Achievement | | | | | | | | Project Target (60 months) | Cumulative % Achieved |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Year 1 (9 months) | | Year 2 (12 months) | | Year 3 (12 months) | | Total (33 months) | | | |
| | # | % | # | % | # | % | # | % | # | % | | |
| **By method** | **1,610,000** | **100%** | **1,192,225** | **100%** | **1,604,863** | **100%** | **1,545,351** | **100%** | **4,342,439** | **100%** | **7,879,553** | **55.1%** |
| Condoms | 238,226 | 14.80% | 189,020 | 15.85% | 257,631 | 16.05% | 367,930 | 23.81% | 814,581 | 18.76% | | |
| Pills | 802,264 | 49.83% | 583,562 | 48.95% | 777,620 | 48.45% | 621,866 | 40.24% | 1,983,048 | 45.67% | | |
| Injectables | 477,072 | 29.63% | 353,164 | 29.62% | 480,953 | 29.97% | 462,978 | 29.96% | 1,297,095 | 29.87% | | |
| Implant | 11,462 | 0.71% | 8,161 | 0.68% | 12,656 | 0.79% | 13,648 | 0.88% | 34,465 | 0.79% | | |
| IUD | 62,969 | 3.91% | 42,913 | 3.60% | 59,584 | 3.71% | 59,091 | 3.82% | 161,588 | 3.72% | | |
| Male sterilization | 9,010 | 0.56% | 7,566 | 0.63% | 8,957 | 0.56% | 9,178 | 0.59% | 25,701 | 0.59% | | |
| Female sterilization | 8,997 | 0.56% | 7,839 | 0.66% | 7,462 | 0.46% | 10,660 | 0.69% | 25,961 | 0.60% | | |
| Total number of SBA deliveries | 22,061 | | 17,663 | | 27,266 | | 34,988 | | 79,917 | | 139,722 | 57.2% |
| Home births | 2,901 | | 2,785 | | 3,861 | | 6,390 | | 13,036 | | 22,291 | 58.5% |
| Facility normal births | 19,160 | | 9,072 | | 15,249 | | 17,614 | | 41,935 | | 117,431 | 57.0% |
| Facility C-Section births | | | 5,806 | | 8,156 | | 10,984 | | 24,946 | | | |

*Source:* USAID-DFID NGO Health Service Delivery Project.

## Table A12. NHSDP performance indicator report–life of project*

The most significant progress has been in pregnant and lactating women being prescribed 30IFA (85 percent), Vitamin A supplementation for children under 5 through U.S. Government-supported programs (71 percent), immediate support for newborns within 72 hours (71 percent), and postnatal care within 48 hours of childbirth (60 percent).

| SL | Indicators | Year-1 (Jan 13 - Sept 13) | | | Year-2 (Oct 13 - Sept 14) | | | Year-3 (Oct 14 - Sept 15) | | | Year-4 | Year-5 | Life of Project (Jan 13 - Dec 17: 60 months) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Target | Achievement | % Achieved | Target | Achievement | % Achieved | Target | Achievement | % Achieved | Target | Target | Cumulative Target* Life of Project | Cumulative Achievement | Cumulative % Achieved |
| | | | | | | | | | | | | | | Jan 13-Sep 15: 33 months (55%) | |
| 1 | # of CYP | 1,190,000 | 1,192,225 | 100.2% | 1,620,000 | 1,604,863 | 99.1% | 1,656,500 | 1,545,351 | 93.3% | 1,689,630 | 1,723,423 | 7,879,553 | 4,342,439 | 55.1% |
| 2 | # of service contacts at NGO partners clinics | 25,875,000 | 26,242,047 | 101.4% | 35,880,000 | 38,197,840 | 106.5% | 39,343,500 | 39,309,855 | 99.9% | 40,130,370 | 40,932,977 | 182,161,847 | 103,749,742 | 57.0% |
| 3 | % of service contacts who qualify as poor | 35.0% | 36.0% | 102.9% | 36.0% | 38.0% | 105.6% | 38.0% | 42.0% | 110.5% | 39.0% | 40.0% | 40.0% | Exceeded target in each year to date. | |
| 4 | # of injectable provided through USG supported program to prevent unintended pregnancies | 1,557,110 | 1,413,180 | 90.8% | 2,242,238 | 1,923,899 | 85.8% | 1,970,114 | 1,852,042 | 94.0% | 2,009,516 | 2,049,706 | 9,828,684 | 5,189,121 | 52.8% |
| 5 | # of deliveries with an SBA in targeted communities | 17,000 | 17,663 | 103.9% | 25,300 | 27,266 | 107.8% | 28,840 | 34,988 | 121.3% | 33,042 | 35,540 | 139,722 | 79,917 | 57.2% |
| 5.a | Home births | 2,494 | 2,785 | 111.7% | 3,716 | 3,861 | 103.9% | 4,753 | 6,390 | 134.4% | 5,462 | 5,866 | 22,291 | 13,036 | 58.5% |
| 5.b | Facility births | 14,506 | 14,878 | 102.6% | 21,584 | 23,405 | 108.4% | 24,087 | 28,598 | 118.7% | 27,580 | 29,674 | 117,431 | 66,881 | 57.0% |
| 6 | # of ANC checkups provided during pregnancy through USG supported programs | 915,546 | 915,546 | 100.0% | 1,336,628 | 1,336,628 | 100.0% | 1,453,292 | 1,684,300 | 115.9% | 1,620,000 | 1,745,000 | 7,070,466 | 3,936,474 | 55.7% |
| 6.a | First visit | 322,758 | 322,758 | 100.0% | 438,256 | 438,256 | 100.0% | 523,185 | 589,516 | 112.7% | 583,200 | 628,200 | 2,495,599 | 1,350,530 | 54.1% |
| 6.b | Fourth visit | 151,592 | 151,592 | 100.0% | 283,109 | 283,109 | 100.0% | 305,191 | 321,506 | 105.3% | 340,200 | 366,450 | 1,446,542 | 756,207 | 52.3% |
| 7 | # of adolescent/youth (15-25 years) accessing reproductive health services | 4,400,000 | 0 | 0.0% | 4,600,000 | 6,220,441 | 135.2% | 6,500,000 | 7,439,070 | 114.4% | 6,600,000 | 6,700,000 | 28,800,000 | 13,659,511 | 47.4% |
| 8 | # of newborns born in supported clinics and catchment area receiving immediate newborn care (within 72 hours) | 35,828 | 40,335 | 112.6% | 50,085 | 83,616 | 166.9% | 86,000 | 123,916 | 144.1% | 88,580 | 91,237 | 351,730 | 247,867 | 70.5% |
| 9 | # of childhood pneumonia cases treated with antibiotics | 113,400 | 113,343 | 99.9% | 158,800 | 164,134 | 103.4% | 169,000 | 140,463 | 83.1% | 172,380 | 175,828 | 789,408 | 417,940 | 52.9% |
| 10 | # of children less than 12 months of age who received Penta3 from USG-supported programs | 255,420 | 250,691 | 98.1% | 354,175 | 377,193 | 106.5% | 388,500 | 384,110 | 98.9% | 396,270 | 404,195 | 1,798,560 | 1,011,994 | 56.3% |
| 11 | # of pregnant women who receive counseling on adoption of IYCF practices | 123,174 | 0 | 0.0% | 127,486 | 0 | 0.0% | 518,000 | 864,393 | 166.9% | 528,360 | 538,927 | 1,835,947 | 864,393 | 47.1% |
| 12 | # of vitamin A supplementations provided to children under 5 through USG supported programs in targeted areas | 410,000 | 1,354,726 | 330.4% | 420,000 | 2,528,900 | 602.1% | 2,200,000 | 1,387,704 | 63.1% | 2,211,000 | 2,222,055 | 7,463,055 | 5,271,330 | 70.6% |
| 13 | # of Pregnant & Lactating Women prescribed with 30IFA | 108,000 | 49,882 | 46.2% | 116,000 | 89,006 | 76.7% | 300,000 | 827,049 | 275.7% | 306,000 | 312,120 | 1,142,120 | 965,937 | 84.6% |
| 14 | # of service contacts with children under 5 that included growth monitoring in USG supported programs in project areas | 81,000 | 56,156 | 69.3% | 116,200 | 92,744 | 79.8% | 416,000 | 539,565 | 129.7% | 420,160 | 424,362 | 1,457,722 | 688,465 | 47.2% |
| 15 | # of PNC service provided to women with childbirth within 48 hours after birth | 0 | 0 | 0.0% | 76,853 | 235,522 | 306.5% | 227,225 | 219,535 | 96.6% | 229,497 | 231,792 | 785,367 | 455,057 | 59.5% |

* Life of project (LOP) targets are subject to annual review and adjustment as per request by USAID. Several indicator targets have been revised upwards during the past three years. The adjustments are included in a series of revisions of the M&E Plan, the latest approved version of which is dated June 2015 (approved by USAID on 1 July, 2015). The LOP target listed here is the latest version for each indicator.

## Table A13. Health delivery service distribution in Chittagong Division–clinic service status of Chittagong Hill Tracts in Chittagong Division

| Year | # of Clinics | CYP | % Poor | Total Service Contacts | FP-Method Injectables # | Total Delivery | Home Delivery | C-Section Delivery | Facility Delivery | Total ANC | ANC 1 | ANC 4 | Adolescent (15~25 Years) | Newborn Care (3 days) | Under-5 Child Pneumonia | Children Received Penta3 | IYCF Counseling to ANC/Postnatal Care | Child Vitamin A | 30IFA | GMP | Postnatal Care (48 Hours) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 3 | 2,642 | 39 | 176,104 | 3,902 | 88 | 54 | - | 34 | 4,922 | 1,428 | 997 | - | 138 | 277 | 557 | - | - | - | - | |
| 2 | 6 | 4,384 | 42 | 294,195 | 4,784 | 227 | 105 | - | 122 | 8,618 | 2,655 | 2,150 | - | 341 | 341 | 418 | - | - | 4 | 15 | 1,611 |
| 3 | 7 | 4,727 | 47 | 364,650 | 8,329 | 487 | 289 | - | 198 | 21,596 | 7,019 | 4,288 | - | 1,444 | 860 | 573 | 4,849 | 9 | 3,396 | 629 | 1,977 |
| **Subtotal:** | | 11,753 | 43 | 834,949 | 17,015 | 802 | 448 | - | 354 | 35,136 | 11,102 | 7,435 | - | 1,923 | 1,478 | 1,548 | 4,849 | 9 | 3,400 | 644 | 3,588 |

## Table A14. Health delivery service distribution in Chittagong Division–clinic service status without Chittagong Hill Tracts in Chittagong Division

| Year | # of Clinics | CYP | % Poor | Total Service Contacts | FP-Method Injectables # | Total Delivery | Home Delivery | C-Section Delivery | Facility Delivery | Total ANC | ANC 1 | ANC 4 | Adolescent (15~25 Years) | Newborn Care (3 days) | Under-5 Child Pneumonia | Children Received Penta3 | IYCF Counseling to ANC/Postnatal Care | Child Vitamin A | 30IFA | GMP | Postnatal Care (48 Hours) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 66 | 210,012 | 37 | 5,069,774 | 298,695 | 7,044 | 613 | 1,107 | 6,431 | 235,888 | 79,447 | 41,688 | - | 12,666 | 28,053 | 60,099 | - | 268,817 | 0 | 0 | 0 |
| 2 | 72 | 298,062 | 38 | 6,584,416 | 437,881 | 12,097 | 901 | 1,479 | 11,196 | 352,238 | 100,821 | 81,081 | 1,120,168 | 22,727 | 41,616 | 78,676 | - | 501,807 | 11,507 | 11,100 | 38,825 |
| 3 | 77 | 259,517 | 46 | 7,108,691 | 368,920 | 14,043 | 872 | 1,978 | 13,171 | 397,898 | 134,360 | 80,851 | 1,618,380 | 26,600 | 30,310 | 68,774 | 257,247 | 330,829 | 153,797 | 82,336 | 57,536 |
| **Subtotal:** | | 767,591 | 41 | 18,762,881 | 1,105,496 | 33,184 | 2,386 | 4,564 | 30,798 | 986,024 | 314,628 | 203,620 | 2,738,548 | 61,993 | 99,979 | 207,549 | 257,247 | 1,101,453 | 165,304 | 93,436 | 96,361 |

### Table A15. Health delivery service distribution in Chittagong Division–All clinics service status in Chittagong Division

| Year | # of Clinics | CYP | % Poor | Total Service Contacts | FP-Method Injectables # | Total Delivery | Home Delivery | C-Section Delivery | Facility Delivery | Total ANC | ANC1 | ANC4 | Adolescent (15–25 Years) | Newborn Care (3 days) | Under-5 Child Pneumonia | Children Received Penta3 | IYCF Counseling to ANC/Postnatal Care | Child Vitamin A | 30IFA | GMP | Postnatal Care (48 Hours) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 69 | 212,654 | 37.6% | 5,245,878 | 302,597 | 7,132 | 667 | 1,107 | 6,465 | 240,810 | 80,875 | 42,685 | - | 12,804 | 28,330 | 60,656 | - | 268,817 | | | - |
| 2 | 78 | 302,446 | 39.8% | 6,878,611 | 442,665 | 12,3240. | 1,006 | 1,479 | 11,318 | 360,856 | 103,476 | 83,231 | 1,120,168 | 23,068 | 41,957 | 79,094 | - | 501,807 | 11,511 | 11,115 | 40,436 |
| 3 | 84 | 264,244 | 46.6% | 7,473,341 | 377,249 | 14,530 | 1,161 | 1,978 | 13,369 | 419,494 | 141,379 | 85,139 | 1,618,380 | 28,044 | 31,170 | 69,347 | 262,096 | 330,838 | 157,193 | 82,965 | 59,513 |
| **Subtotal:** | | 779,344 | 42% | 19,597,830 | 1,122,511 | 33,986 | 2,834 | 4,564 | 31,152 | 1,021,160 | 325,730 | 211,055 | 2,738,548 | 63,916 | 101,457 | 209,097 | 262,096 | 1,101,462 | 168,704 | 94,080 | 99,949 |

### Table A16. Chittagong Hill Tracts clinics distribution by type and geographic location

| Year | # Clinics | Urban | Rural | Ultra | Vital |
|---|---|---|---|---|---|
| 1 | 3 | 3 | 0 | 1 | 2 |
| 2 | 6 | 3 | 3 | 1 | 5 |
| 3 | 7 | 3 | 4 | 1 | 6 |

### Table A17. Clinic by type, level and project year

| Project Year | Year 1 | | | Year 2 | | | Year 3 | | |
|---|---|---|---|---|---|---|---|---|---|
| **Clinic Type** | **Urban** | **Rural** | **Total** | **Urban** | **Rural** | **Total** | **Urban** | **Rural** | **Total** |
| Vital | 151 | 124 | 275 | 143 | 135 | 278 | 155 | 165 | 320 |
| EMOC-B | 4 | 6 | 10 | 6 | 13 | 19 | 6 | 13 | 19 |
| EMOC-C | 34 | 8 | 42 | 41 | 10 | 51 | 42 | 11 | 53 |
| **Total:** | **189** | **138** | **327** | **190** | **158** | **348** | **203** | **189** | **392** |

**Table A18. Clinic distribution by year, type and geographic location–year 1 (9 months)**

| Division | # Clinics | Rural | Urban | Ultra | Vital |
|---|---|---|---|---|---|
| Barisal | 12 | 5 | 7 | 1 | 11 |
| Chittagong | 69 | 37 | 32 | 14 | 55 |
| Dhaka | 121 | 48 | 73 | 16 | 105 |
| Khulna | 43 | 11 | 32 | 7 | 36 |
| Rajshahi* | 32 | 14 | 18 | 5 | 27 |
| Rangpur* | 28 | 14 | 14 | 8 | 20 |
| Sylhet | 22 | 9 | 13 | 2 | 22 |
| **Year 1 Total** | **327** | **138** | **189** | **52** | **275** |

* Previously reported: Rajshahi division clinic: 34 and Rangpur division clinic: 26

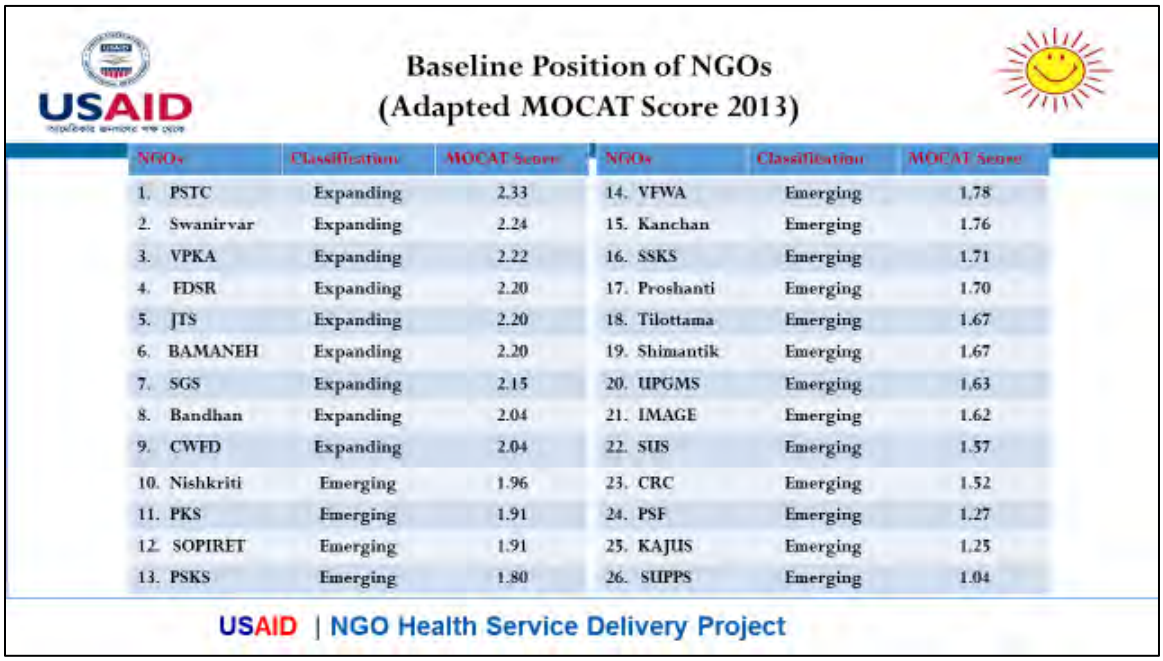
**Table A19. Clinic distribution by year, type and geographic location–year 2 (12 months)**

| Division | # Clinics | Rural | Urban | Ultra | Vital |
|---|---|---|---|---|---|
| Barisal | 12 | 5 | 7 | 2 | 10 |
| Chittagong | 78 | 46 | 32 | 19 | 59 |
| Dhaka | 128 | 55 | 73 | 18 | 110 |
| Khulna | 46 | 13 | 33 | 9 | 37 |
| Rajshahi | 32 | 14 | 18 | 8 | 24 |
| Rangpur | 30 | 16 | 14 | 11 | 19 |
| Sylhet | 22 | 9 | 13 | 3 | 19 |
| **Year 2 Total** | **348** | **158** | **190** | **70** | **278** |

**Table A20. Clinic distribution by year, type and geographic location–year 3 (12 months)**

| Division | # Clinics | Rural | Urban | Ultra | Vital |
|---|---|---|---|---|---|
| Barisal | 16 | 7 | 9 | 2 | 14 |
| Chittagong | 84 | 53 | 31 | 19 | 65 |
| Dhaka | 138 | 60 | 78 | 19 | 119 |
| Khulna | 52 | 17 | 35 | 9 | 43 |
| Rajshahi | 34 | 15 | 19 | 8 | 26 |
| Rangpur | 34 | 18 | 16 | 12 | 22 |
| Sylhet | 34 | 19 | 15 | 3 | 31 |
| **Year 3 Total** | **392** | **189** | **203** | **72** | **320** |

### Table A21. MOCAT scoring



Baseline Position of NGOs
(Adapted MOCAT Score 2013)

| NGOs | Classification | MOCAT Score | NGOs | Classification | MOCAT Score |
|---|---|---|---|---|---|
| 1. PSTC | Expanding | 2.33 | 14. VFWA | Emerging | 1.78 |
| 2. Swanirvar | Expanding | 2.24 | 15. Kanchan | Emerging | 1.76 |
| 3. VPKA | Expanding | 2.22 | 16. SSKS | Emerging | 1.71 |
| 4. FDSR | Expanding | 2.20 | 17. Proshanti | Emerging | 1.70 |
| 5. JTS | Expanding | 2.20 | 18. Tilottama | Emerging | 1.67 |
| 6. BAMANEH | Expanding | 2.20 | 19. Shimantik | Emerging | 1.67 |
| 7. SGS | Expanding | 2.15 | 20. UPGMS | Emerging | 1.63 |
| 8. Bandhan | Expanding | 2.04 | 21. IMAGE | Emerging | 1.62 |
| 9. CWFD | Expanding | 2.04 | 22. SUS | Emerging | 1.57 |
| 10. Nishkriti | Emerging | 1.96 | 23. CRC | Emerging | 1.52 |
| 11. PKS | Emerging | 1.91 | 24. PSF | Emerging | 1.27 |
| 12. SOPIRET | Emerging | 1.91 | 25. KAJUS | Emerging | 1.25 |
| 13. PSKS | Emerging | 1.80 | 26. SUPPS | Emerging | 1.04 |

USAID | NGO Health Service Delivery Project

### Table A22. Level of effort estimates for IR 3

Level of effort data is not provided by IRs. This is the estimated IR 3 direct level of effort for the positions plus Pathfinder headquarters:

| | Level of Effort (number of days) | | |
|---|---|---|---|
| **Name** | **Pathfinder** | **SMC** | **NUK** |
| Pathfinder headquarters | 258 | | |
| Director, CB | 643 | | |
| CB positions | 507 | | |
| Health financing | 435 | | |
| SMC positions | | 2,578 | |
| NUK positions | | | 749 |
| **Total** | **1,843** | **2,578** | **749** |

*Note:* NHSDP. Following the time-charging practices for crosscutting staff (i.e., finance, CMT, management, M&E), we divide levels of effort by IR following the estimated percentage provided in the original contract, page 40, F.6(a)–Level of Effort, which is IR 1–60 percent, IR 2–15 percent and IR 3–25 percent. Similarly, the Senior Management Team's (COP, DCOP, etc.) time is also divided by percentage. So, if we calculate it that way, the IR 3 level of effort will be higher, but that may not provide accurate devoted level of effort to IR 3.

### Table A23. Capacity development training, all three years

| IR | Name of Course | Work Plan Training Reference Number and Name | Duration | Place | Participants | | | Reasons for Variance |
|---|---|---|---|---|---|---|---|---|
| | | | | | Type | Planned number | Achieved number | |
| **NHSDP Training—Year 1 Annual Report** | | | | | | | | |
| **IR 3** | Orientation on Gender and Human Rights Dimension in RH | Work plan 1 | 1 day | Dhaka | PD, CM, EC member | | 50 | |
| **NHSDP Training—Year 2 Annual Report** | | | | | | | | |
| **IR 3** | MOCAT Tool Review, Assessors Orientation and Training | 01: Training on MOCAT assessment to MOCAT assessors (NHSDP) | 1 day | Dhaka | IR team members | 12 | 37 | NHSDP across IRs team members |
| **IR 3** | Governance, Leadership and Management Training | 02,12,13: Training and targeted mentoring on leadership for two NGOs, and Training on good governance for two NGOs | 2 days | Dhaka | NGO EC & management | 168 | 68 | Combined training |
| **IR 3** | Training on Managing Direct USAID Award for NHSDP Transitioning NGOs | 03, 09: Customized management leadership and HRM training to NGO management team and selected EC members, and Training on essential practices for managing a direct USAID award for two NGOs (PSTC + Swanirvar) and NHSDP + USAID | 3 days | Dhaka | NGO management | 78 | 40 | |
| **IR 3** | Workshop on Strategic and Feasibility Planning for NGOs | 05: Workshop on strategic and feasibility planning for NGOs | 3 days | Dhaka | NGO management | 78 | 40 | Combined training with Tr. Sl # 12 |
| **IR 3** | Training on Treating, Counseling and Gender-Based Violence | 06: Training on treating, counseling and gender-based violence | 3 days | Dhaka & Substation | Paramedic, Counselor, CM, SPs | 654 | 656 | |
| **IR 3** | Training on HR Management and Staff Retention Strategy | 03, 15: Support for development and implementation of retention strategy for two NGOs | 1 day | Dhaka | NGO management | 32 | 25 | Combined training with Tr. Sl # 12 |
| **NHSDP Training—Year 2 Annual Report** | | | | | | | | |
| **IR 3** | Quarterly Meeting for FAM | 16: Quarterly Meeting (4 times a year) for FAM | 1 day | Dhaka | FAM, PD | 26 | 52 | Combined with performance-based grants workshop and NGO review meeting |
| **NHSDP Training—Year 3 Annual Report** | | | | | | | | |
| IR.3 | Training on HR Management and Staff Retention Strategy | | 3 days | Dhaka | PD, PM, MO, MISO, FAM, AO, HQ staff from PSTC and Swanirvar | N/A | | |
| IR.3 | NGO Governance and Leadership | | 1 day | Dhaka | NGO contact person | N/A | | |

*Source*: Data were assembled by the evaluation team from NHSDP annual reports.

## Table A24. Summary of institutional strengthening benchmark verification data of network NGOs-NHSDP

| | Benchmark | BAMANEH | Bandhan | CRC | CWFD | FDSR | Image | JTS | Kanchan | Nishkriti | PKS | Proshanti | PSF | PSKS | PSTC | Shimantik | SOPIRET | SSKS | SUPPS | SUS | Swanirvar | Tilotamma | UPGMS | VFWA | VPKA | 24 NGOs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Governance | 75% of EC completed leadership and governance orientation | 75% | 85 % | 75% | 65 % | 75 % | Yes | 88 % | Yes | Yes | 67 % | 90 % | 40 % | 90 % | 75 % | 64 % | 75 % | 80 % | 75 % | 75 % | No | No | No | No | No | 15 yes |
| | Orientation workshop for all NGO staff on completed values statement | Yes | Yes | 50% | No | Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | No | 19 yes |
| | Increased female membership across EC and NMT to a minimum ratio (specific ratio to be defined on an NGO-by-NGO basis) | 65% | 33 % | EC29 % | NA | Yes | No | 33 % | Yes | Yes | 33 % | Yes | 22 % | 33 % | 40 % | Yes | Yes | Yes | No | No | 22 % | 75% | Yes | No | Yes | |
| Management practices | 90% of NGO headquarters management staff complete leadership and management training | 90% | 90 % | 90% | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | No | No | No | No | |
| | Updated NGO organization structure | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| HR | Implementation of tailored retention strategy | No | No | No | No | Yes | No | No | No | Yes | No | Yes | No | No | No | No | Yes | No | No | Yes | No | No | No | No | No | 19 no |
| | Updated gender policy | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes | Yes | Yes | |
| | Updated HR policy | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | 24 yes |
| | Implementation of revised salary scale and benefits package across all staff | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | No | Yes | Yes | No | Yes | Yes | Yes | Yes | 21 yes |

| | Benchmark | BAMANEH | Bandhan | CRC | CWFD | FDSR | Image | JTS | Kanchan | Nishkriti | PKS | Proshanti | PSF | PSKS | PSTC | Shimantik | SOPIRET | SSKS | SUPPS | SUS | Swanirvar | Tilotamma | UPGMS | VFWA | VPKA | 24 NGOs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Customer focus | Increase number of male clients by 20% (leadership from IR 2 team) | 18% | 20 % | Yes | 6% | 20 % | 20 % | 6% | 8% | Yes | 18 % | 10 % | 22 % | 18 % | 26 % | No | 4.63 | 20 % | No | 5% | 15 % | 3.60 % | 21.50 % | No | No | |
| | Women- and girls-centered service strategy implemented (leadership from IR 1 team) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| | CMSS/social mapping established at all clinics (leadership from IR 2 team) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| Quality of customer service | (IR 1) Gap-Poor implementation of quality monitoring and supervision | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | 23 gap ? |
| External relations | 90% monthly coordination meeting with the GoB at district level attended by PD/PM/CM | 90% | 90 % | 90% | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90% | 90% | 90 % | 90 % | |
| | Increase in new customer contacts by 5% (leadership from IR 2 team) | 4.50 % | 5% | 5% | 5% | 5% | 5% | 3% | 5% | 5% | 19 % | 5% | 9% | 19 % | 4% | 4% | 5% | No | No | 5% | 3% | 3.24 % | 5% | 5% | No | |
| | Completed communication plan with associated budget | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | No | No | |
| | Best practice documented | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | |

| | Benchmark | BAMANEH | Bandhan | CRC | CWFD | FDSR | Image | JTS | Kanchan | Nishkriti | PKS | Proshanti | PSF | PSKS | PSTC | Shimantik | SOPIRET | SSKS | SUPPS | SUS | Swanirvar | Tilotamma | UPGMS | VFWA | VPKA | 24 NGOs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Program management & monitoring | Revised (or new) job description to include responsibility for analysis of NGO-wide clinic data and make programmatic recommendations | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | No | Yes | |
| Financial management | Two consecutive internal audits on inventory and asset control mechanisms at NGO headquarters and clinics (half-yearly) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | 90 % | No | No | Yes | Yes | No | No | No | No | 17 yes |
| | 90% of finance and administration staff participate in training | 90% | 90 % | 90% | 90 % | 90 % | 90 % | 90 % | No | Yes | 90 % | 90 % | Yes | 90 % | 90 % | Yes | Yes | Yes | Yes | Yes | 90 % | 90% | No | No | No | 19 yes |
| | Annual audit reports for FY 2013, FY 2014 | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| Revenue stability | Two completed proposals by the end of the project | Yes | Yes | No | No | Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes | Yes | Yes | Yes | N0 | Yes | Yes | Yes | Yes | No | No | Yes | 17 yes |
| | Service fee collection policy in place (full, partial, no fee) endorsed by governing body | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No | |
| | Revenue stability strategy developed | Yes | Yes | Yes | Yes | No | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | |

| | Benchmark | BAMANEH | Bandhan | CRC | CWFD | FDSR | Image | JTS | Kanchan | Nishkriti | PKS | Proshanti | PSF | PSKS | PSTC | Shimantik | SOPIRET | SSKS | SUPPS | SUS | Swanirvar | Tilotamma | UPGMS | VFWA | VPKA | 24 NGOs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cost-consciousness | 90% of NMT completed orientation on USAID A-122 cost principles | 90% | 90 % | 90% | 90 % | 90 % | No | 90 % | 90 % | 90 % | 90 % | 90 % | No | 90 % | 45 % | No | 90 % | 90 % | 90 % | No | 90 % | 90% | No | 90 % | 90 % | |
| | Updated procurement policy | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | |
| | 90% of finance staff attended orientation session on procurement policy | 90% | 90 % | 90% | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90 % | 90% | No | 90 % | 90 % | 22 yes |
| | Updated expense planning strategy and policy | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | 22 yes |

*Note*: This table reports the status of activities/achievements at the 2.5-year mark as high in a number of road map capacity development benchmark areas. The table was provided during the last two weeks of the evaluation team's work in Bangladesh. A summary of the baseline status of activities/achievements of the NGOs in the benchmark areas for comparison was not available. In a phone discussion with Pathfinder headquarters TA, she stated there were no plans for follow-up. In an email, the COR provided information on the timeframe and type of data collectors who collected the information in this table after the evaluation team's international members left Bangladesh.

**Table A25. Select responses to NGO e-survey**

| **Have an NGO road map?** | yes | yes | yes | yes | yes | no | yes |
|---|---|---|---|---|---|---|---|
| **Road map areas initially needed to be strengthened:** | | | | | | | |
| • Governance | x | x | | x | x | x | x |
| • Management practices | x | x | | x | | x | x |
| • Monitoring & evaluation | x | x | | x | | x | x |
| • Program management | x | x | | x | x | x | x |
| • Human resources | x | x | x | x | | x | x |
| • Finance and administration | x | x | | x | x | x | x |
| • External relations | x | x | | x | | x | x |
| • Other | | | | x | | | x |
| • Fund diversification | | | | x | | | |
| **Effectiveness of NHSDP support: 1 to 5** | 2 | 5 | 3 | 4 | 3 | 4 | 3 |
| **Areas of support still needed:** | | | | | | | |
| • Technical assistance to implement capacity road map | x | | x | | | | |
| • New initiatives | | x | | | | | |
| • Expand services | | x | | | | | |
| • Establish vital to ultra | | | | | | | x |
| • Establish EmOC services | | | | | | | x |
| • Monitor program activities | | x | | | | | |
| • Ambulance for EmOC clinics | | x | | x | | | |
| • Vehicle support for field M&E | | x | | x | | | |
| • Staff salary and benefits with market standard package | | x | | x | | | |
| • Increase per diem and accommodation costs for field visits | | x | | | | | |
| • Sustainability strategy | | | x | x | | | |
| • Gender policy | | | | | | | |
| • Financial flexibility | | | | x | | | |
| • More marketing of our products | | | | | x | | |
| • More clinical training | | | | | x | | |
| • Training support | | | x | | | x | |
| • Develop NGO institutional development | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Challenges to strengthening your NGO's institutional development:** | | | | | | | |
| • Lack of knowledge to develop policies/plan | x | | | x | | | |
| • Fund constraint | | x | | | | | |
| • Retention of staff | | x | | | | | |
| • Health insurance, provident fund, gratuity | | | x | | | | |
| • To make SH CSGs function well | | | x | | | | |
| • Strong collaboration with GOB | | | x | | | | |
| • Link with educational institutions | | | | x | | | |
| • No control on Pathfinder | | | | x | | | |
| • NGO no financial activity | | | | | | | x |
| • Single project-based NGO | | | | | | | x |
| • Accommodation | | | | | | | x |
| • No overhead | | | | | | | |
| **Revised Clinic Management Guidelines in Bengali?** | yes | yes | yes | yes | in 80% | no | yes |
| Staff use Bengali guidelines regularly | yes | yes | yes | yes | yes | no | yes |
| Sessions held regularly to orient | yes | | | | | | |

**Table A26. NGO client contact indicators, October 2014–September 2015 (Year 3)**

| Description of Indicators/Items | Year 3: Achievement over Target Ratio | Percent of Poor Served |
|---|---|---|
| Number of couple-years of protection | 1.38 | 42% |
| Number of service contacts at NGO SH clinics | 1.33 | 42% |
| Percent of service contacts who qualify as poor | 0.99 | |
| Number of injectables provided through U.S. Government-supported program to prevent unintended pregnancies | 1.33 | 42% |
| Number of deliveries with an SBA in targeted communities | 0.79 | 43% |
| Home births | 0.99 | 41% |
| Facility births | 0.74 | 43% |
| Number of ANC checkups provided during pregnancy through U.S. Government-supported programs | 1.14 | 43% |
| First visit | 1.16 | 43% |
| Fourth visit | 1.23 | 43% |
| Number of youth (15-25 years) accessing reproductive health services | 1.39 | 44% |
| Number of newborns born in supported clinics and catchment area receiving immediate newborn care (within 72 hours) | 2.83 | 43% |
| Number of childhood pneumonia cases treated with antibiotics | 2.69 | 43% |
| Number of children less than 12 months of age who received Penta3 from U.S. Government-supported programs | 1.54 | 43% |
| Number of pregnant women who receive counseling on adoption of infant and young child feeding practices | 0.97 | 43% |
| Number of vitamin A supplementations provided to children under 5 (including NID) | 61.11 | 44% |
| Number of pregnant and lactating women prescribed with 30IFA (FTF Clinics) | 0.98 | 42% |
| Number of service contacts with children under 5 that included growth monitoring in U.S. Government-supported programs in project areas | 2.97 | 43% |
| Number of postnatal care services by skilled provider within 48 hours of delivery | 1.88 | 44% |

*Source:* NHSDP data

### Table A27. Relative performance of NHSDP catchment areas and national-level performance

| Selected Performance Indicators | NGO Health Service Delivery Project 2014 Baseline Survey (n=32,866) | | Bangladesh Demographic and Health Survey 2014 (n=18,000) | | NHSDP Performing Better? | |
|---|---|---|---|---|---|---|
| | RURAL | URBAN | RURAL | URBAN | RURAL | URBAN |
| Contraceptive prevalence rate | 59% | 70% | 61% | 66% | No | Yes |
| Antenatal care from medically trained providers | 60% | 81% | 59% | 79% | Yes | Yes |
| 4 or more ANC in rural areas | 18% | 50% | 26% | 46% | No | Yes |
| Deliveries assisted by SBA[a] | 31% | 55% | 36% | 61% | No | No |
| Practice of essential newborn care | | | | | | |
| Cord cutting | 85% | 83% | 87% | 90% | No | No |
| No cord care | 54% | 29% | 54% | 41% | No | No |
| Drying | 73% | 69% | 67% | 68% | Yes | Yes |
| Bathing time | 33% | 41% | 35% | 30% | No | Yes |
| Breastfed | 50% | 35% | 58% | 55% | No | No |

*Source:* Baseline Service Delivery Survey, NHSDP 2014; Bangladesh Demographic and Health Survey 2014.
a. Denominator is SBA plus unskilled birth attendant.

### Table A28. Poor and poorest of the poor identification criteria

| Serial | Urban | Rural |
|---|---|---|
| 1 | Living in poor cluster/area | Households who do not have own land |
| 2 | Living on streets/homeless/temporary shelters or slums | People living in and around areas affected by river erosions (Char) |
| 3 | Food or equivalent money is not available for more than three meals at home any time during last week | Food or equivalent money is not available for more than three meals at home any time during last week |
| 4 | Identified as POP/poor by government or other NGOs | Identified as POP/poor by government or other NGO |
| 5 | Anyone who has Surjer Hashi poor card | Anyone who has Surjer Hashi poor card |

*Note:* If 1 out of 5 criteria are met, classified as poor; if more than one criteria met, classified as POP.

## ADDITIONAL INFORMATION ON THE MIS-ACCESS DATABASE AND REPORTING TEMPLATES

The new MIS Access database has been in implementation since July 2015 and was revised in 2016. As of April 2016, all project service statistics have been captured in the consolidated database, eliminating the need for parallel reporting tools. The new MIS database has simplified NGO reporting to NHSDP. NHSDP technical and program staff now have complete access to all M&E performance monitoring data. As of February 2016, the local share drive (O:\Public\Monitoring & Evaluation), which is accessible to all NHSDP technical and program staff members, holds Excel files that present monthly service statistics for each NGO, both in tabular and graphical display. In addition to NGO-level data, clinic-level service data for all 388 SH clinics have been shared with NHSDP staff. The M&E unit regularly shares performance with the all technical and thematic leads through a monthly statistical report. In addition, the key performance data are also shared in monthly NHSDP technical coordination team meetings. The NHSDP M&E team has also provided this data on an ad hoc basis when requested to USAID international development partners and other stakeholders. Each year, NHSDP performance has been provided to the GoB for the national health bulletin.

At the SH clinic level, NGO health facilities have now implemented standard reporting templates as of March 2016. The new NHSDP clinic reporting templates can now be found at each SH clinic and standardize the presentation of key service statistics and targets through graphical visualization of performance monitoring data. Every SH clinic shares monthly performance with the GoB through its prescribed template. Also, clinic staff attend GoB coordination meetings and present data on their performance.

The new MIS Access database and monthly reporting template simplify monthly data review and data check by NGO MIS officers and NHSDP M&E officers. The M&E team has been implementing a multi-level data quality assessment system to ensure accuracy and quality of performance monitoring data. Each NGO's MIS officer conducts routine data quality assessment visits at its supported health facilities. In addition, NHSDP M&E team members conduct data quality assessment site visits to provide additional M&E support and oversight. Finally, a data audit of select M&E indicators (those reported for the performance-based grants) is conducted by an external team every year; this includes data and customer verification.

# ANNEX IV. LIST OF PERSONS INTERVIEWED

**Bangladesh Center for Communication Programs (BCCP)**
Dr. Zeenat Sultana, Senior Deputy Director
Mohammad Shahjahan, Director and CEO

**BRAC**
Dr. Kaosar Afsana, Director, Health, Nutrition and Population Program

**Brandeis University**
Dr. Wu Zeng, MD, Assistant Research Professor, Schneider Institutes for Health Policy

**CARE**
Arshad Muhammad, Assistant Country Program Director
Dr. Jahangir Hossain, Program Director–Health

**Chittagong City Corporation Bangladesh**
Dr. Mohammad Ali, Health Officer and Principal
Dr. Salim Akhter Chowdhury, Chief Health Officer

**EngenderHealth Bangladesh**
Dr. Abu Jamil Faisel, Project Director, Mayer Hashi-II and Country Representative/ED

**Marie Stopes**
Dr. Mohammad Hussain Choudhury, General Manager, Services

**Ministry of Health and Family Welfare (MOHFW)**
Biman Kumar Saha, Additional Secretary
Dr. Dipak Talukder, Deputy Director, Family Planning, Cox's Bazar
Dr. Habib Abdullah Sohel, Director, PHC and Line Director, MNC and AH, Directorate General of Health Services
Dr. Md. Kamar Uddin, Civil Surgeon, Directorate General of Health Services, Cox's Bazar
Dr. Mohammad Azizur Rahman Siddiqui, Civil Surgeon, Directorate General of Health Services, Chittagong
Dr. Shimul Koli Hossain, Program Manager (A&RH), Directorate General of Family Planning
Md. Abdul Mannan Ilias, Joint Secretary
Md. Ashadul Islam, Director General
Md. Helal Uddin, Joint Chief
Prof. Dr. Abul Kalam Azad, Additional Director General (Planning and Development) and Line Director, MIS, Directorate General of Health Services
Zakia Akhter, Deputy Director (PM), Information, Education & Motivation Unit, Dirrectorate General of Family Planning

**Ministry of Local Government, Rural Development and Co-operatives**
Ashoke Madhab Roy, Additional Secretary

**NGO: Concerned Women for Family Development**
Nargis Sultana, Project Director

**NGO: Family Development Services & Research**
Sheikh Nazrul Islam, Project Director

**NGO: IMAGE**
Selina Akhtar, Project Director

**NGO: NISHKRITI**
Dr. Renuka Alam, Project Director

**NGO: Population Services and Training Center**
Dr. Sheikh Md. Nazmul Hassan, Project Director

**NGO: Swanirvar Bangladesh**
Md. Rafiqul Islam, Project Director

**NHSDP**
A K Shafiqur Rahman, Director, Behavior Change Communication
Abu Hasib Mostofa Jamal, BCC and Marketing Coordinator
ARMM Kamal, Community Mobilization Advisor
Bruce Rasmussen, DCOP/Health Service Delivery
Dr. Halida H. Akhter, Chief of Party
Dr. Md. Saikhul Islam Helal, Policy and Coordination Advisor
Dr. Rupa Zaman, ESP Director
Md. Emdad Moslem, Director, Capacity Building/Health System Strengthening
Md. Jannatul Ferdous, Internal Control Specialist
Munsur Ahmed, New Business Initiative Specialist
Shiril Sarcar, DCOP/Finance and Operations
Dr. Roushan Ara Begum, Maternal Health Specialist
Dr. Nahid Ahmed Chowdhury, FP/Adolescent Sexual and Reproductive Health Advisor
Dr. Sanjib Ahmed, Project Manager, Chittagong Hill Tracts
Azizur Rahman, Urban Specialist
Lovely Yeasmin Jeba, Gender Specialist
Dr. Esrat Jahan, Short-Term Technical Assistance
Taskeen Chowdhury, Nutrition Advisor
Dr. Israt Nayer, Newborn Child Health Advisor
Dr. Mohammad Hossain, HIV-TB Advisor
Dr. Farhana Shams Shumi, Clinical Training/Quality Assurance Specialist
Md. Fazlul Karim Chowdhury, Director, M&E
Md. Shahroz Anam, M&E Specialist (Quality)
Aftabul Islan, M&E Reporting Specialist
Shiekh Hassan Jubayer, M&E Reporting Specialist

**Radio Today VOA**
Sakib Swapnil

**Save the Children-Mamoni**
Joby George, Chief of Party, MCHIP, Bangladesh

**SH Clinic: Bangladesh Association for Maternal and Neonatal Health**
Md. Liaquat Hossain, Clinic Manager

**SH Clinic: Family Development Services and Research**
Khandaker Dalower Hossain, Clinic Manager

**SH Clinic: NISHKRITI**
Saroj Kumar Nath, Clinic Manager

**SH Clinic: Population Services and Training Center**
Nasima Akhter, Clinic Manager

**SH Clinic: Swanirvar Bangladesh**
Aysha Akter, Clinic Manager

Mohammad Babul Hossain, Clinic Manager
Nasima Khanam, Clinic Manager

**SMC**
Toslim Uddin Khan, General Manager, Program
Ashfaq Rahman, Managing Director and CEO

**UKAID (DFID)**
Dr. Md. Shafiqul Islam, Health Advisor, DFID

**UNDP**
Robert Stoleman, Chief Implementation

**USAID**
Marietou Satin, Deputy Director, Office of Population, Health, Nutrition and Education
Miranda Beckman, Health and Population Officer, Office of Population, Health, Nutrition and Education
Dr. Ferdousi Begum, Clinic Services Lead, Office of Population, Health, Nutrition and Education
Brenda Doe, Public Health Officer, Office of Population, Health, Nutrition and Education

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Training Need Assessment, Respondents–Counselor.

Training Need Assessment, Respondents–Medical Officer.

Training Need Assessment, Respondents–Paramedics.

# ANNEX VI. ADDITIONAL INFORMATION

## NOTE ON RAPPORT TECHNICAL ASSISTANCE TO NHSDP–CAUSES OF TURNOVER OF EMPLOYEES REPORT AND RETENTION STRATEGY REPORT

In USAID/DFID NHSDP's Staffing, Management Plan & Organogram, developed in March 2014 with the Modification No. 2, it was stated that Rapport, as the local NGO, would provide HR and financial management capacity building for NGOs. NHSDP commissioned two reports: *The Causes of Turnover of Employees in NGOs* and the *Retention Strategy Report*. The evaluation team reviewed the reports and discussed their findings with NHSDP. USAID reported that Pathfinder had substantial methodological concerns with the two reports.

NHSDP addressed some HR issues with the evaluators related to those found in the reports.[99] NHSDP reported different turnover rates for staff and presented justifications for providing different salary increases than those recommended in the *Retention Strategy Report*. However, the evaluation team feels the following issues have merit:

(1) Although NHSDP stated that the NGOs studied were not comparable to NHSDP's NGOs, Rapport states that the "competitor NGOs were jointly selected by Rapport and NHSDP."

(2) The study found that the compensation structure is ad hoc, and the comparison of gross salaries of NHSDP directors, managers and staff show extraordinarily wide discrepancies.

(3) Rapport stated that the basic and gross salaries are far below prevailing market standards, and NSHDP NGOs do not receive most of the benefit components of other NGOs in Bangladesh.

(4) The study further states that the salary increase is limited by the ability and constraints on the part of the employer and recommends an immediate proposed increase of 20 percent.

Even with a 20 percent increase, the researchers noted that "Comparators salary would still be 30.36 percent higher than the proposed salary of NHSDP." NHSDP emails to the evaluators confirmed action on its part, with NGO salary increases of 3-10 percent in 2013, 15 percent (10 percent COLA) in 2014 and 5 percent and a revised salary scale in 2015. Although detailed budget figures were not included in reports, USAID explained that there were constraints due to USAID contract regulations that allow for increases of no more than 5-10 percent. They stated that this does not permit the project to keep pace with current market trends in Bangladesh (doctors salaries doubling, etc.). There were also explanations of the context that over the past year, the project has worked through a $13 million shortfall in the GUC line item due to the failure of transition grants.

The 2015 benchmark verification data in Annex III (Table A15), report that revised salary scales were implemented and HR policies were revised, but at the same time they reported that no tailored retention strategy was implemented. Salary issues were repeatedly mentioned during NGO staff and directors' interviews with the evaluators as constraints on recruiting and retaining qualified staff. NGOs state that grants allow essentially no overhead or contingency fees to use to build capacity and to address NGO-identified needs. NGO staff believe that that salaries are fixed by NHSDP and that they do not have the flexibility to set them, even though they are considerably lower than those of other NGOs. It was not clear that NGO staff interviewed were told or that they were aware that staff salaries are set by the NGOs and that they can use the performance-based grant incentives to increase them.

In 2015, NHSDP developed the *NHSDP Staff Retention Strategy Development Guidelines for SH NGOs*. USAID acknowledged to the evaluators that recruitment and retention of quality staff is a key issue.

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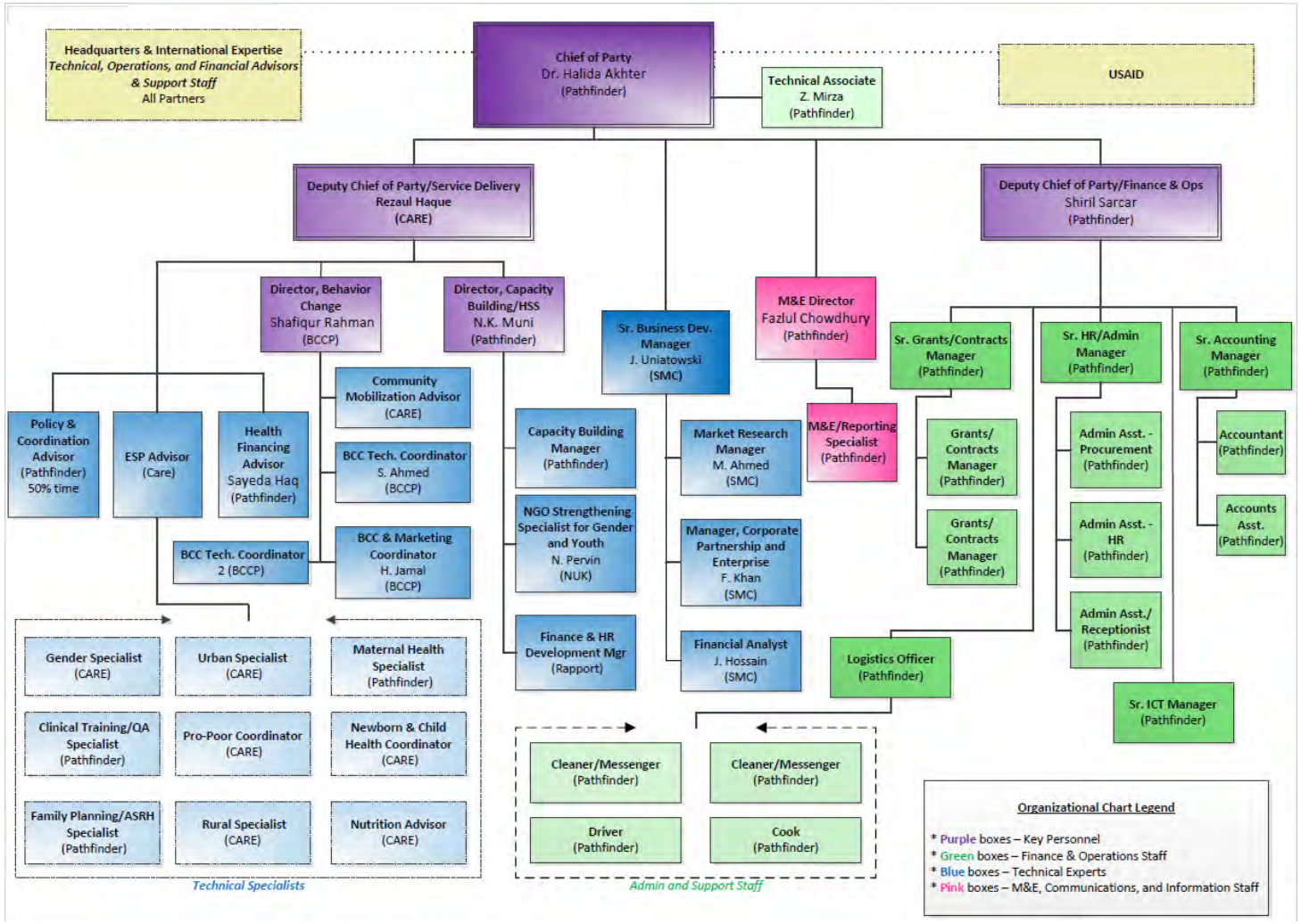
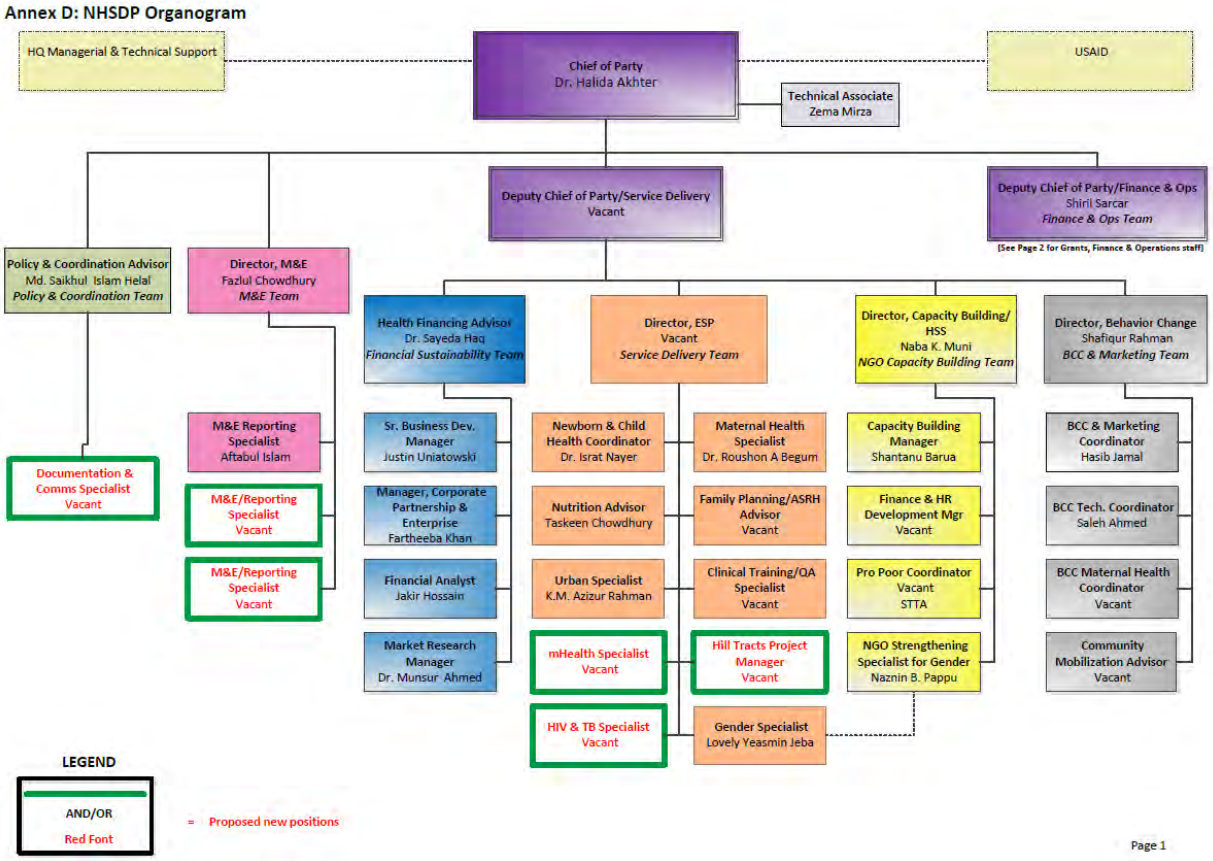
[99] According to USAID/Bangladesh, Pathfinder had substantial methodological concerns with the two Rapport reports, which in part contributed to the decision to terminate that sub.

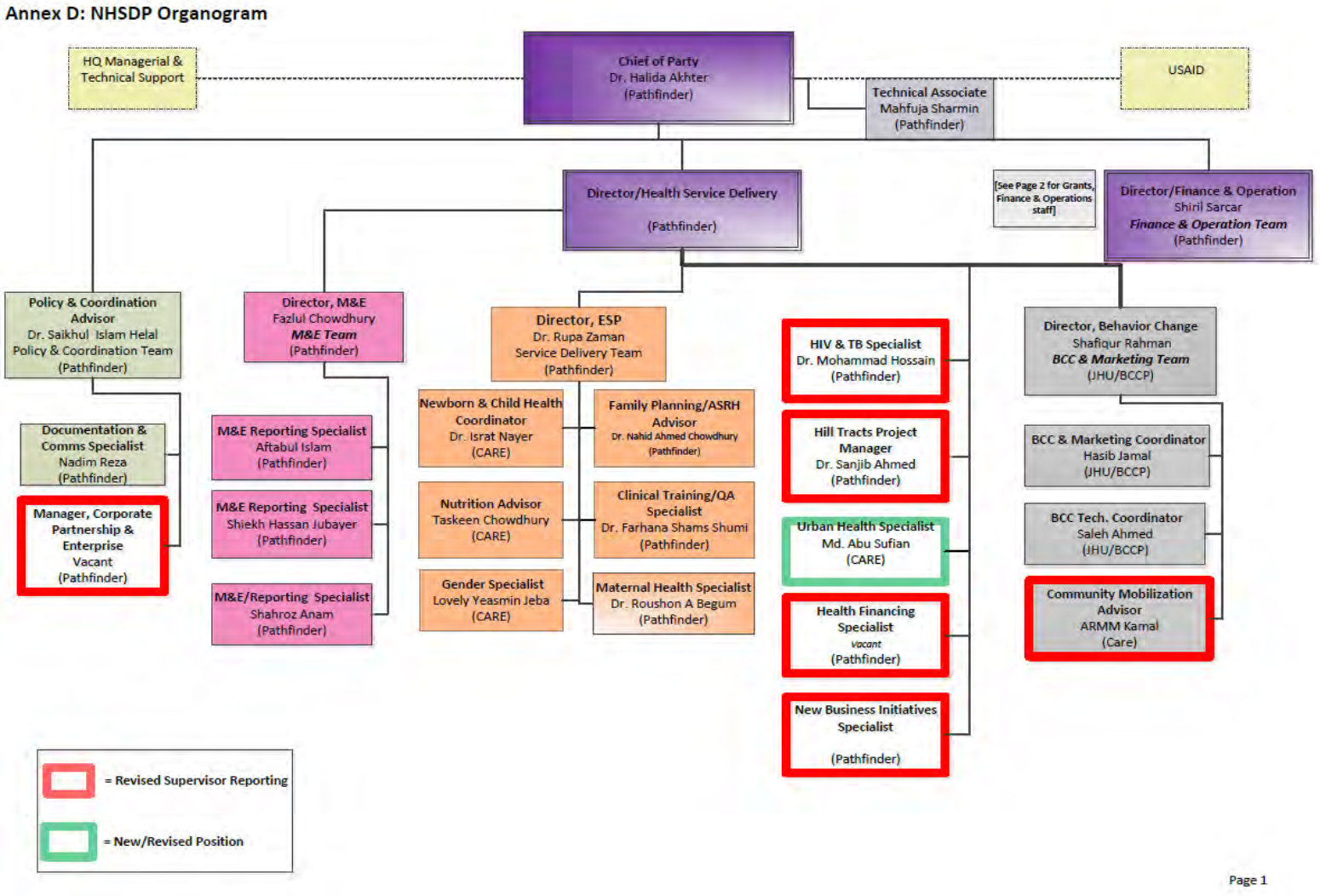
## Figure A9. NHSDP organizational chart (from proposal)



## Figure A10. Revised NHSDP organizational chart (post-USAID comments, Jan. 27, 2014)



## Figure A11. August 2015 NHSDP organizational chart



# ANNEX VII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

**USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT**

**USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project**

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE** The undersigned accepts the terms and conditions of this Agreement.

Signature Date September 18, 2015

Soliman F. Guirgis Dr.

Name Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE**

The undersigned accepts the terms and conditions of this Agreement.

Signature Najmul Hossain Date 7 August 2015

Name NAJMUL HOSSAIN Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE**
The undersigned accepts the terms and conditions of this Agreement.

12.06.2016

Signature Date

Name Nasima Safa Kamal Title Dr.

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE**

The undersigned accepts the terms and conditions of this Agreement.

Rose M. Schneider — 10/2/15

Signature — Date

Rose M. Schneider — Senior Health + HIV Specialist

Name — Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE**

The undersigned accepts the terms and conditions of this Agreement.

| | |
|---|---|
| CStover | 5-31-2016 |
| Signature | Date |
| CARINA STOVER | CONSULTANT |
| Name | Title |

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

**ACCEPTANCE**

The undersigned accepts the terms and conditions of this Agreement.

Usha K. Vatsia
Signature

Date 9/25/15

USHA VATSIA
Name

Title MNCH + Family Planning Consultant, GHP2O

For more information, please visit
www.ghpro.dexisonline.com

**Global Health Performance Cycle Improvement Project**
1331 Pennsylvania Avenue NW, Suite 300
Washington, DC 20004
Phone: (202) 625-9444
Fax: (202) 517-9181
www.ghpro.dexisonline.com