Urban Primary Health Care Services Delivery Project (UPHCSDP)

Local Government Division

Ministry of Local Government, Rural Development & Cooperatives

Quarterly Report

(January–March 2016)

Major Activities and Outcomes of the Project Performance Monitoring and Evaluation

Eusuf and Associates

Project Performance Monitoring and Evaluation Firm

April 2016

ABBREVIATIONS

ADB	-	Asian Development Bank
AG	-	Adolescent Group
ANC	-	Antenatal Care
ANC	-	Antenatal Care
CL	-	Community Leaders
CRHCC	-	Reproductive Health Care Center
FY	-	Fiscal Year
FMIS	-	Financial Management Information System
FGD	-	Focus Group Discussion
GIS	-	Geographical Information System
HMIS	-	Health Management Information System
HQ	-	Headquarters
HW	-	Health Workers
ISI	-	Integrated Supervisory Instrument
IDI	-	In-depth Interview
ICDDR,B	-	International Centre for Diarrheal Disease Research, Bangladesh
LGD	-	Local Government Division
MTR	-	Mid Term Review Mission
MDG	-	Millennium Development Goal
M&E	-	Monitoring and Evaluation
MG	-	Men’s Group
MUF	-	Members of Users Forum
Mo LGRDC	-	Ministry of Local Government, Rural Development and Cooperatives
MFSTC	-	Mohammadpur Fertility Services Training Center
MCH	-	Mother and Child Health
PPP	-	Public Private Partnership
PPM&E	-	Project Performance Monitoring and Evaluation
PA NGO	-	Partnership Area Non-government Organization
PHC	-	Urban Health Care
PHCC	-	Urban Primary Health Care Center
PMU	-	Project Management Unit
PIU	-	Project Implementation Unit
PRA	-	Participatory Rapid Appraisal
PNC	-	Postnatal Care
QTR	-	Quarterly Report
QA	-	Quality Assurance
RHSTEP	-	Reproductive Health Services Training and Education Program
SIDA	-	Swedish International Development Association
UF	-	Users’ Forum
ULB	-	Urban Local Body
UHS	-	Urban Health Survey
UPHCSDP	-	Urban Primary Health Care Services Delivery Project
UNFPA	-	United Nations Fund for Population Administration
UPHCSDP	-	Urban Primary Health Care Services Delivery Project
UPHCSD	-	Urban Primary Health Care Service Delivery
VG	-	Vulnerable Group
WPHCCC	-	Ward Primary Health Care Coordination Committee
WG	-	Women’s Group

Executive Summary

A. Project Background

1. The Urban Primary Health Care Services Delivery Project (UPHCSDP) started in July 2012 and will close in June 2017. The project engaged Eusuf and Associates as the Project Performance Monitoring and Evaluation firm (PPM&E Firm) and signed a contract on the 16 August 2015 for providing monitoring and evaluation services up to 30 June 2017. The purpose of the PPM&E is to undertake regular monitoring of the inputs and outcomes of the project in line with the project objectives aiming at improvement of the health conditions of the people of the project area particularly the poor women and children. The health services are delivered through partnership area non-government organization ensuring extensive use of the health services facilities again and again established and maintained under the project for providing primary health care services to the clients.

Scope of PPM&E Activities

2. The main objectives of engaging the PPM&E firm is to monitor and evaluate the extent of use of the health services facilities for the cause of the improvement of health conditions of the target population through quality and effective services and report to the project. The PPM&E firm will provide their outputs of routine monitoring and overall performance monitoring evaluation through the following time-bound deliverables.

- Qualitative Survey – Once at the beginning;
- Health Facility Survey- Once in the beginning and again at the closing;
- Training Program Assessment (intermittent but continuous monitoring and outputs once at the end;
- GIS data base and mapping – once in the beginning and again at closing;
- Half-yearly ISI performance monitoring and evaluation;
- Annual poverty updating and red card verification once at the beginning and again at the closing;
- Project endline survey and impact evaluation at the closing; and
- Periodic and Quarterly Reports.

Progress of Second Quarter (Jan-Mar 2016)

3. The contract on PPM&E was signed on 16 August 2015 and became effective from 1 September 2015. The PPM&E started to work from the 1 September 2015. The firm took advance actions to establish a fully fledged PPM&E consultant office at Gushan -1, Dhaka with all necessary logistic facilities and services. The firm recruited all the experts and professional support staff. The consultant team comprised of three key experts for monitoring and evaluation, public health, and sociology; six non-key experts on Geographical Information System (GIS) and mapping, monitoring evaluation, statistics, survey and data management and quality control; and eight professional support staff including programmer, secretary, financial management, data entry operators (four), and office assistant. The team accomplished the following major activities during the quarter and produced specific outputs.

4. The PPM&E firm having started in a time of the beginning of the fourth year of the project when several agreed deliverable became due such as qualitative survey (due at the beginning of the project), health facility survey (due at the beginning of the project), web enable GIS based mapping (due in the beginning of the project), ISI survey- Round I (due after six months of the beginning of project), training program monitoring (continuous as an when any new training program takes place). As a result, the PPM&E firm initiated all these surveys within the first quarter (Sep-Dec 2015) which was four monthly quarter. The design (methodology and tools) of the qualitative survey, health facility survey, ISI survey, and web-enable GIS based mapping were discussed and agreed within the first two months after inception and surveys took place for the qualitative survey, health facility survey, and GIS mapping survey in November 2015 and completed in December 2016.

5. The PPM&E firm analyzed the data of all four surveys (qualitative survey, health facility survey, GIS mapping survey, and ISI survey) during the first one and a half months by 15 February 2016 and prepared the draft reports within the second quarter (January-March 2016). The findings of the qualitative survey and the ISI survey were presented in two day-long workshops (23-24 March 2016) at Elenga Resorts, Tangail.

6. The PPM&E firm prepared the draft report on health facility survey within the in the second quarter (Jan-Mar 2016) and presented the findings in April 2016 at a half-day workshop held in BIAM Conference Hall (Late Mahbubur Rahman Memorial Hall) on 23 April 2016. In the same workshop the PPM&E firm presented the review findings of the ISI survey responding to the questions raised by the PA NGOs in the workshop held at Elenga Resort on 23 March 2016.

7. The PPM&E firm as part of on-going monitoring of training programs monitored two programs comprising of five batches. A brief report on the monitoring feedback was submitted to the project.

Plan for the Third Quarter (April-June 2016)

7. The draft web enabled GIS mapping of 20 PA NGO areas was completed by the end of the second quarter (Jan-Mar 2016) and the GIS mapping of the rest 5 PA NGOs was complete by 15 April 2016. The PPM&E firm as per its methodology and work plan decided review all 25 GIS maps first with the respective PA NGO at the respective towns and then demonstrate to the PMU after incorporating the findings of spot checks and validation and sharing the draft maps with respective PA NGOs. The spots check and validation at site and sharing with the respective PA NGOs are scheduled to complete by first week of April 2016. The PPM&E firm plans to share all 25 draft GIS maps after incorporation of findings of spot check and field level suggestions of respective PA NGOs some times in late April 2016. The PPM&E firm plans to monitor all on-going training programs including selective number of batches as convenient in the next third quarter (April-June 2016).

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SECTION I

THE PROJECT

A. Background

1. Primary health care (PHC) 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. The 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..

2. The Government of Bangladesh 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).

3. 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.

4. 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. 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.

B. The Project

5. Considering the trend for high rate of urbanization and rapid growth of urban population particularly in the city areas Government initiated the Urban Primary *Health Care Project (UPHCP) in Dhaka, Chittagong, Rajshahi and Khulna city* corporations during 1998-2005 to provide primary health care services primary health care facilities under the local government bodies with assistance of the Asian Development Bank (ADB) and the Swedish International Development Association (SIDA. The initiative proved excellent and created interests among the city dwellers and local government bodies.

6. Subsequently it was extended up to 2005-2012 in 15 cities as *UPHCP-II.* The present on-going Urban Primary Health Care Services Delivery Project (UPHCSDP)

covers 14 towns[1] (ten city corporations and four municipalities). The project is financed by the Government of Bangladesh, Asian Development Bank (ADB), Swedish International Development Agency (SIDA) and United Nations Fund for Population Administration (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.

C. Project Impact and Aim

7. The UPHCSDP has been providing health services to the fast growing urban population specially targeting poor segments of women and children in all the city corporations except Chittagong city and four municipalities of Gopalganj, Kisoregang, Sirajganj and Kustia. It is the 3rd phase in continuation of two earlier stages of Urban Primary Health Care Project (UPHCP). The present study is the qualitative assignment by the Project Performance Monitoring and Evaluation team. The main objective of the study is to monitor and evaluate prevailing health services and related stakeholder’s perception and the highest wealth quintile in urban areas is reduced by 15%.

D. Outcome/ Objectives

8. 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).

E. Project Outputs/Components

9. The project components/outputs include (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 (PPP) and (iii) effective support to decentralized project management.

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

10. The target indicators of the outputs/component for improving accessibility through Public private partnership (PPP) performance and accountability improves adequately to ensure achievements of the PA NGOs.

11. 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.

F. Project Overall Scope

12. 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 (PHCC) and Satellite Clinics 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.

SECTION II

PROJECT PERFORMANCE MONITORING AND EVALUATION

A. Introduction

13. 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.

B. Objectives of the Assignment

14. 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.

C. Scope of Services and Major Tasks

15. 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 as for example the monitoring& evaluation report on Training programs of the UPHCSDP.

D. Major Deliverables and Timelines

16. 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.

17. 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).

E. Methodology and Tools

Strategy and Approach

18. 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.

19. 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.

20. 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 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

21. The team adopted Participatory Rapid Appraisal (PRA) method following the techniques of FGD, Survey, Transect walk, Venn Diagram, Social Mapping, Problem Ranking and In-depth Interview (IDI)

SECTION III

PROGRESS IN BRIEF – QUALITATIVE SURVFEY

A. Monitoring Studies and Activities of the Quarter

22. In the quarter four out of seven major studies were undertaken namely, qualitative survey, health facilities survey, monitoring of training programs, and GIS database and mapping. The section presents briefly the progress of qualitative survey. The purpose of the qualitative survey is to know in advance of household survey various aspects of health service management and provisions. This study was expected to be undertaking at the onset of the project as proper if not during the design of the project.

23. The qualitative survey is 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 (WPHCCC), status of users' forum (UF), 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.

B. Objectives

24. The specific objectives of the qualitative survey are to:

- ✓ Identify the status of Ward Primary Health Care Coordination Committees;
- ✓ Identify poor households with red cards;
- ✓ Determine community awareness of health care providers and knowledge of available services;
- ✓ Identify health care seeking behavior of the urban poor and the criteria used by them in selecting health care providers and assessing quality;
- ✓ Understand information network and sources of information about health care issues and service providers among the urban poor;
- ✓ Identify and assess gender-based equity situation in the health care service;
- ✓ Identify and assess violence against women in the project area;
- ✓ Identify the status of Users' Forums; and
- ✓ Assess the responsiveness of UPHCSDP, PA -NGOs partners and other organizations.

C. Methodology and Techniques of the Qualitative Survey

25. In order to achieve the objectives of the qualitative survey, the study team used Participatory Rapid Appraisal (PRA) techniques for collecting data from 25 PA-NGO areas, all the 25 CRHCCs and one PHCCs (randomly selected by taking distance as a focal point) from each PA-NGO area.

26. Participatory Rapid Appraisal (PRA) is a specific form of research technique developed in the late 1970s and early 1980s by researchers in international

development as an alternative and complement to conventional sample surveys. PRA is a way of learning from, and with, community members to investigate, analyze, and evaluate constraints and opportunities, and make informed and timely decisions regarding development projects. It is a method by which a research team can quickly and systematically collect information.

27. The approach of PRA owes more to gain an understanding of the complexities of a topic rather than to gather highly accurate statistics on a list of variables. Moreover, in PRA understanding qualitative nuances within a topic is just as important as finding general averages. The PRA is used here to obtain a differentiated understanding of the population's attitudes, beliefs, and behaviors towards disease and health care. PRA is applied most effectively in relatively homogeneous rural communities which share common knowledge, values. beliefs although it has also been used in more complex urban environments. Its short duration and low cost also make it possible to carry out a series of PRAs rather than having to rely on the results of one large survey. The following PRA tools were used for conducting the survey:

D. Focus Group Discussion (FGD)

28. A focus group discussion is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs, and attitudes towards any topic. It is a form of group interviewing in which a small group – usually 10 to 12 people – is led by a moderator (interviewer) in a loosely structured discussion of various topics of interest. The course of the discussion is usually planned in advance and most moderators rely on an outline, or moderators guide, to ensure that all topics of interest are covered.

- ✓ Health workers
- ✓ Vulnerable groups
- ✓ Women's groups/men's groups/members of users' forums
- ✓ Community leaders
- ✓ Adolescent groups

E. Types of Participants of FGD

29. A total of 50 focus Group Discussions (FGDs) was conducted with Community Leaders (CL), Women's Group (WG), Men's Group (MG), Members of Users Forum (MUF), Health Workers (HW), Vulnerable Groups (VG) and Adolescent Groups (AG). Participators by category and number are as below:

Number of FGDs by participants

Women's Group	18
Men's, Group	05
Community Leader	06
Vulnerable Group	06
Users Forum	02
Adolescent group	06
Health worker	07
Total	50

G. In Depth Interview (IDI)

30. In-depth interviewing is a qualitative research technique that involves conducting intensive individual *interviews* with a small number of respondents to explore their perspectives on a particular idea, program, or situation.

H. Types of Participants of IDI

31. In depth interviews (IDI) were conducted to Ward commissioners, Female ward commissioners, Poor women members of WPHCCC, Victims of violence/family members of victims, Members of users' forums, Chairpersons/secretaries of user's forum, MBB doctors/quacks/kabiraj/ homeopaths/traditional healers, Clinic manager cum-medical officers of CRHCC/PHCC/ UPHCSDP, Paramedics/counselors of CRHCC/ PHCC/UPHCSDP, Counselors of CRHCC/PHCC/UPHCSDP 50 in each category. Transect walk, Social mapping, problem ranking and Venn diagram in each PAA, CRHCC and sampled PHCC was conducted 50 in each category during the field survey. The survey was monitored by the team of consultants and experts from the PPM&E firm Eusuf and Associates.

Table 1: Number of IDI participants

Respondent Types	Number
Ward commissioners	50
Female ward commissioners	50
Poor women members of WPHCCC,50	50
Victims of violence/family members of victims,	50
Members of users' forums	50
Chairpersons/secretaries of user's forum	50
MBBS doctors/ quacks/ kabiraj/ homeopaths/ traditional healers	50
Clinic manager cum-medical officers of CRHCC/PHCC/UPHCSDP	50
Paramedics/counselors of CRHCC/PHCC/UPHCSDP,	50
Counselors of CRHCC/PHCC/ UPHCSDP	50

I. Transect Walk

32. A *transect walk* is a systematic *walk* along a defined path (*transect*) across the community/project area together with the local people by observing, asking, listening, looking and producing a *transect* diagram.

33. It compares the main features, resources, uses, and problems of different zones participated by community members who are knowledgeable and willing to participate in a walk through their surrounding areas and

34. To achieve the goal of qualitative survey Participatory Rapid Appraisal (PRA) techniques were applied to collect data from the field. Along with FGD and IDI were to followed The survey team members with the help of stakeholders like beneficiaries, clients of UPHCSDP of the locality, member of User's Forum, members of WPHCCC and outreach workers of PA NGO have visited the catchments area of respective PA

from one end to other. They talked to the people of the locality, asked about health services status, health service providers available in the vicinity, problem in availability of health services towards poor and ultra poor, listed prominent objects, buildings, educational institutions, connecting roads, important structures, hospitals, clinics, diagnostic centers, parks, mosques, temples, shopping molls, apartments, markets, police stations, post office, slums playground and all other noticeable infrastructures of the area one after another and noted. Independent lists 25 PA areas were prepared for every CRHCC separately. Another set of 25 transect list for 25 PHCC having one from each PA area were also prepared. Surveyors plotted all the noted objects on a large sheet of paper for every CRHCC and PHCC.

J. Social Mapping

35. Social mapping is a visual method of showing the relative location of households and the distribution of different people (such as male, female, adult, child, landed, landless, literate, and illiterate) together with the social structure, groups and organizations of an area.

36. Social Mapping presents different house-holds, land record, land, and other assets, holdings, social groups/categories, relative locations of homesteads, different street/paras, location of schools, hospitals, markets, shops, ponds, dikes, mosques are also useful in discussing social problems, coping strategies and solutions. Participants prepare the map indicating the relative locations on the ground and validated by the group by consensus.

37. During transect walk, the main objectives of the survey team were to prepare a list of objects like buildings, educational institutions, connecting roads, important structures, hospitals, clinics, diagnostic centers, parks, mosques, temples, shopping malls, apartments, markets, police stations, post office, slums, playground and all other noticeable infrastructures etc of the area one after another

38. Surveyors prepared 50 social maps for all 25 CRHCCs and 25 selected PHCCs covering all PA areas. Social maps show the location of PAA Head Quarters', CRHCC, PHCCs, Satellite Clinics. Social mapping presents different street/paras, location of schools, madrasah hospitals, markets, shops, mosques, graveyard, temple, church, government and corporate organizations and establishment police station. NAGAR BHABAN & Baitul Mukarram mosque is located in DSCC- PA-2 (CRHCC)

39. Connecting roads moving toward CRHCC and PHCC were prominently shown. These maps provide the easier way to identify the destination like CRHCC and PHCC by holding numbers showing roads, lane bye lane and route also.

K. Problem Ranking

40. Problem Ranking is a participatory technique that allows analyzing and identifying problems participants share in order to implement adequate improvements and solutions in their community and area. The participants discussed which the most important problems they faced on health services in their community in all 25 CRHCCs and 25 selected PHCCs catchments areas. Afterwards,

the participants ranked these problems in regards to their importance. The results of this method provided base for discussions on possible solutions to the priority problems.

L. Venn Diagram

41. A Venn diagram (named after the man who created it) is an illustration of the relationships between and among sets, groups of objects that share something in common. Usually, Venn diagrams are used to depict set intersections. A Venn diagram shows the key institutions and individuals in a community and their relationships and importance for decision-making. In all 25 CRHCC and 25 selected PHCC Venn Diagrams were drawn identifying the importance and linkage of local groups and institutions; participation of different institutions, agencies involvement in the delivery of services, administration by making circles off different size on the ground by the participants.

M. Field Works and Data Collection

42. A team of 12 field research assistants was engaged and provided intensive training on PRA techniques. They collected data and information from the stakeholders administering the following tools starting from November 2 to 27, 2015.

- ✓ Guidelines for health worker
- ✓ Guidelines for women's group
- ✓ Guidelines for community leader
- ✓ Guidelines for vulnerable group
- ✓ IDI for ward commissioner/female ward commissioner
- ✓ Guidelines in-depth interview with MBBS doctor/Quack/ Kabiraj/ Homeopath/ Traditional healer
- ✓ Guidelines in-depth interview with women members of WPHCCC representative from poor households
- ✓ Guidelines in-depth interview with clinic manger cum Medical officer/ Paramedic/ Counselor of PHCC/ UPHCSD
- ✓ Guidelines in-depth interview with Victim/Family Members of Victim/Law enforcing agency
- ✓ Transact walk
- ✓ Social mapping
- ✓ Problem ranking and
- ✓ Venn diagram

43. The information data collected through PRA techniques are transcribed and processed as per objectives of the study. The survey was monitored by the team of consultants and experts from the PPM&E firm.

SECTION IV

PROGRESS IN BRIEF - GIS DATABASE AND MAPPING

44. 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.

45. 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.

46. As per suggestions of the project the team have met and discussed with the ICDDR,B who are also establishing GIS database for their action researches and plans to prepare maps. The team agreed to continue further discussions and find ways and means in a coordinated manner avoiding duplications and waste. The PMU will be in the centre of the cooperation and coordination and approving the scope and activities.

47. 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.

48. The PPM&E firm collected 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 are 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 centers, hat, bazaar, religious centre, etc.).

49. The PPM&E firm will code City Corporation, Municipality, PAHQ, CRHCC, PHCC, and Satellite Clinic/Outreach for easy identification. Orientation training is provided to field staff for downloading GIS captured data, cross checking, editing and preparing GIS using collected data. Base map by PA NGO is prepared and linking GIS database into HMIS database. The PPM&E Firm utilized 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, guidance of the PMU.

50. Progress Report covers Mapping and GIS Database and others such as:

- ✓ 10 City Corporations and 4 Municipalities updated master maps were collected.
- ✓ GPS field survey of 25 Partnership Areas for facilities locations and their relevant landmarks were completed.
- ✓ 25 Partnership Areas map works are being going on.
- ✓ 25 Partnership Areas GIS database works are being going on.
- ✓ Map of each Partnership Area will be covered in followings:
- ✓ Catchments area of PA – showing Wards / Mohall as
- ✓ Facilities locations of UPHCSDP – showing PAHQ, CRHCC, PHCC and Satellite / Outreach
- ✓ Other Health Facilities locations – showing Hospital and other health center
- ✓ Relevant Landmarks locations – showing Govt. Organizations, Education Center, Religious Center, Market / Shopping Center, Utility Service Center and Industry.
- ✓ Communication Systems – showing roads, railways, bridge, flyover and river.
- ✓ Others – showing slum areas for dwelling place of poor and ultra poor and water-bodies.

GIS Database of each Partnership Area is covered in followings:

- ✓ Catchments area / Services delivery area of PA – showing Wards and their attributes
- ✓ Facilities locations of UPHCSDP - PAHQ, CRHCC, PHCC and Satellite / Outreach and their attributes.

Future Plan

- ✓ Final Map of 25 Pass will be completed within February, 2016.
- ✓ GIS database 25 Pass will be completed within March, 2016.
- ✓ 10 Pass of Dhaka North and South City Corporations will be prepared showing mohalla boundary
- ✓ 15 PAs of 8 City corporations and 4 Municipalities will be prepared showing ward boundary.
- ✓ Poverty or other aspect maps of PA will be prepared considering ISI surveyed data.

SECTION V

PROGRESS IN BRIEF - HEALTH FACILITIES SURVEY

A. Health Facility Survey

51. Health facilities survey includes (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.

52. There are 25 project office/headquarters; 25 CRHCC facilities; 115 PHCC facilities; and 226 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.

53. 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.

54. 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

B. Field Works and Data Collection

55. A team of 23 field research assistants was engaged and provided intensive training on PRA techniques. They collected data and information from the stakeholders administering the final tools starting from November 07 to08 December, 2015.

56. The information and data collected are transcribed and processed as per objectives of the study. The survey was monitored by the team of consultants and experts from the PPM&E firm.

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

58. The UPHCSDP has three components: 1) strengthening institutional governance and local government capacity to sustainably deliver Urban Primary Health Care (PHC) services; 2) improving accessibility, quality, and utilization of urban PHC service systems via public-private partnership; and 3) supporting effective decentralized project management.

59. Improving the governance and capacity building of the Urban Local Bodies (ULBs) and service providers is one of the major components of the Urban Primary Health Care Services Delivery Project (UPHCSDP). This will contribute to the achievement of the ultimate aim as well as the immediate outcomes of the project. For this purpose the project has a significant training component to build capacity in management, service delivery, and project monitoring and reporting skills for staff at various levels.

60. The Project Performance Monitoring and Evaluation (PPME) Firm has been given the responsibility to conduct monitoring of the training courses and assessment on impacts of the Project’s training programs. The Firm will conduct qualitative assessment of the Project’s training program for Local Government Division (LGD), Urban Local Bodies (ULB), and Partnership Area Non- Government Organizations (PA NGO).

SECTION VI

PROGRESS IN BRIEF - MONITORING OF TRAINING PROGRAMS

A. Objective of Training Monitoring by PPM&E Firm

61. The objective of the training monitoring by the PPM&E Firm is to help the project authority to strengthen its training activities through time to time feedback and submission of two reports on the monitoring of the training program being sponsored by the project at mid-term and end line.

B. Monitoring of Training Activities of UPHCSDP during the Quarter

62. During the reporting period September-December 2015 three (03) training programs in five (05) batches were monitored by the PPM&E firm. The monitored training programs were as follows:

- Training on Antenatal Care (ANC) and Postnatal Care (PNC) for Doctors (2 batches);
- Training on Infection Prevention for the Doctors, Paramedics and Nurses (1 batch);
- Training on ANC and PNC for the Paramedics and Nurses (2 batches).

It may be noted that the 2nd batch of ANC & PNC training covered the period of 2nd to 7th January, 2016
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C. Methodology used for Monitoring

63. To observe the total organization and management of the training activities from organization to the completion of the training program two methods were followed:

- **Observation method**. For observation by the PPME Firm, a checklist was used to observe different aspects of the training, which included venue, facilities, methods of training, participation of trainees and trainers, method of evaluation etc.
- **Assessment by the Participants**: For assessment by the participants, a structured Questionnaire was used for interviewing the sample participants.

D. Summary of Findings

1. Training on Antenatal Care (ANC) and Postnatal Care (PNC) for Doctors.

64. Training Course on **Antenatal Care (ANC) and Postnatal Care (PNC)** sponsored by the Urban Primary Health Care Services Delivery Project (UPHCSDP) was held in two batches at Mohammadpur Fertility Services Training Centre (MFSTC) for the Doctors of PA NGOs under the UPHCSDP. The first batch of the course was held from 7th November to 12th November 2015 and the second batch was held from 14th November to 19th November 2015.

65. All the participants in both the batches were Doctors working at different PA-NGOs under the UPHCSD Project. Number of participants in each batch was 15 and all of them were female.

66. Mohammadpur Fertility Services Training Centre (MFSTC) was the venue for both the batches. Training venue was located in a convenient place of the city with well decorated room having required audio-visual facilities and other logistics. Venue being located in a 100 Bedded Mother and Child Health (MCH) Hospital was suitable for demonstration and holding practical sessions.

67. Most of the Resource Persons were from the Mohammadpur Fertility Services Training Centre (MFSTC). All the Resource Persons having both theoretical and practical knowledge were fully prepared to conduct their respective sessions. They followed a printed Training Manual prepared for Antenatal Care (ANC) and Postnatal Care (PNC) training.

68. Most of the trainers used lecture methods followed by discussion, besides most of the topics had practical sessions, group works and demonstrations using dummy. Pre training evaluation was done to evaluate the level of knowledge of the participants using a structured question paper during the opening day of the course and a post training evaluation was done on the closing day using the same set of question paper to measure the improvement in the level of knowledge of the participants.

69. The training program on ANC and PNC was highly appreciated by the participants. This course was highly relevant to their present job, as they have to continuously deal with the pregnant mothers and the new born children.

70. Printed training schedule was frequently changed, due to heavy involvement of the speakers in their regular duties; this to some extent broke the chronology of the course content.

71. There was no provision to evaluate the trainers and course management by the participants. Feedback from the participants may be taken for qualitative improvement of the Resource Persons/Trainers as well as the training course.

2. Training on Infection Prevention for Doctors, Paramedics and Nurses.

72. Training Course on Infection Prevention sponsored by the Urban Primary Health Care Services Delivery Project (UPHCSDP) was held in three batches at NGO Forum for Public Health, 4/6 Block- E Lalmatia, Dhaka for the Doctors, Paramedics and Nurses of PA NGOs under the UPHCSDP. The training was organized by the Reproductive Health Services Training and Education Program (RHSTEP.. The duration of training was for three days and it was conducted in three batches in the same venue. The first batch of the course was held from 28th to 30th November 2015, the second batch from 6th to 8th December 2015, and the third batch during 13-15 December 2015. Out of three batches only 3rd batch was monitored.

73. In the 3rd Batch out of 30 participants, 11 were Doctors, 11 were Paramedics and 08 were Nurses. Among the participants only one was male, who was a Doctor. NGO Forum for Public Health at Lalmatia, Dhaka was used as the venue for all the three batches of the training on Infection Prevention facilitated by the RHSTEP. The venue being located in the heart of the town was easily accessible for the participants.

74. Four Resource Persons were used, of which two were from the RHSTEP. Most of the sessions were conducted by the Course Coordinator, who is a Physician and a regular trainer of the organization. They followed a printed training manual on Infection Prevention prepared by the RHSTEP.

75. Trainers of the course were all medical practitioners and regular trainers. Sessions were made highly participatory by the trainers. In most of the sessions Multimedia was used for presentation. Besides, almost all of the presentations were followed by Video Presentation.

76. All the participants felt that the course was 'Relevant' to their profession. All of them felt 'Highly Satisfied' with the course content. It was expressed by the participants that this training enabled them to know some of the details of Infection Prevention.

77. Training Manual on Infection Prevention prepared by the RHSTEP in simple Bangla with illustrations covered all the relevant topics of the training. This would be useful for all categories of participants to use as hand book in their work place.

78. No training material was displayed in the class room. Some posters on Infection prevention could be displayed in the class room, which could create added attraction to the participants.

79. In this course also there was no provision to evaluate the trainers and course management by the participants. Feedback from the participants may be taken for qualitative improvement of the Resource Persons/Trainers as well as the training course.

3. Training on ANC and PNC for the Paramedics and Nurses.

80. Six days Training Course on Antenatal Care (ANC) and Postnatal Care (PNC) for the Paramedics and Nurses of PA-NGOs sponsored by the Urban Primary Health Care Services Delivery Project (UPHCSDP) was held in two batches at Mohammadpur Fertility Services Training Centre (MFSTC). The first batch of the course was held from 26th December to 31st December 2015 and the second batch was held from 2nd January to 7th January 2016.

81. In total 30 Paramedics and Nurses attended in two batches, of which 16 were Paramedics and 14 were Nurses. Number of participants in each batch was 15 and all of them were female.

82. All the Resource Persons of the course were from the Mohammadpur Fertility Services Training Centre (MFSTC).

83. A Training Manual was prepared in Bangla on ANC and PNC for the training of Paramedics and Nurses. A copy of the Manual was given to each of the participants.

84. Multimedia was used for presentation in most of the sessions. Supplementary handouts were also supplied which were not covered in the training manual. Video presentation was made in some of the topics.

85. Pre and post training evaluation of the participants was conducted using a structured questionnaire.

86. The training program on ANC and PNC for the Nurses and Paramedics was well accepted by the participants, as it was highly relevant to their job.

87. Practical sessions were extremely useful to them, as they got the exposure to variety of cases in the Hospital and they could individually participate in the practical sessions.

88. Most of the sessions could not be held as per schedule, frequent changes had to be made due to the involvement of the Resource Persons in their emergency duties in the hospital; this to some extent broke the chronology of the course content. Efforts should be made to avoid this kind of situation as much as possible.

SECTION VII

MANPOWER RESOURCES

89. 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 2.

Table 2: Manpower

Position(s)	Name	Total Inputs	
Key Experts		**Total**	**During QTR**
Team Leader (Performance Monitoring & Evaluation Specialist)	Prof.Dr.Md.Nurul Islam	22	3
Public Health Management Specialist	Prof.Dr.Md.Abdur Rahman	22	2
Sociologist	Mr.Kazi Bazlul Karim	20	3
Key Experts			
GIS Specialist	Mr. Muhammad Ullah Khan	10	3
Coordinator (Reproductive Health)	Prof.Dr.Rashida Begum	12	3
Coordinator (Survey)	Engr.Md.Habibur Rahman	12	3
Monitoring and Evaluation Officer	Mr.Md.Awlad Hossain	12	3
Statistician 1	Dr.Helal Uddin Ahmed	6	3
Statistician 2	Mr.Md.Mehedi Hasan	6	3
Support Professionals			
Project Coordinator – 1 Person	Mr.Nitai Chand Das	22	3
Programmer – 1 Person	Mr.Md.Muneer Hussain	10	3
Secretary – 1 Person	Mr.Md.Mokbul Hossain	22	3
Manager Accounts – 1 Person	Mr.A K M Obaidul Huque	22	3
Data Entry Operators – 4 Persons	Four Persons	88	12
Office Assistant – 1 Person	Mr.Md.Manik Miah	22	3

90. The PPM&E firm in consideration of the work plan for monitoring and evaluation and carrying out specific surveys and report preparation prepared the following manpower schedule (Table 3). The endline survey and project impact study due to take place after the close of the project in three months (23, 24 & 25th months (July-August 2017).

SECTION VIII

PLAN FOR THE NEXT QUARTER

91. The PPM&E firm has few activities of the last quarter that will continue through the next quarter (April-June 2016), few activities limited to the next quarter only, and few other activities that will continue further to the third quarter. The planned activities of the follow –up quarter (April-June 2016) as at table 3

Table 3: Planned Activities of Quarter 3

PPME Years	2015				2016												2017								
Duration of PPME >>>>>>>>>>>>>>>>>>	QTR I				QTR II			QTR III			QTR IV			QTR V			QTR VI			QTR VII			QTR VIII		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
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

Planned
Actual
Intermittent