



Urban Primary Health Care Services Delivery Project

Local Government Division

Ministry of Local Government, Rural Development & Cooperatives

Project Performance Monitoring and Evaluation

FINAL INCEPTION REPORT



Eusuf and Associates

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Executive Summary

1. The Local Government Division, Ministry of Local Government, Rural Development, and Cooperatives (MoLGRDC) is presently implementing the Urban Primary Health Care Services Delivery Project (UPHCSDP) in 10 city corporations and four municipalities¹. The project started in July 2012 and is scheduled to close in June 2017.

2. Project overall impact objective is to improve the health condition of the urban population particularly the poor, especially the women and children. Project impact indicators include reduced maternal mortality rate, reduced under five mortality rates, reduced proportion of under weight and stunting, maintaining the total fertility rate at 2.0, and the present gender equity and level of preference to the poor are maintained.

3. The outcomes/benefits include: sustainable good quality urban primary health care services provided in project area targeting the poor and needs of women and children. The outcome/benefit indicators are: increased proportion of births under skilled health personnel, improved achievements on service delivery to under-five children, increased acceptance rates of contraceptives, increased number of poor households are rightly identified and get access to free PHC services, and almost all clients are satisfied with the services.

4. The outputs/components are to: (i) strengthen institutional governance capacity to sustainably deliver of urban primary health care services; (ii) improve the accessibility, quality, and utilization of urban primary health care services delivery, with a focus on the poor, women, and children through public private partnership; and (iii) effective support to decentralized project management.

5. Target achievement objectives, outcomes, and outputs are: improving accessibility to PHC services in the urban areas; ensuring the delivery of quality PHC services to urban population; increasing utilization of PHC services by urban poor, especially women, newborns, and children; strengthening institutional arrangements for delivery of PHC services in urban areas; increasing capacity of urban local bodies to ensure the delivery of PHC services; and increasing sustainability of the delivery of urban PHC services by strengthening ownership and commitment of the urban local bodies (ULBs) to ensure the delivery of PHC services particularly for the poor.

6. Project will achieve objective and outcome and outputs in terms of delivering extended service delivery packages through establishing primary health care service network with Comprehensive Reproductive Health Care Centers (CRHCCs), Primary Health Care Centers (PHCCs), and Satellite Clinic in 25 partnership areas; and the provisions of training for building capacity in management, service delivery, and project monitoring and reporting skills of the staff at various levels.

¹ Dhaka (North), Dhaka (South), Rajshahi, Khulna, Barisal, Sylhet, Rangpur, Narayangong, Gazipur, and Comilla city corporations; and Gopalgonj, Sirajgong, Kushtia, and Kishoregonj municipalities

7. Project engaged a Project Performance Monitoring and Evaluation (PPM&E) firm to: (i) provide implementation support through process monitoring and evaluation of on-going activities of the project feedback, and (ii) measure project output, outcome and impact compared to project design monitoring framework (DMF) and other relevant indicators to assess project achievements..

8. PPM&E firm will assist project management to track progress of Partnership Area NGOs (PA NGOs) in achievement results, provide a regular independent assessment of performance, conduct mapping activities, carry out routine project monitoring, suggest improvements in performance based on results and facilitate broader awareness and participation among stakeholders in the use of monitoring and evaluation, quality assurance, and data of geographical information system.

9. PPM&E firm will also undertake the following tasks particularly in assuring the quantity and quality of PHC services to the poor targeting achievement of full utilization of the health facilities by ever increasing numbers of target population again and again with improved quality PHC services at the reduced cost.

- a. Contribute to refinement and improvement of project M&E and quality assurance;
- b. Contribute to providing GAP measurement indicators as needed by HMIS;
- c. Follow up with and receive feedback from QA team and PMU for enhancement of achievements of the PA NGO service delivery;
- d. Work with QA team to identify potential synergies in development and revision of the ISI tools and QA tools and use of ISI and QA results;
- e. Coordinate with HMIS to provide technical guidance on the health data that will be included in the HMIS; and
- f. Coordinate with project to analyze routine service delivery data from HMIS as inputs to quarterly and other reports, participation in meetings held with PMU, PIU, project city corporations/municipalities, collaborate with PMU's QA team to determine quality requirements of each component of the project and identify areas that need enhancement.

10. The PPM&E firm will undertake surveys and studies and prepare the following seven specific reports at set timelines.

- a. Qualitative survey report (once at beginning of first year of PPM&E and at the end of project);
- b. Health facility survey report (once at beginning of first year of PPM&E and at the end of project);
- c. Training program assessment report;
- d. GIS data base and mapping;
- e. Half-yearly ISI performance monitoring system reports (January and July every year till completion);
- f. Annual poverty updating and red card verification report (at beginning of first and second year of PPM&E); and
- g. Project end line survey and impact evaluation report (within three months after completion of project).

11. PPM&E firm will monitor the PA NGO activities and their achievements per set time bound targets using the above ISI tools. Finally, the PPM&E firm will assess overall performance of the PA NGOs based on the combined achievements of their HQ, CRHCC, PHCC, Satellite clinic in terms of quantity, quality, and management on a total 1,000 scope points. The score points are distributed for quantity, quality and management.

12. PPM&E firm started to work from 1 September 2015 as scheduled and recruited necessary manpower (three key experts, six non-key experts and six support professionals), established office with required facilities, carried out review of secondary materials, prepared work plans and numbers of tools for monitoring and evaluation and carried out the following activities and made good progress since commencement of the assignment on 1 September 2015.

- a. Establishment of project office and equipped with logistics and facilities and employment of experts and support personnel.
- b. Common understanding among the team members with regard to project activities and scope of monitoring and evaluation;
- c. Team meetings and developed work plan and monitoring tools
- d. Drafting inception report for discussion in the inception workshop including work plan for PPM&E;
- e. Inception workshop planned arranged in consultation with PMU on 11 October 2015 at Bangabandhu International Convention Centre (Windy Town Hall);
- f. Stocktaking and reviewing of existing materials;
- g. Letter from the Project Director, PMU, UPHCSDP introducing PPM&E firm to the PIUs and PA NGOs requesting all concerned to provide supports to PPM&E firm in the monitoring and evaluation activities;
- h. Guideline/checklist for visits to PHC service centers (CRHCC, PHCC, and Satellite) are being developed;
- i. Program for training of Surveyors/Research Assistants have been prepared;
- j. Manuals in Bangla were prepared for survey guidance of the Enumerators;
- k. Visited a number of PA NGO HQs, CRHCCs and PHCCs in Dhaka, Barisal and Comilla for greater understanding;
- l. GIS database and mapping work initiated and base maps of few partnership areas already collected;
- m. Monitoring and evaluation tools for different surveys such as GIS mapping, ISI, Red Card updating, training assessment, health facilities survey, qualitative survey, and endline survey have been completed had been prepared in the earlier phase and also by ADB Staff Consultants with the help of executing agency and pre-tested. These tools were used in the earlier phase.
- n. The experts of the PPM&E firm reviewed these tools further, pre-tested them in the present field conditions, discussed in number of meetings with project respective experts and relevant professionals and ADB Consultants, and finally placed in the Inception Workshop for final review held on 11 October 2015;
- o. All the above mentioned tools were presented, discussed and no major suggestions for improvements of any tool could be reached even after three two weeks after the workshop although all participants were requested to forward any suggestions (if any).

13. PPM&E firm in association with the Project arranged an Inception Workshop on 11 October 2015 at the Bangabandhu International Convention Center (Windy Town Hall). The workshop was participated by more than 50 participants from the Local Government Division of the Ministry of Local Government and Rural Development and Cooperatives, Planning Commission, ADB, UNFPA, SIDA, PMU< PIU, LGU, PA NGOs, ICDDR.B, PPM&E Experts, etc. The workshop discussed and approved the methodologies and tools of monitoring and evaluation to be used for project performance monitoring and evaluation with suggested improvements.

14. The PPM&E firm considering delays of PPM&E activities of the project due to delay in recruitment of PPM&E firm promptly initiated actions based on preparations of the last two month inception stage. As of 5 October 2015, GIS database and mapping activities made good progress, Quality Qualitative Survey started in the field, and Health Facilities Survey will start from 7th October 2015. Other PPM&E activities have been agreed and presented in the implementation plan.

Abbreviations

ADB	Asian Development Bank
ANC	Antenatal care
ARI	Acute respiratory infection
MBBS	Bachelor of Medicine and Bachelor of Surgery
BCC	Behavior change communication
CRHCC	Reproductive Health Care Centre
DCC	Dhaka City Corporation
DMF	Design Monitoring Framework
DOTS	Directly observed treatment short-course
FGD	Focus group discussion
GAP	Gender action plan
GIS	Geographical information system
HMIS	Health management information system
HIV	Human immuno-deficiency virus
ISI	Integrated supervisory instrument
IUD	Intra Uterine Device
IEC	Information, education and communication
LGD	Local Government Division
LQAS	Lot quality assurance sampling
MDG	Millennium Development Goal
MMR	Maternal mortality rate
M&E	Monitoring and Evaluation
MR	Menstruation regularization
MCH	Maternal and child health
NGO	Non-government organization
OCC	Other city corporations
PIU	Project Implementation Unit
PPM&E	Project Performance Monitoring and Evaluation
PA NGO	Partnership Area Non-government Organization
PHC	Primary health care
PNC	Postnatal care
PAHQ	Partnership area headquarters
PRA	Participatory rapid appraisal
PSU	Project Support Unit
PA	Partnership Area
PMU	Project Management Unit
QA	Quality assurance
QPR	Quarterly progress report
RRP	Report and Recommendations of the President (of the ADB)
RH	Reproductive health
RTI	Reproductive Tract Infection
SIDA	Swedish International Development Agency
STD	Sexually transmitted disease
SPSS	Statistical package for social science
TFR	Total fertility rate
TB	Tuberculosis
TT	Tetanus Toxoid
UNFPA	United Nations Fund for Population Activities

U5MR	Under five mortality rate
UPHCP	Urban Primary Health Care Project
ULB	Urban Local Body
UPHCSDP	Urban Primary Health Care Services Delivery Project
WPHCC	Ward Primary Health Care Coordination Committee

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CHAPTER I

AN INTRODUCTION OF THE PROJECT

1. Background

1. The people generally needs primary health care services which includes essential health care based on practical, scientifically sound and socially acceptable methods and technology that is universally accessible to individuals and families in the community with full participation at no or affordable cost. In fact primary health care is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy and it includes all areas that play a role in health, such as access to health services, environment and lifestyle.

2. The ideal model of health care was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata, Kazakhstan in 1978 (known as the "Alma Ata Declaration"), and became a core concept of the World Health Organization's goal of Health for all. The Alma-Ata Conference mobilized a "Primary Health Care Movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "politically, socially and economically unacceptable" health inequalities in all countries. There were many other factors that also inspired PHC.

3. Government follows a pro poor health policy to ensure health care services for all at no or affordable costs even though health services are generally expensive everywhere. Consequently despite many adversaries, Bangladesh made plausible achievements in the health sector particularly in the last two decades and met most of the Millennium Development Goals (MDG).

4. Although the maternal mortality rate has declined but the MDG goal is yet to be achieved. Several other challenges remain unmet such as high rates of adolescent pregnancies and early marriages coupled with low rates of antenatal care (ANC). Only 26% of pregnant women attend at least four ANC visits during their last pregnancy. In addition, there is a strong preference for home deliveries with only 29% of women delivering at a health facility within the last three years. This rate declines with age less than 20% of women over the age of 35 delivering at a health facility.

5. The mortality rate for children under 5 in urban slums is 91 per 1,000 live births as compared with 77 per 1,000 live births in rural areas. Urban children from the poorest wealth quintile are four times more likely to be chronically malnourished than children from the wealthiest urban quintile. While government achieved food self-sufficiency and average per capita food intake increased yet the country is fighting hard for reducing severe child malnutrition. In Bangladesh child malnutrition is quite high with 41% of children stunted and 36% underweight. Urban slum dwellers also have a higher total fertility rate of 2.46 as compared to non-slum dwellers at 1.85.

6. Government considering the trend for high rate of urbanization and rapid growth of urban population particularly in the city areas of poor urban health care facilities initiated to provide primary health care services through establishing primary health care facilities in selected major city areas under the local government bodies. The Government with assistance of the Asian Development Bank (ADB) and the Swedish International Development Association (SIDA) developed and implemented the Urban Primary Health Care Project in four major city corporations² during 1998-2005. The initiative proved excellent and created interests among the city dwellers and local government bodies. Government following the success of first phase designed and implemented the Second Urban Primary Health Care Project in 15 cities³ with the financial assistance of Asian Development Bank and other development partners during 2005-2012. The Second Urban Primary Health Care Project also proved successful and continuation and replication in new major cities.

7. The Government further designed the present on-going Urban Primary Health Care Services Delivery Project and implementing in 14 different cities⁴ with the financial assistance of ADB, SIDA and UNFPA during FY2012-13 to FY2016-17. The three projects are designed with program approach, under public private partnership (PPP), decentralized project management, and institutional governance capacity building of the local government bodies to deliver PHC services in a sustainable manner. The target beneficiaries include the poor particularly the women and children of the project areas.

2. Project Area

8. The project area covers 14 major cities including ten city corporations and four municipalities. Although the project covers large cities like corporations and major municipalities yet the project target locations are limited to areas with relatively thick population and population of low income bracket where generally there is lack of sufficient health care facilities accessible to the poor.

3. Project Impact and Aim

9. The intended aim and impact of the project is improved health of the urban population in Bangladesh, particularly the poor, women, and children. The performance target indicators for achievements of the project impact include to: (i) reduce maternal mortality rate (MMR) from 194 to 143 per 100,000 live births, (ii) reduce under five mortality from 63 to 48 per 1,000 live births and gender discrepancies eliminated (5% difference), (iii) proportion of under weight is reduced from 28% to 21% and stunting from 36% to 27% and gender disparities reduced (5% differences between sexes), (iv) total fertility rate (TFR) is maintained at 2.0, (v) differentials in MMR, U5MR, TFR and child malnutrition between the lowest wealth quintile and the highest wealth quintile in urban areas is reduced by 15%.

² Dhaka, Chittagong, Rajshahi and Khulna

³ Dhaka North, Dhaka South, Rajshahi, Chittagong, Khulna, Barisal, Sylhet, and Comilla city corporations; and Bogra, Sirajgong, Madhabdi, Savar, Gopalganj, Monohardi, and Kushtia seven municipalities

⁴ Dhaka South, Dhaka North, Barisal, Khulna, Rajshahi, Sylhet, Rangpur, Comilla, Gazipur, and Narayanganj city corporations; and Gopalganj, Sirajganj, Kushtia, and Kishoreganj municipalities

4. Outcome/ Objectives

10. The expected outcomes include sustainable good quality urban primary health care services provided in project area that target the poor and needs of women and children. The performance target indicators of achievements of the outcome/objectives are: (i) 60% of births are attended by skilled health personnel (baseline:26.5% BMMS 2010), (ii) at least 80% of growth monitoring and promotion performed on under -5 children (baseline:43.3% UPHCP II 2008), (iii) at least 60% of eligible couples use modern contraceptives (baseline:53% UHS 2006), (iv) at 80% of poor households are properly identified as eligible for free health care (baseline: 67% UPHCP II 2008), (v) at least 80% of the poor access project health services when needed (baseline: 64.7% UPHCP II 2008), and (vi) at least 90% of project clients express satisfaction with project services (baseline: 76% UPHCP II 2009).

5. Project Outputs/Components

11. The project components/outputs included: (i) strengthening institutional governance capacity to sustainably deliver urban primary health care services; (ii) improving the accessibility, quality, and utilization of urban primary health care services delivery, with a focus on the poor, women, and children, through public private partnership; and (iii) effective support to decentralized project management.

12. The target indicators of the outputs for strengthening institutional governance and local government capacity to sustainably deliver urban PHC services are to meet the following target indicators. Governance and capacity of all ULBs improve to ensure: (i) permanent and functional inter-agency coordination structure for urban health is established by December 2013; (ii) all project ULBs have a functioning health department with at least one staff in each health department trained in PPP contract management and core project management audits by 31 December 2013; and (iii) gender responsive data collection and analysis are computerized through HMIS in 80% of partnership areas by 31 December 2014. In addition, sustainability and commitment improves so that: (i) at least 50% increase in overall allocation to the urban health sustainability fund compared to UPHCP II (baseline: 2011 Tk.38 .5 M); and (ii) at least 5% per annum increase of ULB annual development plans and block grants allocated for PHC and public health related services (2011 baseline:0).

13. The target indicators of the outputs/component for improving accessibility, quality, and utilization of urban PHC services with a focus on the poor, women, and children through PPP are the following. The performance of accountability and utilization improve by midterm and sustain until project completion for the following indicators. Accessibility and utilization is increased at least 30% of each of the major project health care services (including caesarean section) is provided free-of-charge to holders of government issued red cards that identify them as poor; and at least 80% of the facilities planned for construction and upgrading are functioning normally within 3 years of loan effectiveness (12 CRHCCs and 26 PHCCs). Quality of services improves by at least 80% of children consulting project PHC services for acute respiratory infection receive correct treatment; and at least 80% of children consulting for diarrhea receive correct treatment. Public private partnership (PPP) performance and accountability improves adequately to ensure achievements of the PA NGOs.

14. The target indicators of the outputs/component for effective support for decentralized project management are the following. A fully functional PMU with at least 20% of the staff female is established by loan effectiveness and PIUs are established in ULBs within 3 months of loan effectiveness; computerized FMIS is functioning fully in partnership areas by 31 December 2014, streamlining accounting procedures and processes at all levels of project implementation (PMU, PIUs, and partner NGOs); and project monitoring and evaluation surveys, follow-up on findings, data collection, and quarterly progress reporting are implemented on schedule.

6. Project Overall Scope

15. The scope of the project includes: (i) improving accessibility (financial and physical) to PHC services in the urban areas covered by the project; (ii) ensuring the delivery of quality PHC services to urban populations; (iii) increasing utilization of primary health care services by the urban poor, especially women, newborns, and children; (iv) strengthening institutional arrangements for delivery of primary health care services in urban areas; (v) increasing capacity of the urban local bodies to ensure the delivery of primary health care services, according to their mandate; and (vi) increasing sustainability of the delivery of urban primary health care services by strengthening ownership and commitment of the urban local bodies to ensure the delivery of primary health care services particularly for the poor.

16. The project will achieve objective outcome and outputs in terms of delivering extended service delivery packages through establishing primary health care service network with Comprehensive Reproductive Health Care Centers (CRHCC), Primary Health Care Centers, and Satellite Clinic in 25 partnership areas. The project also has a significant training component to build capacity in management, service delivery, and project monitoring and reporting skills for staff at various levels.

CHAPTER II

PROJECT PERFORMANCE MONITORING AND EVALUATION

1. Introduction

17. The Urban Primary Health Care Services Delivery Project (UPHCSDP) has a provision for conducting Project Performance Monitoring and Evaluation (PPM&E) through an external independent agency as PPM&E firm. Eusuf and Associates (a private project management consultant firm specialized in monitoring and evaluation) was engaged on 16 August 2015 as PPM&E firm for 22 months starting 1 September 2015. The PPM&E firm started to work from 1 September 2015 with experts and professional support staff.

2. Objectives of the Assignment

18. PPM&E firm will work as an external professional agency to assist the project management to track progress of PA NGOs in achievement results, provide a regular independent assessment of performance, conduct mapping activities and provide support for routine project monitoring conducted by the project. The PPM&E firm will also suggest improvements in performance based on results and facilitate broader awareness and participation among stakeholders in the use of monitoring and evaluation (M&E), quality assurance (QA) and geographical information system (GIS) data.

3. Scope of Services and Major Tasks

19. The scope of services and tasks of independent project performance monitoring and evaluation (PPM&E) firm are to support the project management to measure project outputs and impacts through surveys. The measurement of the outputs and outcome and impacts are based on project DMF impact, outcome and output indicators. The PPM&E firm has to assess project outputs, outcome and impact using the DMF and additional indicators and proxy indicators as needed to monitor project implementation outputs, objective outcome, and project target impact targets. These output, outcome and impact will come through all the project outputs/components. Therefore, the PPM&E firm will assess project performance from outputs, outcome and impact of the interventions made under the components/outputs. The PPM&E firm as per contract and approach plan will capture necessary data corresponding to the DMF indicators for impact, outcome and outputs using various tools and produce the results as output deliverables. In addition, agreed output deliverables additional reports as may be prepared in the course of the PPM&E studies.

20. In addition, the PPM&E firm is responsible in general for the following tasks particularly in assuring the quantity and quality of primary health care services to the poor targeting achievements of highest possible utilization of the health facilities by maximum numbers of target urban population again and again every time with high quality primary health care services at least cost.

- ✓ Contribute to refinement and improvement of project M&E and Quality Assurance;
- ✓ Contribute to providing GAP measurement indicators as needed by HMIS;
- ✓ Follow up with and receive feedback from QA team and PMU for enhancement of ISI over the project period;
- ✓ Work with QA team to identify potential synergies in development and revision of the ISI and QA tools and use of ISI and QA results;
- ✓ Coordinate with HMIS to provide technical guidance on the health data that will be included in the HMIS; and
- ✓ Coordinate with UPHCSDP to analyze routine service delivery data from HMIS as inputs to QPR and other reports, participate in meetings held with PMU, PIU, project city corporations/ municipalities, collaborate with PMU's QA team to determine quality requirements of each component of UPHCSDP and identify areas that needs enhancement.

4. Major Deliverables and Timelines

21. PPM&E firm will provide regulars progress reports quarterly and annually to supplement project management in periodic reporting. In addition, the PPM&E firm will prepare the end of the project impact report.

22. PPM&E firm will specifically prepare the following seven specific reports in certain agreed intervals as specified against each hereunder. The detailed timelines of preparation and submission of the reports is at implementation schedule.

- ✓ Qualitative survey report (once at beginning of first year of PPM&E and at the end of project);
- ✓ Health facility survey report (once at beginning of first year of PPM&E and at the end of project);
- ✓ Training program assessment report;
- ✓ GIS database and mapping (once at the beginning and again at the end);
- ✓ Half-yearly ISI performance monitoring system reports (every January and July meaning three times during the tenure of PPM&E firm);
- ✓ Annual poverty updating and red card verification report (once at beginning of first year of PPM&E and at the end of project); and
- ✓ Project endline survey and impact evaluation report (once on project completion using household endline survey data compared with baseline with appropriate treatment and comparisons overtime).

CHAPTER III

METHODOLOGY AND PROCESS AND OUTCOME

1. Strategy and Approach

23. PPM&E firm will follow overall general strategic strategies and approaches. The strategic strategies and approaches will include: (i) team synergism maintaining independent characteristics as monitoring firm; (ii) cost-effective approaches and methodologies; (iii) separate strategy and methodologies for individual component of the project; (iv) reliability and acceptability of data and feedback; (v) making monitoring feedback useful to improving quality of program outputs; and (vi) highly efficient fieldwork.

24. The PPM&E firm's approaches to the strategy for team synergism maintaining independent characteristics as monitoring firm to follow PMU-PIU guidelines, jointly develop tools, data analysis plans, and reporting format, undertake joint field visits, frequent interactions targeting end results of no differences in opinion but having left no stone unturned to propose and advise best possible technical, social and professional options.

25. Optimum number but high quality manpower will be deployed; field work will be undertaken in batches to reduce cost in field travel; monitoring field team by City Corporation/Municipality instead of unit monitor in each project location will be engaged; well thought need-based data collection and processing will be done and reporting using concise high value reports will be prepared to reduce waste; field work by central team over longer time in each City Corporation and Municipality will be undertaken in planned way.

26. PPM&E firm will adopt separate approaches for monitoring of individual component of the UPHCSDP, develop separate monitoring tools and separate data processing and tables and interpretations and present in individual report as applicable.

27. The firm will adopt the approaches to the strategy for high quality of data, in-depth analysis and interpretations, data representativeness (sound sampling), demonstrated data comparability, sharing of data correctly with all concerned, no ambiguity and unclear and doubtful data. As per design of the UPHCSDP the endline survey data will be used as the baseline data of the project in all matters where applicable.

28. The firm will adopt the approaches to disseminate the feedback at all appropriate and relevant levels, prepare action plans for implementation, motivation of field staff of PA-NGOs for adopting approaches and adopt the approaches to the strategy for training, logistic, monitoring program supervision and quality control, coordination, dissemination of feedback to field, interactive professional exchange of views on feedback.

29. The specific strategies and approaches apply to various activities of the performance monitoring and evaluation include planning and programming, field work, data processing and analysis, and presentation. The proposed specific strategies and approaches do not limit to but include the following major monitoring and related activities. PPM&E firm also plans to adopt and follow specific strategies and approaches for any further activity that might arise in due course of the administration of the monitoring contract over the years as needed by UPHCSDP and also felt and proposed by the PPM&E firm and agreed by the client.

- ✓ strengthening institutional governance and local government capacity to sustainable deliver urban PHC services
- ✓ improving accessibility, quality, and utilization of urban PHC service systems via public-private partnerships;
- ✓ supporting effective decentralized project management
- ✓ conducting household survey
- ✓ conducting health facility surveys
- ✓ conducting qualitative survey
- ✓ measuring Gender Action Plan indicators
- ✓ preparing endline GIS mapping
- ✓ conducting independent performance assessment
- ✓ linking ISIs with NGO performance incentive scheme
- ✓ assessment on impact of the project's training programs
- ✓ annual updating of the red card system - annual verification and updating of the poverty listing
- ✓ preparing GIS database and mapping
- ✓ coordination and support with the HMIS
- ✓ management responsibilities
- ✓ quality control for the data - collection, data coding, data scrutiny, data management and computerization issues
- ✓ preparation of various reports as scheduled
- ✓ CRHCC/PHCC/satellite clinic, access and quality of services
- ✓ Orientation of supervisors and surveyors
- ✓ Coordination at all levels including UPHCSDP
- ✓ Reporting
- ✓ Dissemination of feedback

2. Standards and Quality of Methodology and Tools for PPM&E

30 UPHCSDP is in the middle of its third phase in implementation. The project has a design of its own and becoming a replicable model in similar conditions. Design of the methodologies and tools started in 1998 with the implementation of the first phase and are still undergoing improvements by the experts of LGD, PMUs, different participating NGOs, consultants provided implementation supports, and the consultants of the donors particularly the ADB. The PPM&E firm plans to take the advantage and make best use of the gained invaluable experience and expertise. PPM&E firm plans to prepare all methodologies and tools using past experience and commonly used ones instead to changing without reasons. PPM&E has prepared all the methodologies and tools and discussed with PMU and placed in the Inception workshop for detailed discussions and comments and suggestions. PPM&E firm will use the methodologies and tools finalized after incorporating the suggestions

received from the inception workshop. Importantly the methodologies and tools prepared by Mr Richter Kerry, Staff Consultant of ADB. PPM&E in association with the PMU organized an Inception Workshop on 11 October 2015 at the Bangabandhu International Convention Centre (BICC) to discuss and agree the methodologies and tools. The program, participants, and proceedings of the inception workshop are at Appendixes I, II and III respectively.

3. Methodology and Process and Tools

31. The PPM&E firm will follow separate methodology for each component of the project for project performance monitoring and evaluation. The detailed methodology for each component is presented in the following paragraphs.

Project Component/Output 1: Strengthening Institutional Governance and Local Government Capacity to Sustainability Deliver Urban PHC Services

32. A number of activities will be undertaken for strengthening institutional governance and local government capacity to sustainability deliver urban PHC services. The major activities are design survey methodology and sampling techniques for household, health facility and ISI surveys; design instruments for all PPM&E surveys as required, following protocols developed by the PMU and ADB when appropriate; coordinate all tasks as outlined in this document, including scheduling, managing resources, and recruiting field staff; provide training to the field staff and ensure monitoring, supervision and quality checks of field work; design data entry package; data management, and analysis for quantitative surveys; design analysis framework for qualitative surveys; develop GIS system to support mapping capability for key project outcomes; manage the core PPM&E team as well as field staff; linkage with different governments, NGO, and donor agencies who are stakeholders for this research, in consultation with the PMU; prepare survey reports; disseminate survey findings; provide feedback about progress, outcomes and strength and weaknesses of the PA-NGOs to the stakeholders and assist PAs and other firms in taking necessary decisions based on results.

33. The team of experts will work in close cooperation with the PMU-PIU and develop procedures and guidelines for monitoring activities following national or international standard and monitor training of the staff of the client and PA-NGO staff so that they can undertake the similar activities themselves when there will be no consulting firm in the city corporation/municipality.

Project Component/Output 2: Improving Accessibility, Quality, and Utilization of Urban PHC Service Systems via Public-Private Partnerships

34. It is very important to improve accessibility, quality, and utilization of urban PHC service systems via public-private partnership. Social analysis is an important issue for the urban primary health care project as the project target populations is urban poor, essentially the slum dwellers who are generally disadvantaged by lack of access to equitable income and suitable environment being poor and victims of deprivation. Awareness of the slum dwellers about health care services is also low. Motivation of raising awareness is needed among them vis-à-vis the service providers should be more active for providing quality services to the target population

for gaining their confidence for receiving the health care services. In addition to the awareness, infrastructure facilities, amount and quality of medicines, cost of medicines, number of doctors at the health care centers, management will be highlighted.

35. The team of experts will review the procedure of motivating the slum dwellers for receiving primary health care services from the CRHCC and PHCC undertake field visits, assessing need for improvement of accessibility, quality and utilization of urban PHC service system. According to the needs the team will develop necessary system for improving accessibility, quality, and utilization of urban PHC service systems. The team will maintain close cooperation with the concerned officials of PMU-PIUs and sharing the development and constraints in implementation of the activities and develop ways for resolving constraints. At every stage counterpart staff of the client will be involved with a view to institutionalizing and capacity building and sustaining the activities.

Project Component/Output 3: Supporting Effective Decentralized Project Management

36. The team will review the procedures of decentralized project management and assess its effectiveness, undertaking field visits, discussing the concerned officials, local elite, service providers and service recipients. The team will assess the weakness of effective decentralized project management and inform the client for making arrangement for reducing the weaknesses of implementation to become the system effective. The PPM&E firm will prepare several deliverables during the assignment period. Implementation methodologies of each deliverables are presented in the following paragraphs individually.

4. Geographical Coverage and Sample Sizes

37. The PPM&E firm will cover all 14 city corporations and municipalities (100%) and sampled households under each city corporations and municipalities. In annual red card updating system survey lot quality assurance sampling (LQAS) will be applied in each city corporation/municipality.

5. Qualitative Survey

38. The qualitative survey will be designed to gain deeper insights on various aspects of health service management, service provision, community awareness, client perceptions and others. It will investigate such aspects as status of ward primary health care coordination committee, status of users forum, community and service provider perceptions of the distribution and utilization of red cards, community awareness of health care services and providers, health care seeking behavior of urban poor, sources of information about health care services, responsiveness of service providers, awareness and service responsiveness to gender equity and violence against women, and linkages with legal aid services. The qualitative survey will be conducted before the household survey to provide information helpful to the design and inclusion of topics in the household questionnaire. The qualitative survey will utilize participatory rapid appraisal (PRA)

techniques as well as other qualitative evaluation techniques designed in collaboration with the PMU and the ADB M&E consultant.

39. The team of experts will conduct qualitative survey in the commencement of the assignment and before conducting the household survey. All the key experts, Reproductive Health Specialist, Monitoring and Evaluation Expert, Statistician, GIS Specialist, Project Coordinator and research assistants will undertake the qualitative survey and will be completed in five months time from commencement of the assignment and the feedback of the qualitative survey will help in designing and inclusion of topics in the household questionnaire and other monitoring tools. The qualitative survey will utilize participatory rapid appraisal (PRA) techniques as well as other qualitative evaluation techniques, designed in collaboration with the PMU and the ADB M&E consultant so that no gap can be existed in implementation of the monitoring and evaluation of the assignment. In addition to project experts three facilitators and 15 research assistants will undertake the qualitative survey and will be completed in one month time from commencement of the assignment.

40. Focus group discussions (FGD) and in-depth interview will be conducted during qualitative survey. FGD will be conducted in each of the CRHCC and one PHCC from each PA NGO. Total 50 FGD sessions will be conducted. Six in-depth interviews will be conducted in the area of each CRHCC and selected PHCC. Total number of respondents will be 300 (25x6 + 25X6).

41. The qualitative survey will use 11 different tools for capturing the qualitative data and feedback listed hereunder.

- ✓ Guidelines health worker;
- ✓ Guidelines for women's group;
- ✓ Guidelines for community leaders;
- ✓ Guidelines for vulnerable group;
- ✓ IDI for ward commissioner/female ward commissioner;
- ✓ Guidelines for in-depth interview with MBBS doctor/quack/kabiraj/homeopath/traditional healer;
- ✓ Guidelines for in-depth interview with women member of WPHCC coordination representatives from poor households;
- ✓ Guidelines for in-depth interview with clinical manager cum medical officer/paramedic//counselor of PHCC;
- ✓ Guidelines for in-depth interview with victim/family members of victim/ law enforcing agency;
- ✓ Final decisions made on the guidelines for qualitative survey in the meeting; and
- ✓ Additional questions added to different guidelines.

42. The feedback of the qualitative survey will be analyzed by the team of experts and prepare report on qualitative surveys and share the report with the client and incorporate the logical suggestions of the client and use feedback of qualitative survey for the designing of household survey questionnaires and other related tools.

6. GIS Database and Mapping

43. GIS database is an essential requirement with provision of updating as well as linking with HMIS and M&E. GIS-database is a digitized version of traditional database. It is needless to mention that digitized database is dynamic, easy to maintain and update and up-grade, expand scope, scope of linking with other parallel or complementary data management systems. The most unique feature and advantage is geo locating advantages and high degree of accuracy. In fact, the delay in starting the GIS database and mapping in the project due to late engagement of the PPM&E and other relevant firms has limited its scope to some extent than if it could be established in the initial stage of the project at start. Besides, GIS database and mapping could be started with the first phase and continue building upon the database of the earlier phases where appropriate. The GIS database is supported by mapping making it further functional and useful. However, in addition to health facilities by partnership area to improve referral linkages, data from various components of the M&E system will be used for mapping of such aspects of the UPHCSDP as poverty, coverage, accessibility of services and service quality.

44. The request for proposal and tender documents and later the contract provide provisions of GIS baseline and endline mapping. The PPM&E firm considers that GIS database and mapping is need for updating the GIS maps of all PA NGO showing the important information of relevant health service facilities established during the earlier phase and under the UPHCSDP. An updated GIS mapping is essential for planning services programs by the PA NGOs and the UPHCSDP, and others concerned. The PPM&E firm needs a GIS ma for each of the PA NGO for monitoring and evaluation. Sampling under PPM&E requires GIS mapping to better systematic sampling purpose and data collection.

45. The project has nearly two years prior to the endline survey and impact study. It is natural that major development of the project and physical progress will take place during the last 40% time as is observed in most cases, the GIS mapping will have greater opportunities to recording these developments for future reference. As major activities will take place during the remaining period the need for an end line GIS mapping will be justified and badly needed. It may be mentioned that GIS mapping has not been undertaken under the present project due to delay in recruitment of a PPM&E firm. An important use of the GIS mapping is linking with HMIS and M&E system and Quality Assurance system. These functions are still underway and need GIS mapping information and inputs. It is also agreed that the end line survey households during impact study will also be digitized through GIS coordinates and maps prepared showing major locations, reference objects, health facilities, PA NGO catchment areas, poverty survey sampled areas, major POIs, etc. The endline GIS mapping may also be regarded as "endline household survey and GIS mapping".

46. PPM&E firm will establish GIS database to serve as a dynamic data source providing link to information periodically with those collected through HMIS, ISIs, facility surveys, poverty survey, endline household survey, and also prepare maps showing the important locations, facilities, objects.

47. As per suggestions of the project we have met and discussed with the ICDDR,B who are also establishing GIS database for their action researches and plans to prepare maps. We agreed to continue further discussions and find ways and means in a coordinated manner avoiding duplications and waste. We will discuss mainly on technical points as needed to prepare high quality GIS database and good value maps useful for the project having scope of gradient color maps for a web-enabled GIS platform. The PMU will be in the centre of the cooperation and coordination and approving the scope and activities.

48. GIS Mapping is the primary responsibility of PPM&E firm and the PPM&E firm will accomplish the task with technical support of the HMIS firm. This is important for wider utilization of the GIS technology as well as to ensure common platform, interoperability etc. The PPM&E firm will provide inputs for the GIS database while the HMIS firm will provide technical inputs for setting up the database. The GIS will be capable of producing maps that show aspects of service delivery coverage, poverty, service accessibility, quality, and others. The PPM&E firm will incorporate a GIS component into the ISIs and endline surveys and will work closely with the PMU and HMIS firm to link these with HMIS data.

49. The PPM&E firm will provide inputs for the GIS database that is linked to the HMIS, ISIs and poverty data. The GIS will produce maps that show aspects of service delivery coverage, poverty, service accessibility, quality, and others. The PPM&E firm will incorporate a GIS component into the ISIs, endline surveys, and will work closely with the PMU and HMIS firm to link these with HMIS data. Results of the endline household survey will be mapped and linked to other aspects of the project in the GIS database. The following activities will be involved in preparing GIS and mapping.

50. The PPM&E firm will collect relevant data and maps from secondary sources like PMU, PIUs, PA-NGO HQs, City Corporations, Municipalities, BBS and other organizations. The major information will include all types of health facilities in the catchments area of the respective PA NGO with address, households of sections/block in the sampling units of PA-NGOs. The collected maps will be scanned for digitization and locating city corporation, municipality, ward boundary, roads, railways, rivers, khals, water points, utility services, settlement area and slum area, health facilities (public hospitals, NGO clinics, private hospitals) and landmarks (school, college, University madrasha, orphanage, public offices, NGO office, factory, shopping centres, hat, bazar, religious centre, etc.).

51. The PPM&E firm will code City Corporation, Municipality, PAHQ, CRHCC, PHCC, and Satellite Clinic/Outreach for easy identification. Orientation training will be provided to field staff for downloading GIS captured data, cross checking, editing and preparing GIS using collected data. Base map by PA NGO will be prepared and linking GIS database into HMIS database. The PPM&E Firm will utilize the services of one GIS Expert, two GIS Associates, four GIS Operators and six GIS Operators/Surveyors for each time of mapping. PPM&E firm used one data collection sheet for survey and data collection for the GIS based data and mapping. GIS Database and mapping is now agreed to be a coordinated effort of the PPM&E, ICDDR,B, HMIS, M&E and others involved in the matter and therefore, there will be

further discussions and improvements on its development under the leadership of and guidance of the PMU.

7. Health Facility Survey

52. Health facilities survey will include (i) clinic manager interviews; (ii) service provider interviews; (iii) client exit interviews; (iv) observation of services; and (v) a mystery client survey. The consultants will interview of the manager of all the clinics operating under the project, interview of all the service providers, interview of the exit client on sample basis, observation of services of all the service providers, and a mystery client survey.

53. There are 25 project office/headquarters; 25 CRHCC facilities; 112 PHCC facilities; and 224 satellite clinics. The consultants will cover 100% of the project office/headquarters, CRHCC facilities, PHCC facilities and satellite clinic. The interviews, observations and surveys will be performed twice in the project period. In each time one month will be spent for interview and observations. From each PA-NGO 200 client exit interview will be conducted. The client will be distributed among the CRHCC and PHCCs of the respective PA-NGO. Four teams, each team consists of two supervisors and eight research assistants will be deployed for conducting interview, observation, and mystery client survey.

54. In conducting mystery client survey three different approaches such as, checking all relevant registers maintained in each CHRCC and PHCC regarding service delivery and distribution/issue of medicines, checking records of clients served, and on sample basis spot verification. Information of the mystery survey will be analyzed properly and present the in the health facility survey report with suggestions for overcoming the weaknesses (if any). The consultants will share the findings of the mystery client survey with PMU, PIUs and PA-NGOs.

55. PPM&E firm during the design and implementation of the health facility survey used as many as seven tools. These tools are:

- ✓ Client exit interview
- ✓ Tools for observation of services
- ✓ Mystery client guideline
- ✓ Interview of client managers
- ✓ Tools for service providers' interview
- ✓ Inventory verification guidelines

8. Performance Assessment of PA NGO using ISI Tools and Surveys

56. The PPM&E firm will undertake the ISI surveys twice in a year (in January and July) using a detailed protocol developed by the PMU and the ADB M&E consultant. In total three times ISI survey will be conducted. The ISI methodology will be consistent for all partnership areas to allow comparisons across PA-NGOs and over time (including during the previous phase of the UPHCP, if possible). ISIs will be implemented at the PA-NGO headquarters, the CRHCCs, the PHCCs, the satellite clinics and in community level. The sampling frame for ISI surveys by area (city corporation/municipality) is presented in the table1. The number of PA-NGO

headquarters, the PHCCs, the CRHCCs and the satellite clinics are shown in the table based on the available information with the consultants which will be used for purpose of estimation of workload and these will be adjusted at the time of implementation of the assignment. Number of sample households for ISI will be determined using Lot Quality Assurance Sampling (LQAS) technique.

Table 1: Sampling Frame for ISI Surveys by Area

City Corporation/Municipality	Headquarters	CRHCC	PHCC	Satellite clinic	Total
1. Dhaka South	5	5	30	60	100
2. Dhaka North	5	5	26	52	88
3. Rajshahi	2	2	10	20	34
4. Rangpur	1	1	3	6	11
5. Khulna	2	2	12	24	40
6. Comilla	1	1	5	10	17
7. Barisal	1	1	4	8	14
8. Sylhet	1	1	6	12	20
9. Gazipur	2	2	4	8	16
10. Narayanganj	1	1	3	6	11
11. Sirajganj	1	1	3	6	11
12. Kushtia	1	1	2	4	8
13. Gopalganj	1	1	2	4	8
14. Kishoreganj	1	1	2	4	8
Total UPHCSDP	25	25	112	224	386

57. The project needs assess the performance of all the PA NGO using a common tool applicable for every PA NGO and city corporations and municipalities (no matter large or small) to promote higher progress with better quality in shorter time span ensuring highest efficacy of the project implementation. The assessment is also needed to provide an incentive package to motivate and reward the PA NGOs to stimulate their interests.

58. The project with the help of one staff consultant of the ADB prepared a standard tool called Integrated Supervisory Instrument (ISI). We have reviewed the tool and found excellent and consider that it can be used for the purpose without any major improvements. We understand that the tool was prepared through intensive consultation and trails and meetings with all parties involved and the stakeholders. In addition, we plan to pre-test the toll in the field during the training of our enumerators both in classroom and field conditions and see if there is any need at all for improvements with approval of the project. The ISI tool has used all necessary and pertinent indicators for the purse.

59. ISI included CRHCC, PHCC, Satellite Clinic/Out Reach, PA NGO HQ, field survey, community score card surveys of total 475 (19X25). In the CRHCCs the PPM&E firm will check target registers, red card, birth record, stock register and observe various services. Similarly, in the PHCCs, the PPM&E firm will check target registers, red card, child health records, and observe various services. In satellite clinics, check service records and observe services at satellite clinics. In PA NGO HQ, PPM&E firm will check management issues. In addition, field survey will be conducted on sample basis using LQAS technique. In 22 months time three ISI

surveys (two surveys in January 2016 and 2017 and one survey in July 2016) will be conducted. In each time, one month will be spent for conducting ISI survey. Fourteen teams, each team consists of one supervisor and two research assistants will be deployed for conducting ISI survey. The first ISI survey will start tentatively from January 2016. December 2015 has been allocated for preparation particularly for training of enumerators and preparation of sufficient numbers of copies of the data collections ISI sheets. The PPM&E firm has already prepared manual in bangle for guidance of the enumerators to educed confusions and errors.

60. The PPM&E firm will monitor the PA NGO activities and their achievements per set time bound targets using the above ISI tools. Finally, the PPM&E firm will assess overall performance of the PA NGOs based on the combined achievements of their HQ, CRHCC, PHCC, Satellite clinic in terms of quantity, quality, and management on a total 1,000 scope points. The score points are distributed for quantity, quality and management as follows.

Table 3: Overall Scoring Scheme for ISI

Facility Station(s)	Score Assigned for			
	Quantity	Quality	Management	Total Score
CRHCC	100	100	50	250
PHCC	150	250	50	450
Satelitte Clinic	50	100	20	170
PA NGO HQ	50	-	80	130
Total	350	450	200	1,000

61. The PPM&E firm considers that the assessment will help all concerned to plan how best the project targets can be achieved every six months and optimize the delivery of quality services. This will also help the respective PA NGOs to plan their service delivery to achieve targets. It may be mentioned that the ISI tools along with the overall scoring scheme was developed by a Staff Consultant of the ADB in consultation with the Project/Government. The PPM&E firm plans to use the ISI tools along with the overall scoring scheme transparently in a participatory manger and share the assessment with the project and the respective PA NGOs professionally.

9. Training Program Evaluation

62. PPM&E firm will conduct a qualitative assessment of the project's training program for LGD, ULBs, and PA-NGOs. Each training component for the project will be evaluated through pre/post testing, formative assessments, summative assessments, participant interviews, and/or other methods. PPM&E firm has developed evaluation tools based on a general but project related PHC service management and delivery to assess the effectiveness of the training component and will analyze the results and present the assessment in training evaluation reports at mid-term and endline.

63. In the assessment of impact of the project's training programs the PPM&E firm will collect the training schedule in advance and deploy any of the team members to observe the training activities right from the organization to the completion of the training program. The expert will observe the environment of

training, venues, facilities, methods of providing training, participation of trainees and trainers, method of evaluation, and conclusion. The expert will make an assessment of the participants before commencement of the training and another assessment will be conducted at the end of the training program. Among other things these two assessments will provide impact of the training program.

64. A team of one supervisor and four research assistants will be deployed in conducting impact assessment of training program. Two such impact surveys will be conducted during the project period. The team will provide feedback of the training to the client time to time but provide two reports on the impact of the training program - one at mid-term and another at endline. The team of experts and support professionals of the firm will be involved in assessment of impact of the project's training program for LGD, ULBs, and PA-NGOs and preparation of reports.

10. Monitoring Red Card System and Annual Verification and Updating

65. Red Card is a tool to ensure that no person living in the UPHCSDP area will be deprived of getting primary health care services due to poverty. A target of 30% poor and ultra poor is to put within the umbrella of UPHCSDP. A set of social and economic indicators had been developed for identification of the poor households to be eligible for getting a red card.

Table 4: Major Indicators

- ✓ Number of family members
- ✓ Occupation
- ✓ Per capita income
- ✓ Annual family expenditure
- ✓ Illness
- ✓ Education level of family members
- ✓ Number of children
- ✓ Housing condition
- ✓ Age of children
- ✓ Household assets
- ✓ Nature of employment
- ✓ Floating and homeless people
- ✓ Female headed household
- ✓ Widow/divorce/separated
- ✓ Single living female workers
- ✓ Disabled persons
- ✓ Transgender
- ✓ Sex worker
- ✓ Drug addicted
- ✓ Otherwise distressed
- ✓ Status in the red list (if any)
- ✓ Source of drinking water
- ✓ Source of lighting
- ✓ Structure of house
- ✓ Place of defecation
- ✓ Environment of dwelling area

- ✓ Cleanliness
- ✓ Prevalence of diarrhea and acute respiratory infection among children
- ✓ Nutritional status of children
- ✓ Frequency of eating meat, fish and egg per week
- ✓ Frequency of drinking milk per week

66. The poor are identified through poverty survey categorized into three groups on the basis of per head monthly income of taka 2,000 for Dhaka, Narayanganj, Gazipur and Barisal city corporation; taka 1,500 for other city corporations and taka 1,000 for all municipalities.

67. The main purpose of the PPM&E study is to observe and analyze the functioning of the Red Card to reach the targeted 30% of the poor and ultra poor leading to the improvement for the system for sustainability.

68. The PPM&E firm will follow the under mentioned steps and techniques for the purpose of updating red card system:

- ✓ Collect the list of Red Cardholders and study available data from the service providers PA NGOs
- ✓ Collect data from the Red Cardholders using Lot quality assurance sampling technique.
- ✓ The sample will be determined from the project area in consultation with the client.
- ✓ Survey schedule will be based on selected indicators and available services.
- ✓ Organize Focus Group Discussion (FGD) participated by the beneficiaries, service providers, and local management committees with specific agenda. Number of FGD will be decided in consultation with the client.
- ✓ The report will be prepared annually.

69. The PPM&E firm will independently verify and update red card households annually and support the PA-NGOs for effective management of the red card system. It will develop an appropriate methodology for conducting spot-checks of current red card holders to verify, confirm and correct current lists and for identifying new poor households in the project areas. Lot Quality Assurance Sampling (LQAS) will be considered as a potentially useful method for monitoring the red card system. Sample households from all the project city corporations and municipalities will be collected for updating of the red cards system. The PPM&E firm has prepared a tool for the updating red card system survey by updating and improvisation of the tool used in the earlier project.

70. As mentioned here above Lot Quality Assurance sampling will be used. So data of household from each sampled city corporation and municipality will be collected identifying proper cluster. Two annual updating of the Red Card System surveys will be conducted during the period of the assignment of the PPM&E firm on and reported on an annual basis.

11. Endline Survey and Project Impact Evaluation

Background

71. The PPM&E firm is mandated to undertake an endline survey and impact assessment of the UPHCSDP. According to the DMF, the impact of the project is “Improved health of the urban population, particularly the poor, women, and children”. The project will achieve the impact if the intended outcomes are adequately attained. The intended outcomes are “sustainable good quality urban PHC services provided in the project areas and target the poor and the needs of women and children.” The intended outcome will be achieved through the three outputs of the project such as: (i) Strengthened institutional governance and local government capacity to sustainably deliver urban PHC services; (ii) improved accessibility, quality, and utilization of urban PHC services, with a focus on the poor, women, and children through PPP; and (iii) effective support for decentralized project management.

72. The project was designed to establish primary health care services delivery facilities (outputs), motivate people to receive PHC services, some other people are trained to provide PHC services, beneficiary people get cured and attain and maintain improved health. The goal and objective of the project is to create sustainable impact on the health condition of the beneficiaries. The intended impact goal and objective is improved health condition of the urban population particularly the poor especially the women and children. How to measure the impact of all the beneficiaries? Project DMF has set impact measurement indicators such as reduced maternal mortality rate, reduced under five mortality rate, reduced TFR (total fertility rate), reduced incidence of certain common diseases, proportion of underweight and stunting are reduced, reduced gender disparities and differentials of maternal mortality rate, under five mortality rate, TFR and child malnutrition between the highest and lowest wealth quintile reduced. In addition, the impact study will measure outcome in numbers of areas including impacts of institutional capacity building of the ULBs to independently undertake the project responsibilities and sustainability operate.

73. The PPM&E firm will collect measurement indicator data of the set indicators and immediate indicators and also many unlisted additional indicators to have a comprehensive impact assessment. DMF indicators are prime and indicative indicators but other additional indicators are needed in all impact assessments. PPM&E firm based on the experience of previous two project impact studies, HIM, M&E, and experience of monitoring over the next two years list many other indicators and finalize a long list of indicators and find methodologies for collecting those data.

74. The PPM&E firm will finalize based on the present design an effective impact evaluation study that will rely on both the household survey and the impact evaluation methodology although the two are interdependent. While the design of the household survey is determined by the impact evaluation design, the quality of the impact evaluation results depends on how efficient the household survey is in addressing the issues of spill-over effects, selection bias and others. It is also crucial to collect a control sample on which the welfare of the project beneficiaries will be

compared to vis-à-vis a relative comparison between endline and baseline health status of the beneficiaries served.

Strategies and Approaches

75. RRP of the project specified that the endline household survey of UPHCP-II will be treated as the baseline status of the UPHCSDP. Therefore, it would be proper to follow the endline sample design of UPHCP-II in the endline survey of the UPHCSDP to ensure the comparability of the surveys in impact evaluation. It will be also proper to analyze status of the 14 city corporations and municipalities in comparable groups separately such as: (i) Dhaka City Corporation (DCC), (ii) Other City Corporations (OCC), and (iii) Municipalities. Dhaka City Corporation consists of 10 PA areas, Other City Corporations (OCC) consists of 11 PA areas, and the municipalities consist of 4 PA areas. With the separation of DCC into Dhaka North and Dhaka South City Corporations, the PPM&E firm gathers clear understanding of the changes in the ward codes needs to be well documented in order to make the UPHCSDP geographically comparable by areas to the UPHCP-II areas.

76. The impact evaluation will use a properly selected sample that address all potential issues in data collection and follow a methodology that pool a cross-section regression-based difference-in-differences (DID) between baseline and endline comparing the PA and NPAs. Project impacts will be computed for the poor households, and for the overall population. Control variables especially important socio-economic variables will be added to improve the estimate of project impact. Furthermore, information related to health projects other than UPHCSDP will also be included in the DID model to control for their potential influence. The endline survey will be consistent and comparable to the baseline survey and data sets with treatment and control groups. The control group or NPA will be a valid counterfactual of the treatment group meaning that the characteristics of the PA and NPA groups are similar at the onset of the project or at least that the NPA will behave like the PA areas as if there were no project.

77. The PPM&E firm plan to design the sampling of endline survey and impact evaluation using a two-stage cluster probability sampling technique. In the first stage, 18 mohallas will be randomly selected from each PA area. In the second stage, 20 households will be selected per mohallah using systematic sampling from a newly created household list consisting of 100 households.

Control Group

78. PPM&E firm will also design the sample frame for survey and data collection from equal numbers of non-beneficiary households. The sample PA households of control groups must not have ever utilized any of the UPHCDSP health facilities and services. The control group will comprise of the households from non-project areas and households eligible for PHC services from PA NGO area but did not receive services for any reason, Broadly, control households will be selected using a two-stage sampling technique like the project beneficiary households. The control households will be similarly profiled, urban poor, women, and children but drawn from an area different from the PA area have not availed similar PHC facilities from the UPHCSDP and other public or private PHC facilities.

79. Control households will be drawn from the non-project wards in the city corporations. The NPAs will be selected considering the distance of the wards in the control group from UPHCSDP and other programs health facilities. The NPAs should have the similar characteristics as their PA counterpart, and their location should not be too close to PA areas to minimize project spill-over effects. In case of municipalities however, non-neighboring municipalities with similar characteristics will be selected as NPA. Selection of these NPA municipalities will be guided by the construction of a similarity index that is composed of socio-economic characteristics, such as population, average per capita income, poverty incidence, level of education, and various health indicators measured prior to the project implementation. The variables in the similarity index could be collected from official statistics and previous household surveys, such as Household Income Expenditure Survey (HIES), Demographic Health Survey (DHS) and Urban Health Survey (UHS). The use of a similarity index will ensure that the selected NPA are valid counterfactuals for the PA areas.

Design of Survey Questionnaires

80. For consistency the questions of the endline survey of the UPHCP-II will be used and to collect additional information as mentioned here above new questions will also be developed. The impact indicators and outcome indicators specified in the DMF have been discussed respectively at para 9-13 of the Inception Report. A manual will be prepared for each questionnaire for clear and common understanding, definitions, explanations, meaning, and how to ask each question consistent to the DHS.

81. The additional questions over the DMF target indicators may include for example, the number of visits, household members who visited with their respective ages, nature of the visit and the level of satisfaction, utilization of health facilities under other health projects, and private hospitals and clinics. These questions will also form part of the formal questions and the data may provide necessary feedback for potential spill-over bias. The questionnaire will also include questions on beneficiary perceptions of the importance and effectiveness for easy access, due attention, quality services, and relief at reasonable time and cost. This brand quality of the UPHCSDP among the beneficiaries will be assessed as an indicator of the reputation and goodwill of the facilities and services and its effectiveness, sustainability, and impact.

Inclusiveness of the Urban Poor, particularly the women, and Children

82. Impact evaluation will place special emphasis on inclusiveness of the poor particularly of women and children, ethnic minority and disabled. Specifically, the impact study will try to capture the level of satisfaction of beneficiaries with the quality of services provided to the poor households.

83. PPM&E firm will use the strategy followed by Urban Health Survey (UHS) that divided each city corporations into slum and non-slum areas. We plan to group the 14 towns into four groups like (i) Dhaka South, (ii) Dhaka North, (iii) other city corporations, and municipalities. Later, each group will be divided as slum areas and non-slum areas and the total domains will be eight. The sampling frame of poor

households will be constructed from the list of red card holders. The slum area domains will be added seamlessly in the overall design of the survey so that the domains of poor households augment the data in the overall impact evaluation. The Demographic Health Survey (DHS) approaches, tools and questions may also be welcome.

84. This survey will assess the impact of the interventions on health service utilization and health status, particularly on maternal and child health (MCH). A sample of ever-married women of reproductive age will respond to questions in eight areas: (i) household characteristics; (ii) knowledge and utilization of urban PHC services; (iii) reproductive health and reproductive history; (iv) services during and after pregnancy; (v) immunization status of children; (vi) prevalence of diarrhea and acute respiratory infection among children; (vii) nutritional status of children; and (viii) knowledge and awareness about HIV/AIDS and its prevention.

85. The survey will use a cross-sectional design to show the estimates of relevant program indicators in the Partnership Agreement (PA) areas covering ten city corporations and four municipalities covered under the project. The primary focus of the survey is to do the project evaluation to oversee the effectiveness of the project. In the impact evaluation the endline survey data of the UPHCP-II will be used as the baseline data. This approach is proposed in the design of the UPHCSDP and the PPM&E firm considers the approach justified and sound. Besides, the PPM&E firm plans to undertake impact assessment by comparing the above mentioned baseline data on the one side of the scale and comparing with the project DMF indicator targets for impact, outcome and outputs on the other side of the scale.

86. The PA area is defined with catchments wards. Ideally, the PA area covers under UPHCSDP services through CRHCC and PHCC. The survey will be conducted in three different areas for separate evaluation of the project in Dhaka City Corporation (DCC), other city corporations (OCCs) and municipalities. Equal number of mahallas will be covered from each PA Area. DCC area consisted of 10 PA areas, OCC area consisted of 11 PA areas, and municipality area consisted of 4 PA areas.

87. The survey will use two-stage cluster sampling method. At the first stage, equal numbers of mohallas (18 mohallahs) will be selected randomly as the sample cluster from the list of all mohallahs under each PA wards. In DCC area 180 mohallahs, OCC 198 mohallahs and municipalities 72 mohallahs will be selected at random. In the second stage of selection, 20 households per mohallah will be selected with an equal probability (systematic selection) from the newly created household list of 100 households. Thus, 360 households (18 mahallas X 20 households per mohallahs). This sample size per PA NGO is representative let alone the project. All ever-married women aged 15-49 who are usual members (not visitor/guest) of the selected households will be selected for interview. Total number of respondents from DCC will be 3,600 (180x20).

88. In selecting respondents from other city corporations and municipalities similar principle will be used. In OCC areas total 198 mohallahs will be selected and total number of respondents from OCCs will be 3,960 (198x20). In the municipality areas total 72 mohallahs will be selected and total number of respondents from

municipalities will be 1,440 (72x20). Therefore, in total 9,000 households from 450 mohallas of 25 PA NGO wards will be selected for interview.

Statistical Sample Frame

89. Sample design is very important for conducting Impact Evaluation Survey. It is found from the End-line Household Survey that 28 percent women received delivery care from CRHCC (End-line Household Survey under Second Urban Primary Health Care Project – Other City Corporations, page 9). The sample size for 95% level of precision and confidence under a given level of population variability is given by the following equations:

The general formula (Cochran) is;

$$n = \frac{(Z_{0.95}^2 PQ)}{e^2} = 309.7866, \text{ say } 360$$

Where,

n= Sample size

P= 28% (Prevalence rate - 28 percent women received delivery care from CRHCC)

Q= 1-P

Z_{0.95} =1.96

C= Correction factor = $1 + \frac{n_0}{N}$

e= precision rate = 5%

90. The survey activity will start with a day-long inception workshop to share the draft survey tools and agreed implementation plan for timely completion of the survey. The survey team members, UPHCSDP team members, researchers, statisticians, and other government and partners' representatives will attend the workshop.

91. In the field implementation stage, household listing will be done in the selected cluster to prepare a list of 100 households. The listing team will prepare a sketch map of all clusters. Cluster information on availability of health facilities and providers will be collected during listing and will be used by survey enumerators for correct identification during field survey. The listing operation will be carried out at the commencement of endline survey (planned in July 2017).

92. Three types of tools will be used to obtain information. These are household questionnaire, individual woman questionnaire, and cluster information on availability of health facilities and service providers. The household questionnaire will be used to list all usual members in the selected household. The individual questionnaire will be used to collect information from ever-married women age 15-49. The questionnaires contain household characteristics, incidence of communicable diseases, characteristics of respondent, exposure to UPHCSDP program components,

knowledge on pregnancy, danger signs, signs/symptoms of ARI, HIV/AIDS risk behaviors, birth history and under-five deaths, reproductive health care, incidence of STD, child health care and child nutritional status. The questionnaires have been developed based on the above recommended set of indicators. The questionnaire is in English and will be translated in Bangla during administration. The survey questionnaires will be pre-tested in DCC area. After the incorporation of the suggestion of pre-test, the questionnaires will be finalized after approval of the client. A household endline survey and data collection questionnaire has been prepared through updating and improvising the questionnaire used in the earlier project.

93. Fourteen teams, each team of one supervisor and three research assistants will be deployed in conducting endline survey. The team will work under the supervision of experts and the professional personnel of PPM&E firm.

94. Basically the endline survey and impact study is scheduled to take place during July-September 2017 after the close of the project on 30 June 2017. The design of the impact study will be reviewed and finalized prior to conducting the study in mid 2017. The PPM&E firm will generate endline data through a well designed survey and compare them with the endline data of the earlier phase of the project (UPHCDP II) agreed during design of UPHCSDP to consider as the baseline of the present project. Overall the impact evaluation will be conducted by the PPM&E firm following ADB Guidelines for Project Impact Evaluation. The impact evaluation will carry special importance for further multiplication of the PHC delivery model, formulating similar projects under a program approach, and government mass PHC delivery program through all major city corporations and municipalities.

12. Training of Enumerators

95. Intensive training will be provided to the field supervisors and research assistants/enumerators to keep uniformity and accuracy of data collection techniques and approaches among all the field investigators and to maintain the desired quality of data. A four days training course will be organized for the data collection team. Three days will be devoted to classroom training and one day for practical training in the field for pre-testing and sharing field experiences with each other and the experts. Apart from the foundation lectures on how to fill-in the questionnaire, group discussions, role playing in the classroom and question and answer sessions will be arranged in the classroom. The experts and the senior key personnel of the firm will provide the training. Same procedures of training of survey staff will be followed for each category of survey and deliverables.

13. Quality Control

96. For ensuring the quality of data, continuous field monitoring and supervision will be provided at different stages of field work. The experts, supervisors and control officers will undertake field supervision and spot checks and editing during collection of survey data. Besides, professionals of the PPM&E firm and Officials from PMU will make frequent field visits to see the household listing and field survey. A monitoring checklist will be developed and used by the professionals for field monitoring.

14. Data Processing

97. Data processing will start shortly after the commencement of fieldwork. For that reason, filled-in questionnaires will be sent to PPM&E firm headquarters weekly for processing. Data processing will include editing, coding of open-ended questions, data entry, and editing of inconsistencies found by the computer program. A data entry package in accordance with questionnaire with self-edit facilities for response code, range, and skip instruction will be developed and used for data entry. SPSS, excel and access software will be used for entry of data. All data files will be merged together and translated into SPSS for analysis. Analyzed data outputs will be generated using in tabular form for each indicator selected for assessing the outputs, outcome and impact. The analyzed data at this stage will be treated further and feedback generated for presentation of the deliverable reports.

98. The processed data will be analyzes in numbers of ways crossing inter and intra data sets, triangulation, validation to reach closet to the accurate impact of the project. This accuracy may validate the recommendations. In addition, data selected important indicator measurement data will be statistically tested such as (not limiting to only) t-test, chi-square test, etc.

15. Coordination at different Levels

99. The PPM&E firm will cooperate with other functional teams, health care providers, and other stakeholders and report on health-related activities by other organizations; participate in review meetings held between the PMU, PIU, and CCs/municipalities as appropriate, to review overall progress, problems, and discuss options for improvement; and provide information on any staffing matter, which needs to be brought to the attention of the PMU/PIU/CC Municipality (for example in the case of assault or fraud). However, for eventual changes of any senior staff the PPM&E will seek approval of the project.

100. The experts of the PPM&E firm will collaborate with the PMU's quality assurance team to determine quality requirements of each component of the UPHCSDP and identify areas that needs enhancement. These may include: accuracy and reliability of the reports, both narrative and financial, thereby helping the PMU to take decisions about the operational services, risk management, controls, and reporting. The ultimate aim of quality enhancement is to provide cost effective, accurate, and reliable reports on the project.

101. The PPM&E firm will coordinate with the HMIS firm to provide technical guidance on the health data that will be included in the HMIS. It will also provide technical advice about how the data will be compiled and automated to generate the most relevant health outcomes and service delivery performance outcomes as part of the HMIS quarterly reports. Secondly, the firm will provide technical support to the PMU to analyze routine service delivery data from the HMIS as inputs for QPRs and other reporting as required.

16. Management Responsibilities

102. In addition to above described activities the consultants will undertake management responsibilities not limit to but include report to the PMU and adhere

closely to the guidelines provided in this document, the PAM, the contract, hiring and termination of staff with qualifications sufficient to meet service standards and managing and conducting all activities under the contract, provide financial and program records of acceptable accounting standards relevant to the project and is expected to have regular internal and external audits.

103. The PPM&E firm will provide a detailed implementation plan with key activities, reporting requirements, project phasing, project timetables, staffing plan, budget, and schedules. Scheduling of fieldwork will be coordinated with the PMU so that it does not interfere with other project activities.

104. The PPM&E firm will provide an inventory of all project equipment and furniture acquired with the condition on receipt noted and marked identification numbers. Upon completion of the contract, equipment will be accounted for with reasonable depreciation and wear and tear. All equipment purchased by UPHCSDP in terms of furniture, equipment, and durable goods (if any) will remain the property of UPHCSDP and the disposition of these will be determined after the completion of the contract by UPHCSDP authorities.

17. Preparation of Reports and Sharing

105. The PPM&E firm will prepare a number of reports not limiting to but including: (i) qualitative survey report, (ii) GIS database mapping and endline mapping, (iii) Half-yearly ISI Survey report, (iv) training assessment report (midterm and end line assessment), (v) health facility survey report (baseline and end line facility survey), (vi) Annual red card system updating, and (vii) end line project impact evaluation report.

106. These important reports will highlight on accessibility, quality, and utilization of urban PHC delivery system with a focus on the poor, women and children through public private partnership. The reports will also focus on poverty listing, urban PHC services delivery including health education and behavior change communication (BCC), effective reaching the urban poor and women and children ensuring quality of PHC services. In addition access to urban PHC services through improved infrastructure network, effective support for decentralized project management will be addressed. The PPM&E firm will prepare all the reports as scheduled. All reports will be prepared following standard reporting format and guidelines.

18. Dissemination of Monitoring and Evaluation Feedback

107. PPM&E firm will arrange dissemination of the findings of the reports at appropriate levels in consultation with the PMU. The strategies and approaches to be deployed include to disseminating the reports as a routine as well as voluntary responsibility for sharing the report and findings at all levels by the concerned staff of the firm. It will serve in one way to selling the efforts as a good piece of work and also to contribute to enhancing the interests of the concerned to read the report and benefit, take proactive role in advancing the efforts and urge for further improving the performance for higher quality project outputs and impacts. The PPM&E firm will arrange workshop for dissemination of the findings of the assignment. The PPM&E firm will record comments and suggestions of the participants and client for incorporation of the logical suggestions in the respective report and finalize the report incorporating workshop inputs.

CHAPTER IV

OVERALL WORK PLAN

108. The PPM&E firm plan to complete the project performance monitoring and evaluation assignment in 25 calendar months starting from 1 September 2015 and closing in 30 September 2017. The assignment will be grouped in three spells – inception (Sep 2015), performance monitoring and evaluation (Oct 2015-Jun 2017), and impact evaluation/end line impact study (Jul-Sep 2017).

109. The PPM&E firm planned to undertake the performance monitoring and evaluation on a process approach, meaning continuous monitoring and evaluation of implementation and evaluate developments and changes and suggest course corrections as needed to enhance quantity and quality until the project is completed. In the meantime produce specific deliverable reports as well as periodic progress and special reports. Finally, undertake a final evaluation and assessment of the project impacts based on the impact and outcome indicators set in the project appraisal document (RRP) and Design Monitoring Framework (DMF). In the final evaluation, additional indicators may also be used from among those used in the monitoring and evaluation and other pertinent indicators demanded by the design of evaluation.

110. The experts of the PPM&E firm also plans to undertake all activities targeting production of high quality specific deliverable output reports. Therefore, for simplifications, the work plan has been simplified as the schedule of producing the nine specific reports. All PPM&E tasks are bundled together in a harmonic way in an integrated way to bringing out the agreed deliverables on time. Time bound workplan follows at table 5.

Table 5: Work Plan

PPM&E Years	2015					2016										2017											
Duration of PPM&E	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25		
Calendar Months	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		
Inception Report																											
Qualitative Survey Report																											
GIS Database and Mapping																											
Semi-annual ISI Report																											
Health Facility Survey Report																											
Training Evaluation Assessment																											
Annual Red Card Verification																											
Preparation of Final Report																											
Project End line Evaluation Report																											

Legend: Duration Intermittent as and when needed

CHAPTER V

INITIAL PROGRESS AS OF OCTOBER 2015

1. Manpower

111. There are three categories of personnel have been working under the assignment. The categories are key experts, non-key experts and support professionals. Personal inputs are different for individual. The duration of each project personnel is presented at following table 6.

Table 6: Manpower

Position(s)	Name	Input (MM)
Key Experts		
Team Leader (Performance Monitoring & Evaluation Specialist)	Prof.Dr.Md.Nurul Islam	22
Public Health Management Specialist	Prof.Dr.Md.Abdur Rahman	22
Sociologist	Mr.Kazi Bazlul Karim	20
Key Experts		
GIS Specialist	Mr. Muhammad Ullah Khan	10
Coordinator (Reproductive Health)	Prof.Dr.Rashida Begum	12
Coordinator (Survey)	Engr.Md.Habibur Rahman	12
Monitoring and Evaluation Officer	Mr.Md.Awlad Hossain	12
Statistician 1	Dr.Helal Uddin Ahmed	6
Statistician 2	Mr.Md.Mehedi Hasan	6
Support Professionals		
Project Coordinator – 1 Person	Mr.Nitai Chand Das	22
Programmer – 1 Person	Mr.Md.Muneer Hussain	10
Secretary – 1 Person	Mr.Md.Mokbul Hossain	22
Manager Accounts – 1 Person	Mr.A K M Obaidul Huque	22
Data Entry Operators – 4 Persons	Four Persons	88
Office Assistant – 1 Person	Mr.Md.Manik Miah	22

112. The PPM&E firm in consideration of the work plan for monitoring and evaluation and carrying out specific surveys and report preparation based on the available inputs has prepared the following manpower schedule (Table 6). The endline survey and project impact study due to take place during 23, 24 & 25th months (July-August 2017)

Table 7: Fielding Schedule of Manpower

Manpower/ Position	2015				2016												2017								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
PPM&E Duration in Months	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S
Team Leader/ Prof.Nurul Islam	Full-time																								
PHM Specialist/ Prof A.Rahman	Full-time																								
Sociologist/ Mr K Bazlur Rahman	Full-time																								
GIS Specialist/ Mr M. U. Khan	Full-time					Intermittent																			
Coordinator (RH)/Prof Rashida B	Full-time								Intermittent																
Coordinator (Survey)/ H Rahman	Full-time																								
M&E Officer/ Mr Awlad.Hossain	Full-time																								
Statistician(s)-Dr Helal & M Hasan	Full-time																								
Project Coordinator/Mr N.C.Das	Full-time																								
Programmer/Mr Muneer Hossain	Full-time																								
Secretary/Mr.Md Mokbul Hossain	Full-time																								
Manager Accounts/M Obaidul Huq	Full-time																								
Data Entry Operators (4 persons)	Full-time																								
Office Assistant/M. Manik Miah	Full-time																								
Dr M.Eusuf Ali - Study Director	As and when Needed																								

Full-time Intermittent As and when Needed

2. Logistic Facilities and Services

113. The PPM&E firm will provide the following logistic facilities and services (table 6) for smooth implementation of the assignment. However, the Firm has established these facilities within the office of the firm. Indeed, some of the equipment may be used by the experts wherever they like to work with. The logistic facilities will remain the property of the firm.

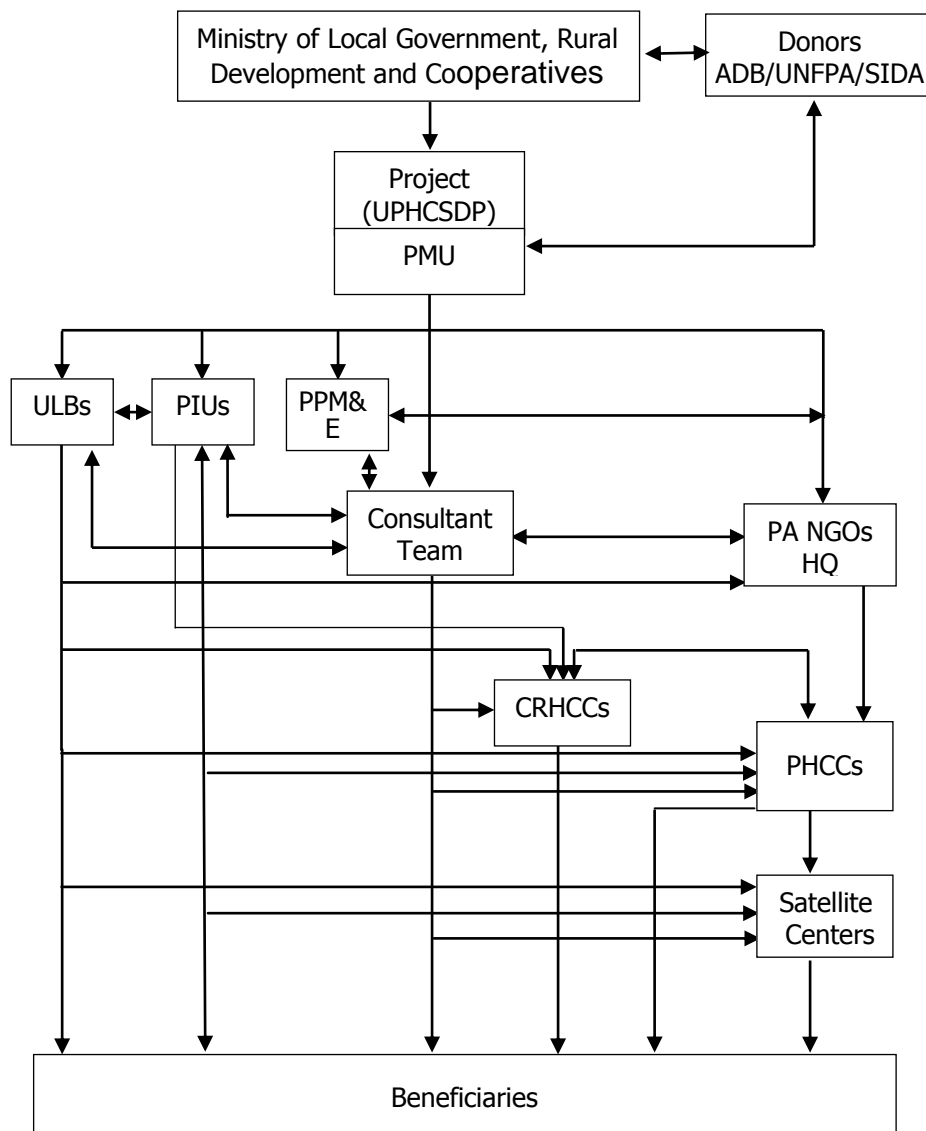
Table 8: Logistic Facilities

Logistic Facilities	Quantity	Logistic Facilities	Quantity
1 Office Space (square feet)	1,500	8 Scanners	2
2 Furniture (Lots as needed)	Lots	9 Land Set Telephones	1
3 Desk Top Computers	10	10 Mobile Phones	1
4 Lap Top Computers	2	11 Facsimile	1
5 Printers	2	12 E-mail	1
6 Photocopiers	1	13 Vehicles	2
7 Cameras (Digital Movie)	3	14 Training Facility	40 persons

3. PPM&E Organogram

114. The PPM&E firm has established PPM&E Assignment implementation unit within the PPM&E firm headquarters with an organization shown at figure 1.

Figure 1: PPM&E Organogram



Program

INCEPTION WORKSHOP
Workshop Project Performance Monitoring and Evaluation (PPM&E)
Inception Workshop

Project Performance Monitoring and Evaluation
Urban Primary Health Care Services Delivery Project
Local Government Division
Ministry of Local Government, Rural Development and Cooperatives

Venue: Windy Town Hall, Bangabandhu International Conference Center

Date: 11 October 2015

Program Schedule

09:00 am. to 09:30 a.m.	Registration	
	Inauguration Session	
09:30 a.m. to 09:35 a.m.	Recitation from the Holy Quran	
09:35 a.m. to 09:40 a.m.	Address of Welcome	Mr Md. Awlad Hosain Vice President, EAA
09:40 a.m. to 10:30 a.m.	Presentation on PPM&E Firm's Assignment	Dr.Mohammed Eusuf All President, Eusuf and Associates
10:30 a.m. to 10:45 a.m.	Speech by the Chief Guest and Inauguration of the Workshop	Ms Zuena Aziz Director General (MIE) Local Government Division
10:45 a.m. to 11:00 a.m.	Tea Break	
	Working Session	
11:00 a.m. to 11:30 a.m.	Presentation of Methodology of Qualitative Survey, Annual Red Card Survey Endline Survey	Prof.Dr.Md.Nurul Islam Team Leader, PPM&E
11:30 a.m. to 11:50 a.m.	Presentation of Methodology of Health Facility Survey	Prof.Dr.Md.Abdur Rahman Public Health Management Specialist, PPM&E

11:50 a.m. to 12:10 p.m.	Presentation of Methodology of Training Assessment	Mr. Kazi Bazlul Karim Sociologist, PPM&E
12:10 p.m. to 12:30 p.m.	Presentation of Methodology of ISI Survey	Prof.Dr.Rashida Begum Coordinator (Reproductive Health), PPM&E
12:30 p.m. to 12:45 p.m.	Presentation of Methodology of GIS Database Mapping	Mr. Muhammad Ullah Khan GIS Specialist, PPM&E
12:45 p.m. to 01:15 p.m.	Open Discussion	
01:15 p.m. to 01:20 p.m.	Speech by the Special Guests	
01:25 p.m. to 01:30 p.m.	Speech by the Chairperson and Closing	Mr. Md. Abu Bakr Siddique Project Director, PMU, UPHCSDP
01:30 p.m.	Lunch	

**Participants of the Inception Workshop
of
Project Performance Monitoring and Evaluation (PPM&E)**

Chief Guest

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Director General (MIE), LGD, and
Chief Project Coordinator, UPHCSDP
Ministry of Local Government, Rural Development & Cooperatives

Chairperson

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REPORT ON THE INCEPTION WORKSHOP

1. An Inception Workshop of the Project Performance Monitoring and Evaluation of Urban Primary Health Care Delivery Project was held at Windy Town Hall, Bangabandhu International Conference Center on 11th October, 2015. Ms. Zuena Aziz, Director General (MIE), Local Government Division, Ministry of Local Government, Rural Development and Co-operatives kindly attended the workshop as the Chief Guest. The Workshop was chaired by Mr. Md. Abu Bakr Siddique, Project Director, and Urban Primary Health Care Services Delivery Project (UPHCSDP). In 53 participants from concerned agencies such as the LGD, Planning Commission, ADB, UNFPA, SIDA, Project Management Unit (PMU), Project Implementation Units (PIUs), representatives from PA NGOs, professionals from the consulting firms such as ICDDR'B and Eusuf and Associates.

2. Registration started at 9:00 A.M. and completed by 9:00 A.M. (Program at Appendix I). There were detailed presentations of the project performance monitoring and evaluation followed by interactive participations and productive discussions. Participants provided important suggestions for improvement. The proceedings of the workshop are summarized in the following paragraphs.



Inaugural session

3. The Chairperson along with the Chief Guest, Special Guests and other important personnel took their respective seats and consented to start the activities of the workshop. Workshop activities started with recitation from the Holy Quran. Mr Md Awlad Hossain, Vice President, Eusuf and Associates welcomed the participants in the workshop and thanked them for kindly attending the workshop leaving behind their other important activities. All participants made self introduction. The chairperson conducted all the sessions.



4. **Dr. Mohammed Eusuf Ali**, President Eusuf and Associates with permission of the chairperson made a brief presentation of the inception report. The presentation



covered background of the Urban Primary Health Care Services Delivery Project (UPHCSDP), purpose and the scope of the Project Performance Monitoring and Evaluation (PPM&E), approach and methodologies and tools for the major activities, and the work plan. Dr. Ali emphasized on the importance of monitoring and evaluation of development programs in general and project performance monitoring and evaluation in particular.

He briefly presented the background of project monitoring and evaluation in Bangladesh context. Dr Ali appreciated the project design for placing very high importance on monitoring and evaluation. Dr Ali outlined the major activities and outcome of the PPM&E including very simplified presentation of the methodology and work plan for accomplishing them. He also outlined how the PPM&E will add value to the quality of project outcomes and impact.

5. **Speech of the Special Guest:** Mr Rudi van Dael, Senior Social Sector Specialist of the Bangladesh Resident Mission of the Asian Development Bank (ADB) spoke in the inaugural session as a Special Guest. Mr Rudi stressed that the workshop should discuss and find how best the quality of the delivery of PHC services can be further improved. He mentioned that there are six reports regarding monitoring and evaluation of the existing delivery system and practices of PHC

targeting improvement of the outputs in quantity and quality of services. Mr Rudi requested everyone to through the important materials and contributing from their respective positions towards improving the access, quantity and quality of PHC services.

6. Mr Rudi van Dael stressed upon the contributions of the PPM&E towards increasing the access to PHC service facilities ensuring maximum utilization, and improving the quality of service delivery system and the quality of services, and improving the beneficiary satisfaction ensuring improved health condition of the urban poor, particularly the worm and children. He also mentioned that the project is part of a program and therefore in order to replicate on a sustainable basis the PPM&E should assess the PHC services delivery in the context of opportunity and environment.



7. Mr Rudi also emphasized on accountability and finance and administration, prompt decision making, proper targeting and PPM&E should critically monitoring and analyze and report along with practical suggestions for improvement. Success of PPM&E lies both on the cover of events and information and insights with higher emphasis placed on analysis and interpretations and realistic suggestions for improvement of the service PHC service delivery under a systematic manner culminating towards an easy to adopt and taking over by the respective LGB on a sustainable basis.

8. Mr. Rudi Van Dael, Senior Social Development Specialist of ADB indicated that in the future program may be expanded in a wider scale given the need of urban population and the success demonstrated by the Local Government Division in the past. He stressed on more discussions on quality of management of CRHCC, PHCC and satellite clinics. He also suggested emphasizing on pneumonia and other diseases.

9. **Speech of the Chief Guest: Ms.Zuena Aziz** as the Chief Guest highly appreciated the purpose and scope of PPM&E program through a systematic use of important standard tools like the Quality Assurance, Geographical Information System, Integrated Supervisory Instrument, Health Facility Surveys, Qualitative Surveys, and Endline survey and impact assessment. She urged that all activities should be carried out professionally, timely and worthy. She mentioned that we have to think better, plan better and do better. She expected that the PPM&E team should point out weaknesses and strengths as well as causes behind it. She also emphasized on the quality and accuracy and correctness of information.



10. The Chief Guest further pointed out that PPM&E is not for only bringing lots of useful data and information of the project but those input data need to be analyzed in-depth targeting project target indicators and presented in terms of project impact, purpose and outcome and benefits. Finally, PPM&E should come up with pragmatic suggestions and recommendations for improvement of the PHC service delivery and using the suggestions for designing similar programs in the future.

11. The Chief Guest concluded her important and lively deliberations thanking everyone present, wishing a very success of the workshop, and inaugurated the Inception Workshop on Project Performance Monitoring and Evaluation.

TEA BREAK

Working Session

12. Immediate after the Tea-Break the Working Session started as Mr Abu Bakr Siddique, Project Director, Urban Primary Health Care Services Delivery Project (UPHCSDP) in the chair. In the working session six important monitoring and evaluation procedures were presented by the PPM&E team members one by one. Presentation of one subject was followed by open discussions of the experienced participants. The presentations included qualitative survey, health facilities survey, training program assessment, GIS database and mapping, half-yearly ISI performance monitoring system, annual poverty updating and red card verification, and end line survey and project impact evaluation.

13. **Professor Dr Md Nurul Islam**, Team Leader of the PPM&E presented Annul Poverty Updating and Red Card Verification System, and End line survey and Impact Study of the Project.

14. **Professor Dr.Md.Abdur Rahman**, Public Health Management Specialist, PPM&E team presented the health facility survey.

15. **Mr Kazi Bazlul Karim**, Sociologist, PPM&E team presented the Training Program Assessment.

16. **Professor Dr Rashida Begum**, Coordinator (Reproductive Health), PPM&E team presented the Half-yearly ISI Red Card Verification System.

17. **Mr.Muhammad Ullah Khan**, GIS Specialist, PPM&E team presented the GIS database mapping.

18. While he was mentioning land mark locations-points/spots, all confessed that Police Station and Fire Service shall be included in GIS locations

OPEN DISCUSSION

19. Discussions were made on Community score Card. Dr. Md. Nurul Islam, Dr. Eusuf Ali, N.C. Das and PD himself clarified the issue of Community Score Card.

20. On Mystery Client, Dr. Abdur Rahman, Dr. Abdur Rahman and Dr. Eusuf Ali clarified in detailed and mentioned two approaches will be applied for checking records of services and drug and material uses and also responsiveness and quality of services through ghost patients.

21. Fewer members from the PIU pointed out that Trans-Gender, Sex worker and Diabetes patients are not inclusive in the project. It was mentioned that they are not excluded either as citizens.

22. **Dr. Zahirul Islam** PO, Embassy of Sweden appreciated the Score Card as a good tool for monitoring and evaluating the performance of health services rendered by the PA-NGOs in an integrated manner combining quantity, quality, and management.

23. Fewer participants wanted to know how the non red card holders can get the services. It was informed that while PHC services are open to all particularly the poor, especially the women and children at cost, the poor unable to pay for the services are given red card for free services.

24. One participant suggested to sequentially presenting the indicators in the inception report. In response it was mentioned that indicators are already arranged in order of components and respective premises and measurements. However, the point will be looked into carefully.

25. Ms Nadia Begum pointed out that there is no labor room in PHC. So it is to be excluded from monitoring. The suggestion was appreciated and monitoring tool will be revised accordingly.

26. Dr. Mahmudad Ali, PO, PIU of DNCC suggested all to cooperate with PPM&E headquarters and the suggestion was highly appreciated. Dr Mohammad Eusuf Ali, President of PPM&E firm requested everyone for support and cooperation and assured professional M&E services.

27. Dr. Matiur Rahman Chief Health Officer, Barisal City Corporation remarked that there are too many indicators and the number of indicators should be reduced. Dr Mohammed Eusuf Ali, President of PPM&E firm informed that each indicator used has relevance to an important measurement and target. The Project Director, UPHCSDP mentioned that the tools are well thought and carefully designed by ADB in consultation of the project and has no benefit of dropping one indicator.

28. Ms Afroza Akter remarked that in case of Participatory Supervision, there will be difference between CCs own house and rented house. Medical officers are frequently changed due to leaving jobs. Before finalization of tools Feedback session is necessary.

29. Md. Nazrul Islam, FMS, PMU said, the sample is little, HFS, cleanliness standard is not defined, number of indicators is too large and difficult for record keeping, financial management. He suggested for provision of evaluating completed trainings and foreign trainings. Dr Mohammed Eusuf Ali, President, PPM&E firm mentioned that completed trainings will be recorded and assessed, future trainings will be monitored and reported.

30. One representative from a PA NGO suggested to engaging senior and experienced monitors for Mystery Patients. Dr. Eusuf Ali said monitoring of Mystery patients is an old but effective monitoring approach for similar cases. He confirmed that all monitoring and evaluation activities will be conducted carefully, professionally, transparently, and fairly by well trained and responsible monitors under supervision of experts. However special attention will be attached to the particular cases.

31. **Dr. Zahirul Islam** PO, Embassy of Sweden appreciated the project provision of monitoring as an effective tool for efficient project implementation for high output and quality outcome and impact. He emphasized that the necessity to ascertain the quality of services of the project in addition to quantity. He also mentioned that donor and government are increasingly becoming aware of access of both service provider and services acceptor towards overall services. He again reported the monitoring of urban demographic health is being regularly conducted and benefiting the planners and researchers and service providers. He also appreciated that while all monitoring and evaluation may not be of very high quality but monitoring feedback must not mislead users in anyway. He also recognized that all service delivery centers may not provide expected services, there may be reasons for weaknesses, monitoring should appreciated those factors as appropriate suggestions for improvements.

32. **Mr. Dhiraj Kumar Nath, Consultant ADB:** Mr Nath thanked PMU and Eusuf and Associates for organizing the very important inception workshop and for inviting him. He remarked that experienced consultants have been appointed and he hoped that they all will work independently. They will monitor all positive and negative matters and irregularities minutely. For any fault, they should suggest appropriate correction measures. He also mentioned that the PPM&E firm will undertake the end line survey and project impact study. The success of the project will be assessed in the end line survey and impact study. At the beginning, base line status should be identified and defined. He also mentioned that endline survey and impact study of the earlier completed phase will serve as the baseline of the present project.



33. Mr Nath mentioned that distribution of 1,000 score for assessing performance of PA NGOs is justified and carefully assigned, He also stated that whether all legendaries listed in the inception report can be presented in small maps to be developed using GIS database mapping. Dr. Mohammed Eusuf Ali, President, PPM&E firm assured that efforts will taken to make each GIS map very comprehensive to its users under the project. Mr Nath suggested to including all information regarding the health facilities, all activities of PA NGO and Non-PA NGO. He also suggested to keeping records of all patients referred from satellite clinic to PHCC, how many patients have been referred from PHCC to CRHCC.

34. Mr Dhiraj Kumar Nath, consultant of ADB informed that ADB has intention to expand PHC services in the future. He emphasized on generating adequate information of good quality. He suggested that both project implementers and evaluators have to emphasize on high quality health related information. He expressed satisfaction with the presentations made by the PPM&E consultants and hoped that they will be able to accomplish their assignment for high quality outputs.

35. There were suggestions for institutional capacity building on health service delivery in local government units such as the city corporations and municipalities. In this regards, suggestions came for construction of clinics by city corporations and municipalities.

36. Representative from ICDRR'B (Dr.Abdur Razzaque) informed that they have developed good ISI tools and he requested PPM&E team to coordinate with him in this regard.

37. Dr. Mohammed Eusuf Ali, President, PPM&E firm responded to several important responses on the presentation of the Inception Report. He explained that the tools prepared by the ADB international staff consultant in intensive consultations with all concerned have been reviewed by the PPM&E consultants and found tested in field conditions. The tools are found suitable and adequate for the monitoring and evaluation and the seven specific studies. Dr Ali opined that these tools do not require further improvements. He instead suggested that given delays steps to start monitoring and evaluation and studies using these tools.

38. Dr. Ali also expressed hopes for coordinated efforts of the PMU, PIU, PA NGOs and the PPM&E firm to work together and ensure delivery of high quality PHC services through the excellent health facilities and professionals provided by the project. Dr Ali also mentioned that like the earlier two phases the on-going project may also become successful provided all out efforts to providing quality PHC services. He mentioned that generally good quality reports are expected from the PPM&E firms but good quality reports can be prepared if the performance of the project is good. The implementing agency and the service providing PA NGOs can make it possible to generate good quality inputs for the good reports and success of the project. Dr Ali requested PA NGOs to extend supports to the PPM&E firm.

39. **Speech of the Chairperson Mr Abu Bakr Siddique, Project Director, UPHCSDP:** The Chairperson summarized the important points discussed and suggested and agreed in the inception workshop. He thanked all participants for their participation and valuable contributions. He also requested the participants to forward addition suggestions for improvements (if any) to the PPM&E firm soonest. He mentioned that the project has enough manpower, fund resources, and all out supports from the Local Government Division through the Project.



40. The chairperson also mentioned based on the detailed presentation of the PPM&E methodology and tools made by the consultants and discussed by the participants from ADB, SIDA, UNFPA, PA NGOs and others concluded that the tools having been prepared jointly by the ADB Staff consultants and PMU and finally reviewed by the PPM&E firm should be used for the respective monitoring and evaluation activities of the project without further delay. He however, suggested that should there be any justified need for improvements of any of the monitoring and evaluation tools that should be discussed with the project and ADB and modified (if needed) appropriately as needed.

41. The Chairperson disagreed with the remarks of Dr. Eusuf Ali that in general, the relations between the Implementing Agency and PPM&E firm are not comfortable. He hoped that the PPM&E firm will get all possible supports and freedom to work independently and contribute to improving the performance of the project to meet the objectives. The chairperson concluded that in overall the

workshop has been useful and effective for the project especially for undertaking the PPM&E activities systematically and for quality outputs.

CLOSING OF THE WORKSHOP

42. The chairperson of the inception workshop Mr Abu Bakr Siddique, Project Director, Urban Primary Health Care Services Delivery Project (UPHCSDP) declared the workshop closed. He thanked the PPM&E firm for presenting a good inception report and successfully organizing the workshop. .

LUNCHEON

43 All participants were invited for a luncheon arranged in the Green Hall adjacent to the Workshop Venue at Windy Town Hall.