Urban Primary Health Care Services Delivery Project (UPHCSDP)

Local Government Division

Ministry of Local Government, Rural Development & Cooperatives

Quarterly Report

(April - June 2016)

Major Activities and Outcomes of the Project Performance Monitoring and Evaluation

Eusuf and Associates

Project Performance Monitoring and Evaluation Firm

June 2016

ABBREVIATIONS

ADB	-	Asian Development Bank
AG	-	Adolescent Group
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	-	Primary Health Care
PHCC	-	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
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
WUHCC	-	Ward Urban Health 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.

B. 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;
- 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 end line survey and impact evaluation at the closing; and
- Periodic and Quarterly Reports.

C. Progress of Third Quarter (April-June 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 deliverables became due such as qualitative survey, health facility survey, 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 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 December 2015.

5. The PPM&E firm submitted 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.

6. The PPM&E firm submitted the final reports on Qualitative Survey and Health Facility Survey in April 2016 and June 2016. These reports are available in printed form. The draft final on ISI Monitoring report- Round 1 is prepared. The draft report on Annual Red Card Verification is in progress. Data collection ISI round-II is completed and data processing is under way.

7. The updated GIS Mapping of 25 PA-NGOs is completed by June after sharing with the concerned PA- NGOs. The GIS mapping activities were shared with the ICDDR'B team.

8. The PPM&E firm as part of on-going monitoring of training programs monitored two programs comprising of three batches during April-June 2016. A brief report on the monitoring feedback was submitted to the project.

D. Plan for the Fourth Quarter (July-September 2016)

9. The ISI Monitoring report- Round 1 final will be submitted in fourth quarter. The ISI Monitoring report- Round 2 draft final will be submitted. The draft report on Annual Red Card Verification will be submitted.

10. The PPM&E firm as per its methodology and work plan decided to review all 25 GIS maps with the PIU 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 draft GIS mapping will be finalized after sharing with PMU &PIU.

11. The PPM&E firm plans to monitor all on-going training programs including selective number of batches as convenient in the next fourth quarter. Annual report on monitoring of training programs will be finalized.

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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 ten city corporations and four municipalities [1]. 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.

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

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.

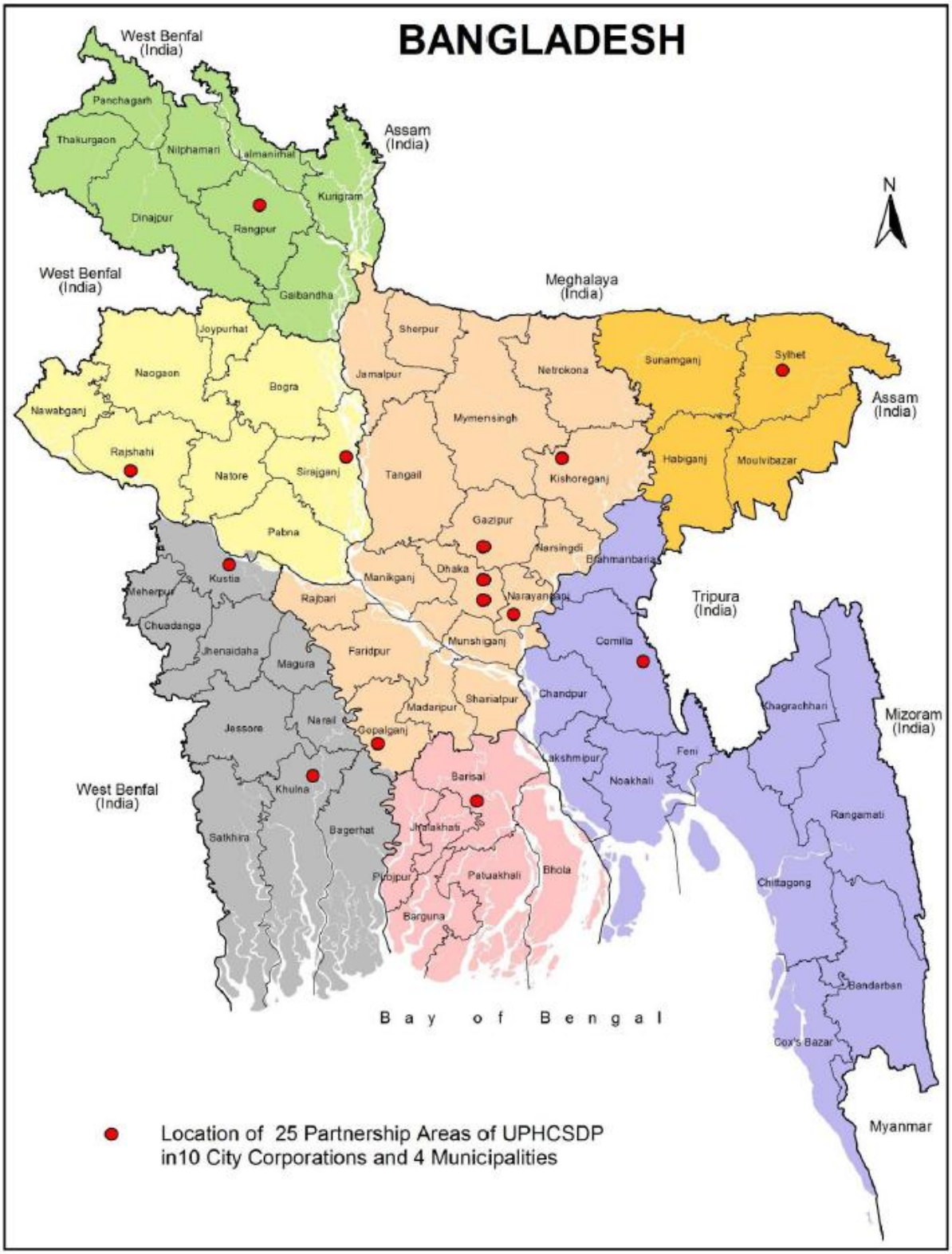
10. The target indicators of the outputs/component for improving accessibility through public private partnership (PPP) performance and accountability improves adequately to ensure achievements of the PA NGOs.

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.

MAP


BANGLADESH
West Benfal (India)
Assam (India)
Meghalaya (India)
Tripura (India)
Mizoram (India)
Myanmar
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Panchagarh
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Sherpur
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Netrokona
Sunamganj
Sylhet
Mymensingh
Tangail
Kishoreganj
Habiganj
Moulvibazar
Gazipur
Narsingdi
Brahmanbaria
Kustia
Meherpur
Chuadanga
Manikganj
Dhaka
Narayanganj
Rajbari
Faridpur
Munshiganj
Comilla
Jhenaidaha
Magura
Madaripur
Shariatpur
Chandpur
Khagrachhari
Jessore
Narail
Gopalganj
Lakshmipur
Feni
Noakhali
Barisal
Khulna
Satkhira
Bagerhat
Jhalakhati
Rangamati
Pirojpur
Patuakhali
Bhola
Chittagong
Barguna
Bandarban
Cox's Bazar
Bay of Bengal
Location of 25 Partnership Areas of UPHCSDP
in10 City Corporations and 4 Municipalities

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)
- ✓ Health facility survey report (once at beginning of first year of PPM&E)
- ✓ 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

18. **Strategy and Approach:** 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 Focus Group discussion (FGD), Survey, transect walk, Venn Diagram, Social Mapping, Problem Ranking and In-depth Interview (IDI)

SECTION III

Qualitative Survey Report

22. The Qualitative Survey Report is submitted in April 2016.The qualitative survey is one of the important deliverables of the Project Performance Monitoring and Evaluation (PPM&E) Firm. The main objectives of the survey are to assess quality of services delivered by the 25 Partnership Areas under the project and seek stakeholder's perception on service delivery with a view to gain deeper insight into various aspects of primary health care services, service provisions, community awareness, client choices and satisfactions.

23. Participatory Rapid Appraisal (PRA) method was followed in the study and qualitative feedback was captured using tools and techniques like Focus Group Discussion (FGD), In-Depth Interview (IDI), Transect Walk, Social Mapping, Problem Ranking and Venn diagram. The participatory respondents were drawn from among the service recipients, service providers and the community at large.

24. The participants of FGD sessions included Members of Women's Group, Men's Group, Vulnerable Group, Users' Forum, Adolescent Group, Community Leaders and Health Workers. The respondents of IDI were Male Ward Councilors, Female Ward Councilors, Poor Women, Members of Ward Urban Health Coordination Committee (WUHCC), Women Victims of Violence, Members of Users' Forum (UF), Chairpersons/Secretaries of UF, and Doctors/Quacks/Kabiraj/ Homeopaths/ Traditional Healers, Clinic Manager cum-Medical Officers, Paramedics/Counselors of CRHCC/ PHCC of UPHCSDP. The participants of transect walk, social mapping, problem ranking and Venn diagram were project beneficiaries and community people.

25. The survey identified diseases that beneficiaries generally suffer in the catchment areas. The diseases are categorized as: (i) adults: cold, fever, cough, diarrhea, tuberculosis (TB), diabetes; (ii) women**:** ante natal care (ANC), post natal care (PNC), post abortion care (PAC), diabetes, menstrual regulation (MR); (iii) children: cold, fever, cough, malnutrition etc.; (iv) adolescent: MR, sexually transmitted diseases (STD), malnutrition, and; (v) elderly people: cold, fever, cough, asthma, diarrhea, TB, diabetes and, old age diseases.

26. UPHCSDP is providing primary health care services through PA NGOs under partnership agreement in 25 Partnership Agreement Areas (PAAs). Services are provided from three levels of facilities such as Comprehensive Reproductive Health Care Centre (CRHCC), Primary Health Care Centre (PHCC), and Satellite Clinic.

27. Health care services available in a CRHCC includes general health care services plus ANC, PNC, MR, Dilatation and Curettage (DNC), PAC, child health care, Normal Vaginal Delivery (NVD), and delivery by Caesarean Section(C/S), Reproductive Tract Infection (RTI), Sexually Transmitted Infection (STI) and Family Planning (FP). In PHCC, the services are general health services, ANC, PNC, MR, diarrhea and FP. In satellite clinics the available services are child immunization, FP. The CRHCCs and PHCCs also provide medical treatments to the victims of Violence against Women (VAW).

28. The survey reflects the major role played by CRHCC and PHCC in providing primary health care services in the catchments area in comparison to other public and private health facilities. The survey also found that PHCC is reaching the majority of the people in the catchments area with health care services. The beneficiaries requested to establish more PHCCs and satellite centers particularly in the newly included city corporations to cover more population in general and the poor in particular. This explains increasing demand and also the popularity of the urban primary health care services of the Local Government Division.

29. Red card was provided to more than targeted 30% poor beneficiaries in the PA-NGO catchments area to avail all type of health services free of cost. The participants suggested to

increase the number of red cards and to improve the management of Red Card distribution system in vogue.

30. Cost of health care services is notified item-wise at the entry point of all the service centers of the project. The beneficiaries mentioned that the cost of medicines as well as the services is lower in the project compared to any other health service facilities. None reported any extra or unwanted payments. The beneficiaries mentioned that the costs of services are generally low. However, in some cases, the cost to beneficiaries located far away from the centers is little higher due to payment of additional travel cost.

31. In general, the participants are satisfied with the availability and quality of services. However, some beneficiaries suggested improvements of existing services. Their suggestions included: increasing service hours of PHCC, service delivery for 24 hours of 365 days a year, creating spacious waiting room, maintaining cleanliness of the centers, ensuring availability of physician and health worker and volunteer, increasing numbers of PHCC and satellite clinics and red card, supply of medicines. The service providers suggested for more training, effective role playing by WUHCC and user's forum, and effective actions on VAW.

32. Gender issue is addressed in the UPHCSDP. At all three levels of service delivery, women service providers over number the men. Likewise, among the service recipients, majority are women. However, among the project managers, men are majority.

33. WUHCC has been formed in all the 25 PA NGOs to address component I of the UPHCSDP for sustainability of the project. WUHCC is helping project implementation through creating awareness among the people. User's forum has been formed with mostly beneficiaries as members. The UF is also helping project implement through creating awareness. The survey also found that WUHCC and UF are helping victims of VAW. The respondents suggested effective role playing and functioning of both WUHCC and UF.

34. UPHCSDP stands by the VAW when needed. It is to be noted that VAW includes mostly physical, mental and sexual harassments. The survey also found that the violence against women are primarily due to poverty, child marriage, drug addiction, dowry, polygamy, illiteracy, promiscuity, inability to give birth or giving birth to only girl child, living in slum, unemployment of the husband etc. The victims get medical treatment at CRHCC and PHCC. The health workers and family welfare assistants help VAW victims through counseling. The WUHCC and UF also provide them with legal aid and mitigation of their grievances.

35. The health workers, family welfare visitors/assistants make people aware of the project through courtyard meeting (Uthan Baithak), distributing leaflet, announcing through miking, using banners and logos of the project and person to person contact. However, almost all the participants suggested regular meetings of user's forum and WUHCC, rally in the slum areas, advertisement in TV channel, use of mike, signboard, banner, leaflet etc for creating effective awareness in the community and publicizing the health care services delivery program.

36. The participants listed some strengths of the project such as: effective counseling by the health care service providers, health services through red card, services to mother and child, services to pregnant mothers with high priority, caesarian done with due care, services at low cost or free of cost, services at door step, good infrastructure facility, ambulance services, etc.

37. The participants listed some weaknesses as well such as: inadequate waiting area, inadequate manpower, location of fewer CRHCC and PHCC far away from some beneficiaries, inadequate medicine, frequent disruption of electricity, inadequate budget, lack of pediatrician, lack of publicity, insufficient ultra sonogram facility, insufficient ambulance service, lack of permanent anesthetist, etc.

38. Almost all participants suggested for improved health services through increasing manpower, facilities, availability of ambulance services, salary of staff, and level of awareness and responsibility.

39. The survey observed that some participants are too ambitious and expect unrealistic expectations for providing services X-Ray, ultra sonogram, all medical tests, and ambulatory facility from PHCC.

40. The recommendations and suggestions from the participants are summarized as follows:

- Simplification of eligibility criteria of red card and increasing the number of red card. Red card should bear photograph of all members of the household and signature of respective Project Manager. There should be a master register for red card;
- Less performing PHCC should be more frequently monitored;
- Role and function of WUHCC and UF should be efficiently monitored by PMU and PIU as per guideline;
- Victims of VAW should get effective support and legal aid for mitigation of grievances and redress of their harassment with security;
- The program for adolescent corner should be activated and monitored regularly;
- Behavior Change Communication (BCC) and awareness creation program should be more effective through print and electronic media and traditional means;
- Urban primary health care services may include diabetes patients; and
- All CRHCCs and PHCCs should be established progressively in own buildings of respective city corporations and municipalities on a permanent basis.

SECTION IV

Health Facility Survey Report

41. Health Facility Survey Report is submitted in June 2016. The project's goal is to improve the health status of the urban people, especially the poor, through improved access to and utilization of efficient, effective, and sustainable primary health care services. The project delivers essential services delivery package through 25 comprehensive reproductive health care centers, 113 primary health care centers, and 226 satellite clinics in ten city corporations and four district municipalities of the country. The services include MCH care, reproductive health care, family planning, nutrition, communicable disease control, limited curative care, health education and diagnostic services. The project is a unique model of public-private partnership (PPP).

42. The main objective of the health facility survey is to know various aspects of health service management, service providers, and clients and to make appropriate recommendations to improve the service delivery system. The survey was designed to gain deeper insights on various aspects of health service management, client perceptions and other aspects as status of primary health care services and providers, health care seeking behavior of urban poor, sources of information about health care services, responsiveness of service providers, and awareness and service responsiveness.

43. Health Facility Survey Report is submitted in June 2016. It was found that the project provided different trainings to all clinic managers on quality service delivery. Sixty percent clinic managers came with a background of private service. It was found that two thirds of the clinic managers received training on management and supervision, while half of them received training on orientation of UPHCSDP. Forty one percent clinic managers received training on planning and only 15% received training on financial management. A small percentage (7%) received training on human resource management (HRM) and management information system (MIS).

44. The key Informants (physicians/paramedics/nurses) received an average of four trainings after joining UPHCSDP. The project provided them 14 different types of trainings that included training on new born care, vasectomy, tubectomy, and counseling. Ninety three percent counselors received different trainings from the project. Seventy two percent received training on adolescent reproductive health, 65% on basic training of counseling, 56% on family planning counseling, 49% on nutrition, 46% on breast feeding, 42% on communication, and 23% on BCC.

45. The survey revealed that almost three-fourths (73%) clinic managers are engaged in management functions and responsible for quality assurance and 94% of them use either a check list or some other tools in supervising staff. Besides, 61% clinic managers play important role in planning and contribute to designing annual work plan. It is found that almost all clinic managers (98%) provide on the job training to the staff. Almost all the clinic managers (96%) organize monthly meetings with the staff and most of them could show minutes of the last monthly meeting. It is found that 85% health facilities maintain sterilization and cleanliness. Data reveal that 86% facilities follow standard protocols.

46. Service providers (physician/paramedic/nurse) play vital role in delivering health services in the health facilities. More than two-thirds of these service providers came from private sector with relevant practical experience and 91% of them are trained personnel. The service providers reported high level of infection prevention practice. Almost service providers have good knowledge of symptoms and management of ARI as well as dehydration due to diarrhea. Majority of the service providers interviewed are able to mention newborn care and danger signs/symptoms of the newborn.

47. More than half of the counselors (55%) reported that they conduct counseling on nutrition and health services, 38% on family planning, and 33% on daily and monthly reporting, 28% on providing information on importance of MCH care. Seventy-two percent of the counselors provide messages on immunizations, but only half of them advise mothers of the newborns in giving exclusive breast feeding for six months and continue breast feeding up to 2 years. Seven of every ten

respondents advise adaptation of family planning methods after delivery. It is found that 36% counselors provide messages on maintaining general health.

48. Observation of services of the health facilities indicated that almost all buildings have ventilation, adequate light, electricity and running water. Facilities are found clean, adequate waiting space, clean toilet for clients although availability of soap for hand wash was comparatively low (80%). Both OPD and in patient services are available in all CRHCCs. It is reported that all facilities have provision of providing ANC and PNC services. It is also found that all CHRCCs have delivery facility for both normal vaginal delivery and caesarean section. All facilities provide oral pills, injections, IUDs and condoms for family planning. Ninety six percent facilities provide Tubectomy and Norplant services while 88% facilities have emergency contraception. Observation noted that 86% health facilities are providing adolescent health care services, 96% offer prevention of RTI/STI/AIDS, 92% provide VAW services, and 88% offer RTI/STI Care services.

49. The service providers reported that there are no facilities for two most important services such as cervical cancer and breast cancer screening. The clinic managers strongly suggested to introducing these service facilities in each CRHCC as incidence of cervical cancer and breast cancer is rising in Bangladesh.

50. Availability of selected child health care services such as immunization service and treatment for diarrhea, ARI and measles were provided by almost all health facilities. Health facilities providing BCC such as health education sessions, counseling, iodized salt promotion are also high. Availability of BCC materials such as brochure and TB posters are found in abundance in each health facility. Diagnostic facilities for blood tests (Hb%, TC/DC and ESR), urine for albumin and sugar, and pregnancy test are available in almost all health facilities.

51. It is found from the interview of exit clients that family income of 81% respondents is low manifesting poor and the rest 19% is higher meaning non-poor. One-thirds of the exit clients visited health facilities for maternal care, 27% for general health care, and one-fourths for child care. The exit clients reported that almost all of them received desired services from the health facilities. They reported unavailability of necessary services such as concerned staff was not available, services are rescheduled another day, and some services are expensive and beyond their means. Three-fourths of the exit clients expressed satisfaction with the services they received. The reasons of satisfaction included quality of services (86%), good behavior of doctors as well as other staff, availability of doctors and staff (36%), and free treatment (20%). It was found that 52% of exist clients paid money for the services received.

52. Among all the exist clients interviewed, 95% received money receipt for their payments made. On verification it was found that amount mentioned in the money receipt was consistent with the reported amount paid in 93% cases. Among the exist clients interviewed, 30% have red cards and 96% of them could show their red cards.

53. Observations by mystery clients visiting in CRHCCs found that the visiting clients received services from the facilities and every client expressed satisfaction about the behavior, attending the patients by the staff, paramedics, counselors and doctors/physicians. Patients entering into the health facility were registered at the reception with proper money receipts. After registration, they were advised to meet the counselor, followed by visit to paramedic, and doctor/physician. The process was found to have been maintained professionally and systematically at all facilities and at all stages. Considering the financial capacity of clients, discount was allowed in price of medicine. Issuance of all medicine was recorded in the respective registers and the registers are found to have been updated regularly.

54. Different relevant messages are provided to the newly married couples, pregnant mothers, mothers of new born child, and advising them on maintaining health and hygiene including cleanliness and eating nutritional foods, advice on danger signs of newborn, adaptation of family planning methods after 42 days of delivery, feeding newborn only breast milk during first six months and immunization schedule.

55. Problems faced by the clinic managers in managing the health facilities for rendering services included: lack of adequate logistic supply, shortage of medicine, lack of USG/Incubator, lack of proper understanding of patients, and frequent failure of electricity supply. It is noted that patients generally do not like to take services through satellite clinics. It is also noted that some facilities lack adequate space and the shortage of doctors.

56. More training is needed for clinic managers particularly on financial management, human resource management, and management information system (MIS); and the clinic managers should carry more roles and responsibilities especially in program design and work plan. Counselors need more training on counseling for adolescent mothers, breast feeding, family planning, nutrition, behavioral change communication (BCC), violence against women (VAW), safe motherhood, and post abortion care and menstruation regularization (MR).

57. High percentage of the clinic managers expressed their satisfaction with the present job. Only 7% clinic managers expressed dissatisfaction with their present job. Reasons for dissatisfaction include low salary and shortage of staff compared to the number of patients and amount of different works. The clinic managers suggested that there should be enough spaces in the health facility, more budgets, motivation of patients, and more training for the staff. Almost half of the service providers proposed to provide training on ANC, PNC, RTI/STIs, and adolescent health, MR, counseling and providing quality services for violence against women.

58. Both service providers and service recipients suggested in general that all health facilities of the project should have uninterrupted electricity supply through stand-by generators; and introducing cervical cancer and breast cancer screening services at all CRHCCs.

SECTION V

ISI Monitoring Report Round-I

59. Among others, the PPM&E firm is responsible to undertake half-yearly performance monitoring and evaluation of the PA NGOs using Integrated Monitoring Instrument (ISI), a standard tool developed jointly by the project. The ISI monitoring survey is conducted in January and July every year to assess the overall performance of each PA NGO based on their activities performed during previous six months. The present ISI Monitoring Survey - Round I was conducted in all PA NGOs covering 25 headquarters, 25 Comprehensive Reproductive Health Care Centers (CRHCCs), 113 Primary Health Care Centers (PHCCs), and 226 Satellite Clinics(SCs).

61. The performance of all 25 PA NGOs was assessed based on the performances of PA HQ, CRHCC, PHCC, and Satellite Clinic in terms of the quality and quantity of services and management of the services related to providing health services during the previous six months (July-December 2015).

62. The draft report ISI Monitoring Report Round-I is prepared. Performance of the PA NGOs manifests largely the performance of the project's service delivery. Average overall performance of all 25 PA NGOs during July-December 2015 is 73.8% that signifies satisfactory performance of the PA NGOs and the project at large. Moreover, out of 25 PA NGOs, 20 PA NGOs (80%), 15 PA NGOs (60%), and 11 PA NGOs (44%) have respectively secured over 60%, 70%, and 80% points. The project shares the high levels of performance achievements by the PA NGOs during surveyed six months. Major other outcomes of the ISI Monitoring Survey – Round I are summarized as follows.

63. Performances of PA NGOs vary with PA Area/ location, experience and commitment of the PA NGO, and overall staff quality and commitment. It is found in the ISI Monitoring Survey – Round I that same PA NGO working in more than one PA areas performed differently.

64. There is general weakness in maintenance and updating of the registers among all PA NGOs. Among the total numbers of patients received services for normal vaginal delivery and caesarean section delivery, 37% and 25% patients are red card holders respectively. Standard infection prevention (IP) practices are generally followed in all CRHCCs and PHCCs.

65. PA NGOs have achieved good level of communication between its physicians and patients which is essential for effective service delivery. Presence of physicians, nurses/paramedics/ midwives, counselors, and receptionists in the health centers is satisfactory and patients' have easy access to them.

66. Among the surveyed households in catchments area of PA NGOs 46.53%, 52.0%, and 1.47% are respectively ultra poor, poor, and non-poor. More than 80% respondents surveyed live in the PA area for more than one year, 56% migrated to the area from village/another town or another slum of the same town. Average family size is 4.13 persons with male female ratio of 49.7 male for 50.3 female.

67. About quality of house, 93% houses are brick built or tin shed and the rest are made of bamboo and timber. The household assets include: television (58%), radio (1%), refrigerator (12%), electric fan and mobile phone (89%), furniture including bed, table and chair (82%).

68. Major expenditures include house rent, food, health care and education of the children. It is estimated that 60% households are solvent (live within their means) and the rest 40% are indebted. More than 99% households get drinking water from safe sources and 84% households use sanitary latrines. It is found that members of 88% surveyed households are familiar with "Rainbow Clinic" as a source of quality health services free of cost or at reasonable cost.

69. Survey team conducted 25 focus group discussions (FGD) in 25 CRHCCs with 247 participants and 113 focus group discussions in 113 PHCCs with 1,077 participants. Participants demonstrated

good opinion and knowledge about the project. Feedback of the focus group discussions are summarized as follows:

- Good atmosphere, convenience and privacy during providing health services;
- Good attitudes of the staff to the service recipients;
- Explanations and information given by medical staff;
- Good quality services are provided by medical staff;
- Low cost or no cost of services and medicine; and
- Four out of every five participants are satisfied with the services.

70. Performance of PA HQs ranged from 60 points to 120 points with an average score of 104.5 points. With an average score 189.6 points, performance of CRHCCs ranged from 110 points to 148 points. Again with an average score of 311.6 points, performance of PHCCs ranged from 160 pointsto447 points. The average score per Satellite Clinic is 131 point within the range from 57.7 points to 170 points. Overall performance score of the 25 PA NGOs ranged between 464.5 points and 969.7 points with average score of 737.7 points out of a total score of 1,000 points. It is also noted that 15out of 25 which is 60% PA NGOs achieved above 70% performance scores.

71. The survey team noted that PA NGOs attach high importance to particular activities affecting overall performance of the project at large. There is need for ensuring that highly experienced and committed staff having leadership ability are employed, retained and provided with necessary trainings.

72. **Data collection for ISI Round-II** completed data is under process.

SECTION VI

Annual Red Card Verification

73. Draft report on Annual Red Card Verification is under preparation. The main objective of the red card verification survey is to verify whether the red cardholder households were available at their addresses and red cards were issued to the eligible ultra poor and poor. PPM&E firm adopted different approaches for conducting (i) household survey and (ii) focus group discussion, and developed separate monitoring tools, data processing software, tables and interpretations but presented in one report. Lot Quality Assurance Sampling (LQAS) was used for selection of households for survey. In the survey, 100% PA-NGOs were selected for collection of information of red cardholder households. Main source of information for sample selection was master register and red card register.

74. Red card holder household record up to 31 December 2015 was considered for sampling and data collection. A total of random 19 sample red card households were selected for interview in each of the PA areas. Location and particulars of sample red cardholder households were collected from red card registers of PHCCs and visited during the survey. A total of 475 red card households were verified of which 362 households were found as per address which is 76%. Around 24% of the red cardholder households were not available at their address during the survey.

75. Out of rest 113, a total of 37 households left addresses and whereabouts not known, 25 red card holders left the addresses and gone back to villages, 11 card holders not available due to demolition of slums, 28 households recorded as red card holders as per red cards register but they did not receive the receive card cards and living of 12 red card holders at the addresses were doubtful.

76. From the estimated calculation it is assumed that out of 115,455 red card households a total of 95,629 nos. of red cardholder households be avaialble while 19,826 nos. will not be availble. This is calcualted based on percentage of availability of the red cradholder households of each PA area during the survey.

77. The availability of red cardholder households between the PA area varied largely. This was calculated dividing the estimated nos. of available red card holder households by nos. of PHCC. It is observed that wide variation of red cardholder households' prevails between the PHCC of PA areas. The reasons for this variation are to be explored and ways to minimize the variation to be discussed with the PA NGOs as the services are being provided with the same human resources.

78. The survey found that 362 red cardholder households were available at their addresses while about 24% cases the sampled households were not available in the area and in most cases whereabouts of those households were not known to the people of the locality.

79. It was found from the assessment of the respondents that almost all (99%) red cardholder households' were rightly identified as either ultra poor or poor by the project and they are receiving free services. It may be mentioned that only 2 of the red cardholder households' were found to be non-poor.

80. Qualitative information was collected during red card verification survey through focus group discussion (FGD). A total of 25 focus group discussions were conducted one in each PA-NGO area. FGD sessions were conducted with three categories of stakeholders of the project. These categories were beneficiaries group (service recipients), WUHCC, UF and Community People, and Service Providers/Health Workers of UPHCSDP. A total of 372 persons participated in those FGD sessions.

81. Findings from **FGDs with beneficiaries:** It was noted that the beneficiaries were informed on the red cards and free services with medicines from the field workers of the PA-NGOs and other women of the locality who already possessed red cards. Field workers of PA-NGOs visited the households to identify the poor by filling up forms. The participants opined that they were satisfied

with the services provided by the PA-NGOs as the red card holders received health services free of cost. They were aware about the types of services available at CRHCC, PHCC and Satellite Clinic. However, they had to spend for some tests and medicines which were purchased from open market. The problems as mentioned by the participants included shortage of medicine, lack of specialized doctors, pediatric complications, no X-ray machine, no Ultrasonography machine at PHCC.

82. Findings from **FGDs with Community People (WUHCC, UF and Community People):** Participants in all the FGDs stated that outreach workers discussed the red card issues with people and community leaders during their visits to households. Majority of the participants of the FGD sessions opined that the poor people in areas were aware about criteria of getting red card and consequently receiving free services and medicines. Participants of all the FGDs stated that health service users were happy with the services of the health service providers. However, they gave some suggestions for further up gradation of the services. Their suggestions included increasing supply of medicine, increasing number of red cardholders, launch publicity in different forms to attract local community to receive services from the CRHCC/PHCC

83. Findings from **FGDs with Service Providers:** Participants of all the FGD sessions stated that PA-NGOs had coordination or networking with other health service providing organizations in the respective areas. Most of PA-NGOs mentioned that they had coordination and networking with BRAC, Marie Stopes, Government Hospitals, Medical College Hospitals for referring the critical patients to them and personal communication was also maintained.

84. The service providers mentioned that the **strengths** of UPHCSDP included (i) provide free health services to the poor urban people (red card holders) and service at reduced cost to others, (ii) diagnostic services and medicine supply at low cost, (iii) availability of Ambulance service at the CRHCC (free for red card holders) and (iv) standard counseling service. The weaknesses of UPHCSDP included (i) rented building, (ii) inadequate numbers of red cards, (iii) insufficient supply of medicines, (iv) inadequate number of field staff compared to area of operation, and (v) staff training is inadequate.

85. Red cards updating at regular interval as stipulated in the project document is to be strictly followed as rate of migration of urban poor is very high. Updated list of red cards will provide opportunity of providing services to new beneficiaries. Future planning for the facilities and providing support services be based on updated red card list and according to the need.

86. Validity period of red cards can be updated with signature of at least two authorized persons and photograph of the red cardholder and his/her family members may be incorporated in the red card for avoiding services to the wrong person(s).

87. The UPHCSDP is reaching the urban ultra poor and poor who are in need with its services through the red cards and ensuring them the availability of the services free of cost. As high migration of the poor people living in the slum is natural, all concern should follow the updating of red cards at regular interval as indicated by the project and monitoring of this to be ensured.

SECTION VII

PROGRESS IN BRIEF - MONITORING OF TRAINING PROGRAMS

A. Objective of Training Monitoring by PPM&E Firm

88. 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

89. During the reporting period April- June 2016 two (02) training programs in three (03) batches were monitored by the PPM&E firm. The monitored training programs were as follows:

- Training on Menstruation Regulation for the Nurses, Paramedics & Family Welfare Visitors (1 batch);
- Training on Post Abortion Care(PAC) for Doctors and Paramedics (2 batches).

C. Methodology used for Monitoring

90. 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 Menstruation Regulation for the Nurses, Paramedics & Family Welfare Visitors

91. Twelve days training on Menstruation Regulation (MR) for the Paramedics, Nurses and Family Welfare Visitors (FWV) of PA-NGOs sponsored by the UPHCSDP was held in four batches at Mohammadpur Fertility Services Training Centre (MFSTC). The second, third, fourth and fifth batches of the courses were held during 6th to 18th February, 27th February to 10th March, 12th to 24th March, and 2nd to 13th April 2016 respectively. During the reporting period fifth batch of training course was monitored. Number of participants in this batch was 15 and all of them were female.

92. Mohammadpur Fertility Services Training Centre (MFSTC) was the venue for the course. The venue was located in a convenient place in the city with well decorated room having required audio-visual facilities and other logistics.

93. All the Resource Persons were regular trainer as well as regular Physicians of their 100 bedded MCH Hospital. A Training Manual prepared by the Directorate General of Family Planning and Marie Stopes, Bangladesh titled: "Bangladesh National Menstruation Regulation Services Guidelines" 2013 in Bangla was followed in the course. Resource Persons used Posters and Multimedia for their presentation, besides video presentations were made in some of the topics.

94. Lecture method followed by discussion and practical sessions in the MR Room was used in almost all the topics. Besides, in some topics dummy was used for demonstration. For Counseling Sessions Role Play method was applied.

95. Pre and post training evaluation of the participants was conducted using a structured questionnaire. However, there was no provision to evaluate the trainers and course management by the participants.

96. Training on MR was appreciated by the participants, as the course was highly relevant to the participants, who were Paramedics, Nurses and FWVs of PA-NGOs under the UPHCSDP.

97. Participants were satisfied with the number of MR clients available at MFSTC, which enabled them to perform variety of MR cases during the training period.

98. Participants of all the batches felt that MR training was very essential for their job, but none had any previous training in this field. As such this training was taken very seriously by the participants.

99. However, the participants as well as the Course Coordinators suggested reducing the number of participants from 15 to10 and increase the duration of the course from 12 to 15 days to allow participants to handle more number of practical cases.

2. Training on Post Abortion Care for Doctors and Paramedics

100. Training on Post Abortion Care (PAC) sponsored by the UPHCSDP was held in two batches at Dhaka Medical College Hospital, Dhaka for the Doctors and Paramedics of PA-NGOs. The training was organized by the Reproductive Health Services Training and Education Program (RHSTEP). The duration of training was for 12 days and it was conducted in two batches in the same venue. The first batch of the course was held from 2nd to 13th April 2016 and the second batch from 16th to 28th April 2016. Number of participants in each batch was 12 and all of them were female. Dr. Mukhlesur Rahman Hall, Ward No. 212, Dhaka Medical College Hospital (DMCH), Dhaka was used as the venue for both the batches of training on PAC facilitated by the RHSTEP. The venue being DMCH was easily accessible to the participants. Training room was not spacious and was not well ventilated; however one split A/C maintained the proper temperature inside the room. Except two, all the Resource Persons used in the course 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. Training sessions were participatory and interactive. A printed training manual on **Post Abortion Care** prepared by the RHSTEP in Bangla was followed in the course. Resource persons used posters, multimedia and video for their presentations. They mostly used lecture methods followed by discussion and practical demonstrations.

101. Participants of training on PAC, who were Doctors and Paramedics of different PA-NGO highly appreciated the course, because it was relevant to their job. Practical sessions were extremely useful to them, as they got the exposure to variety of cases in the DMC Hospital and they could individually participate in the practical sessions.

SECTION VIII

PROGRESS IN BRIEF - GIS DATABASE AND MAPPING

102. 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.

103. 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.

104. 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.

105. 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.

106. 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.).

107. The PPM&E firm coded City Corporation, Municipality, CRHCC and PHCC for easy identification. Orientation training was 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.

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

- ✓ 25 Partnership Areas draft maps are completed
- ✓ 25 Partnership Areas GIS database works are being going on.

Map of each Partnership Area will be covered in followings:

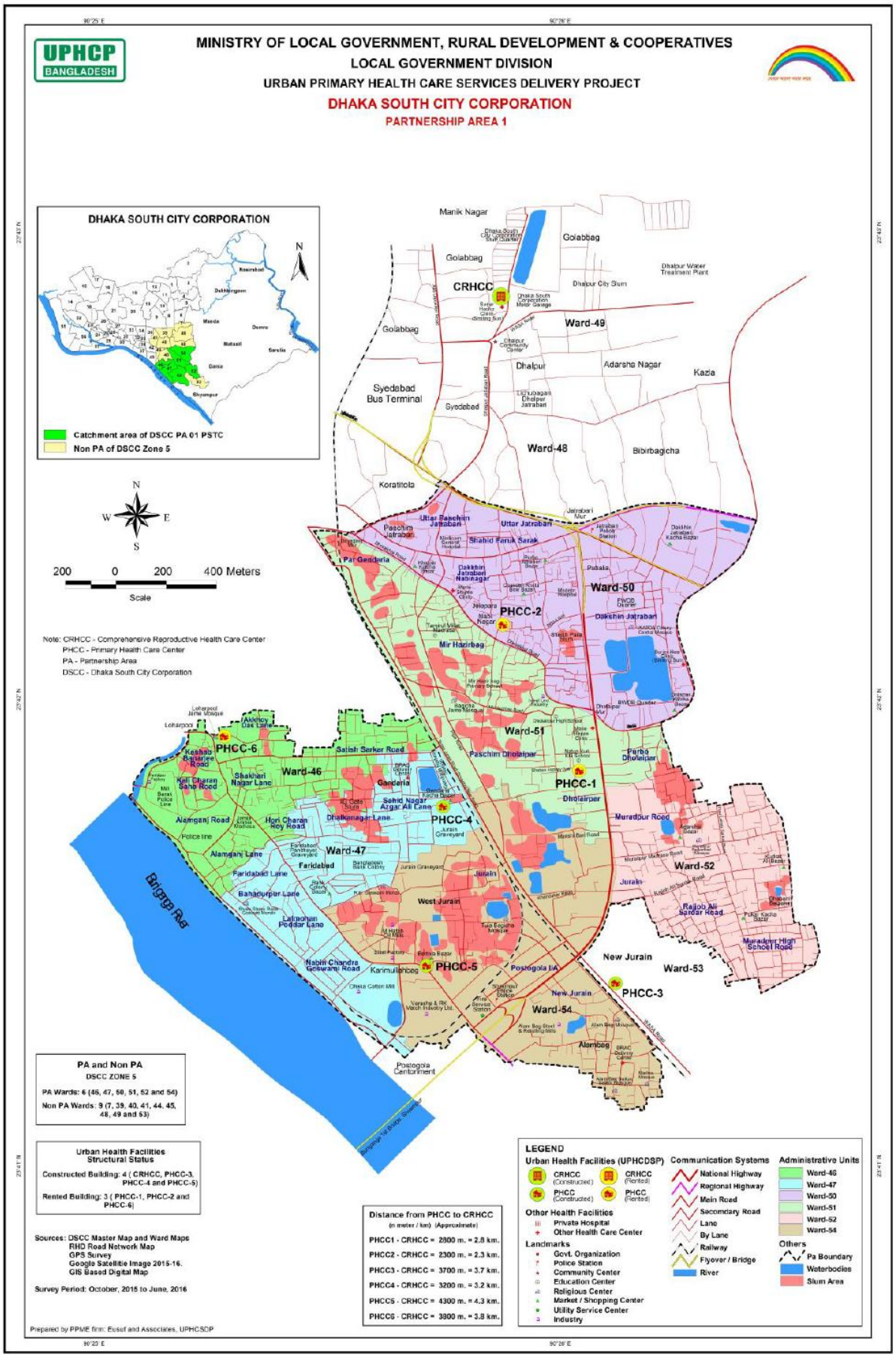
- ✓ Catchments area of PA – showing Wards/Mohallas
- ✓ Facilities locations of UPHCSDP – showing CRHCC and PHCC
- ✓ Other Health Facilities locations – showing Govt. Hospital and major other health centers
- ✓ Relevant Landmarks locations – showing Govt. Organizations, Education Center, Religious Center, 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 – CRHCC and PHCC

Future Plan

- ✓ Final Map of 25 PAs will be completed within September, 2016.
- ✓ GIS database 25 PAs will be completed within September, 2016.


UPHCP BANGLADESH
MINISTRY OF LOCAL GOVERNMENT, RURAL DEVELOPMENT & COOPERATIVES
LOCAL GOVERNMENT DIVISION
URBAN PRIMARY HEALTH CARE SERVICES DELIVERY PROJECT
DHAKA SOUTH CITY CORPORATION
PARTNERSHIP AREA 1
DHAKA SOUTH CITY CORPORATION
Catchment area of DSCC PA 01 PSTC
Non PA of DSCC Zone 5
200 0 200 400 Meters
Scale
Note: CRHCC - Comprehensive Reproductive Health Care Center
PHCC - Primary Health Care Center
PA - Partnership Area
DSCC - Dhaka South City Corporation
CRHCC
PHCC-1
PHCC-2
PHCC-3
PHCC-4
PHCC-5
PHCC-6
Ward-46
Ward-47
Ward-48
Ward-49
Ward-50
Ward-51
Ward-52
Ward-53
Ward-54
Buriganga River
PA and Non PA
DSCC ZONE 5
PA Wards: 6 (46, 47, 50, 51, 52 and 54)
Non PA Wards: 9 (7, 39, 40, 41, 44, 45, 48, 49 and 53)
Urban Health Facilities Structural Status
Constructed Building: 4 (CRHCC, PHCC-3, PHCC-4 and PHCC-5)
Rented Building: 3 (PHCC-1, PHCC-2 and PHCC-6)
Sources: DSCC Master Map and Ward Maps
RHD Road Network Map
GPS Survey
Google Satellite Image 2015-16.
GIS Based Digital Map
Survey Period: October, 2015 to June, 2016
Distance from PHCC to CRHCC
(in meter / km) (Approximate)
PHCC1 - CRHCC = 2800 m. = 2.8 km.
PHCC2 - CRHCC = 2300 m. = 2.3 km.
PHCC3 - CRHCC = 3700 m. = 3.7 km.
PHCC4 - CRHCC = 3200 m. = 3.2 km.
PHCC5 - CRHCC = 4300 m. = 4.3 km.
PHCC6 - CRHCC = 3800 m. = 3.8 km.
LEGEND
Urban Health Facilities (UPHCDSP)
CRHCC (Constructed)
CRHCC (Rented)
PHCC (Constructed)
PHCC (Rented)
Other Health Facilities
Private Hospital
Other Health Care Center
Landmarks
Govt. Organization
Police Station
Community Center
Education Center
Religious Center
Market / Shopping Center
Utility Service Center
Industry
Communication Systems
National Highway
Regional Highway
Main Road
Secondary Road
Lane
By Lane
Railway
Flyover / Bridge
River
Administrative Units
Ward-46
Ward-47
Ward-50
Ward-51
Ward-52
Ward-54
Others
Pa Boundary
Waterbodies
Slum Area
Prepared by PPME firm: Eusuf and Associates, UPHCSDP

SECTION IX

MANPOWER RESOURCES

109. 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 9.1.

Table 9.1: Manpower

Position(s)	**Name**	**Total Inputs**	
Key Experts		**Total**	**During QTR**
Team Leader (Performance Monitoring & Evaluation Specialist)	Prof.Dr.Md.Nurul Islam	22	1.5
Public Health Management Specialist	Dr. Md. Alamgir Hossain	14	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

110. 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 planned activities schedule (Table 10.1). 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 X

PLAN FOR THE NEXT QUARTER

111. 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 10.1.

Table 10.1: 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																									
Quarterly Progress Report																									
Annual Progress 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 Endline Evaluation Report																									

Legend

Planned
Actual
Intermittent