Urban Primary Health Care Services Delivery Project (UPHCSDP)

Local Government Division

Ministry of Local Government, Rural Development & Cooperatives

Quarterly Report

Fourth Quarter (July-September 2016)

Major Activities and Outcomes of the Project Performance Monitoring and Evaluation

Eusuf and Associates

Project Performance Monitoring and Evaluation Firm

October 2016

ABBREVIATIONS

ADB	-	Asian Development Bank
AG	-	Adolescent Group
ANC	-	Antenatal Care
BBS	-	Bangladesh Bureau of Statistics
CL	-	Community Leaders
CRHCC	-	Reproductive Health Care Center
DMCH	-	Dhaka Medical College Hospital
DMF	-	Design and Monitoring Framework
FY	-	Fiscal Year
FGD	-	Focus Group Discussion
FMIS	-	Financial Management Information System
FWV	-	Family Welfare Visitor
GIS	-	Geographical Information System
HMIS	-	Health Management Information System
HQ	-	Headquarters
ISI	-	Integrated Supervisory Instrument
IDI	-	In-depth Interview
ICDDR,B	-	International Centre for Diarrheal Disease Research, Bangladesh
LGD	-	Local Government Division
LQAS	-	Lot Quality Assurance Sampling
MDG	-	Millennium Development Goal
M&E	-	Monitoring and Evaluation
MFSTC	-	Mohammadpur Fertility Services Training Center
MCH	-	Mother and Child Health
MR	-	Menstruation Regulation
NGO	-	Non-government Organization
PA	-	Partnership Area
PAC	-	Post Abortion Care
PPP	-	Public Private Partnership
PPM&E	-	Project Performance Monitoring and Evaluation
PHC	-	Primary Health Care
PHCC	-	Primary Health Care Center
PMU	-	Project Management Unit
PIU	-	Project Implementation Unit
PA NGO	-	Partnership Area Non-government Organization
PRA	-	Participatory Rapid Appraisal
QTR	-	Quarterly Report
QA	-	Quality Assurance
SIDA	-	Swedish International Development Association
UF	-	Users' Forum
UHS	-	Urban Health Survey
UNFPA	-	United Nations Fund for Population Administration
UPHCP	-	Urban Primary Health Care Project
UPHCSDP	-	Urban Primary Health Care Services Delivery Project
WUHCC	-	Ward Urban Health Coordination Committee

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 Fourth Quarter (July-September 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 Annual Red Card Verification report is finalized.

6. The ISI Monitoring report- Round II draft is completed in fourth quarter.

7. The updated GIS Mapping of 25 PA-NGOs is completed by June after sharing with PMU,PMI and the concerned PA- NGOs. The GIS mapping activities were shared with the ICDDR'B team. Final report is submitted by September.

8. The PPM&E firm as part of on-going monitoring of training programs continued. A brief report on the monitoring feedback was submitted. Compilation of training monitoring activities reports up to August 2016 is drafted.

D. Plan for the Fifth Quarter (October – December 2016)

9. The ISI Monitoring report- Round II draft final will be submitted.

10. The PPM&E firm plans to monitor all on-going training programs including selective number of batches as convenient in the fifth quarter. Annual report on monitoring of training programs will be finalized. The preparation for ISI Round III survey, Annual Red Card Verification (II), and End line Household survey.

11. Other activities will be continuing as per schedule.

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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.

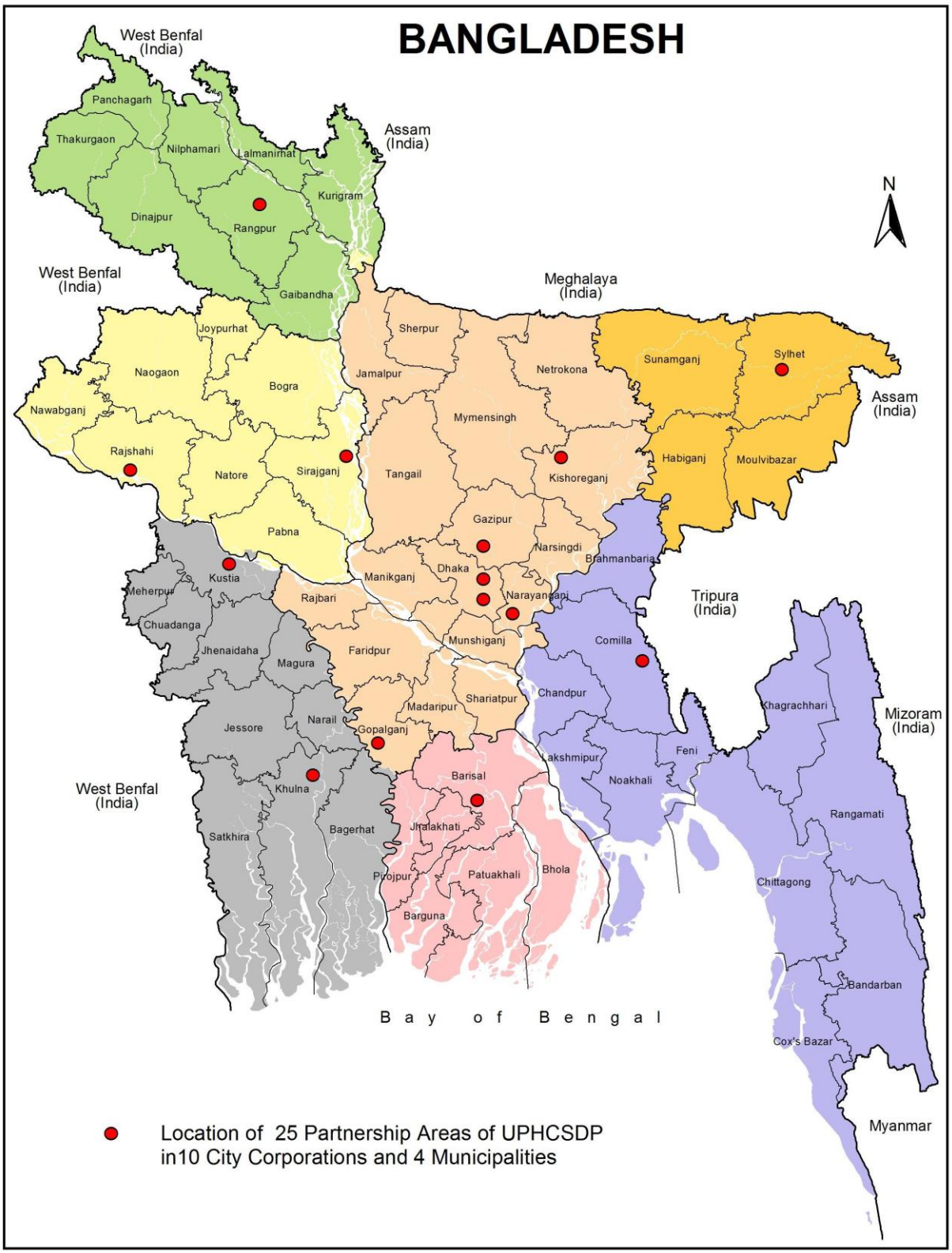
B. The Project

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

MAP


BANGLADESH
West Benfal (India)
Assam (India)
Meghalaya (India)
Tripura (India)
Mizoram (India)
Myanmar
Panchagarh
Thakurgaon
Nilphamari
Lalmanirhat
Kurigram
Dinajpur
Rangpur
Gaibandha
Joypurhat
Naogaon
Bogra
Nawabganj
Rajshahi
Natore
Sirajganj
Pabna
Sherpur
Jamalpur
Netrokona
Sunamganj
Sylhet
Mymensingh
Habiganj
Moulvibazar
Tangail
Kishoreganj
Gazipur
Narsingdi
Brahmanbaria
Dhaka
Manikganj
Narayanganj
Kustia
Meherpur
Rajbari
Chuadanga
Jhenaidaha
Magura
Faridpur
Munshiganj
Comilla
Chandpur
Shariatpur
Madaripur
Jessore
Narail
Gopalganj
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Bhola
Barguna
Lakshmipur
Noakhali
Feni
Khagrachhari
Rangamati
Chittagong
Bandarban
Cox's Bazar
N
B a y o f B e n g a l
Location of 25 Partnership Areas of UPHCSDP
in10 City Corporations and 4 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.

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

Findings of **Annual Red Card Verification**

22. Summary findings of Annual Red Card Verification are as follows:
The main objective of the 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. 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

32. 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.

33. 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.

34. 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.

35. 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).

36. 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 IV

Tentative Findings of ISI Monitoring Round II

37. Summary findings of ISI monitoring Round II (Draft) are as follows: The Government of the People's Republic of Bangladesh has been implementing the Urban Primary Health Care Services Delivery Project in 14 major cities of the country since July 2012. The project goal is to provide services free of cost to the urban poor. The project engaged Eusuf and Associates as Project Performance Monitoring and Evaluation (PPM&E) firm to monitor project outcomes and impact. 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 and donors. 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 II 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).

38. 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.

39. Performance of the PA NGOs manifests partly the performance of the project. Average overall performance of all 25 PA NGOs during January-June 2016 is 91.45% that signifies satisfactory performance of the PA NGOs and the project at large. Moreover, out of 25 PA NGOs, 24 PA NGOs (96%), 23 PA NGOs (92%), and 18 PA NGOs (72%) have respectively secured over 70%, 80%, and 90% points. The project shares the high levels of performance achievements by the PA NGOs during January-June 2016. Major other outcomes of the ISI Monitoring Survey – Round II are summarized as follows.

40. Performance of PA NGOs may 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 II that same PA NGO working in more than one PA areas performed differently.

41. 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, 37.6% and 29.1% patients are red card holders respectively. Standard infection prevention (IP) practices are generally followed in all CRHCCs and PHCCs.

42. 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 is satisfactory and patients' have easy access to them.

43. Among the surveyed households in catchments area of PA NGOs 49.68%, 48.64%, and 1.68% are respectively ultra poor, poor, and non-poor. More than 96% respondents surveyed live in the PA area for more than one year, 46% migrated to the area from village/another town or another slum of the same town. Average family size is 4.10 persons with male female ratio of 48.1 male for 51.9 female.

44. About quality of house, 83% houses are brick built or tin shed and the rest are thatched made of bamboo and timber. The household assets include: television (66%), radio (4%), refrigerator (12%), electric fan (89%), mobile phone (87%), furniture including bed and table and chair (88%).

45. Major expenditures include house rent, food, health care, and education of children. It is estimated that 56% households are solvent (live within their means) and the rest 44% are indebted. About 99% households get drinking water from safe sources and 97% households use sanitary latrines. It is found that members of 93% surveyed households are familiar with "Rainbow Clinic" as a source of quality health services free of cost or at reasonable cost.

46. Survey team conducted 25 focus group discussions in 25 CRHCCs with 242 participants and 113 focus group discussions in 113 PHCCs with 1,098 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.

47. Performance of PA HQs ranged from 80 points to 130 points with an average score of 117.2 points. With an average score 224.1 points, performance of CRHCCs ranged from 125 points to 250 points. Again, with an average score of 412.9 points, performance of PHCCs ranged from 136.5 points to 450 points. The average score per Satellite Clinic is 160.3 point within the range from 88 points to 170 points. Overall performance score of the 25 PA NGOs ranged between 444.5 points and 1000 points with average score of 914.5 points out of a total score of 1,000 points. It is also noted that 24 points out of 25 points, 96% PA NGOs achieved above 70% performance scores.

48. 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.

SECTION V

Progress in Brief - Monitoring of Training Programs

A. Objective of Training Monitoring by PPM&E Firm

49. 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

50. 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

51. 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

52. 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.

53. 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.

54. 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.

55. 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.

56. 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.

57. 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.

58. 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.

59. 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.

60. 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

61. 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.

62. 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 VI

Progress in Brief - GIS Database and Mapping

63. 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.

63. 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.

64. 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.

65. 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.

66. 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.).

67. 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.

68. 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 completed.

Map of each Partnership Area will be covered in followings:

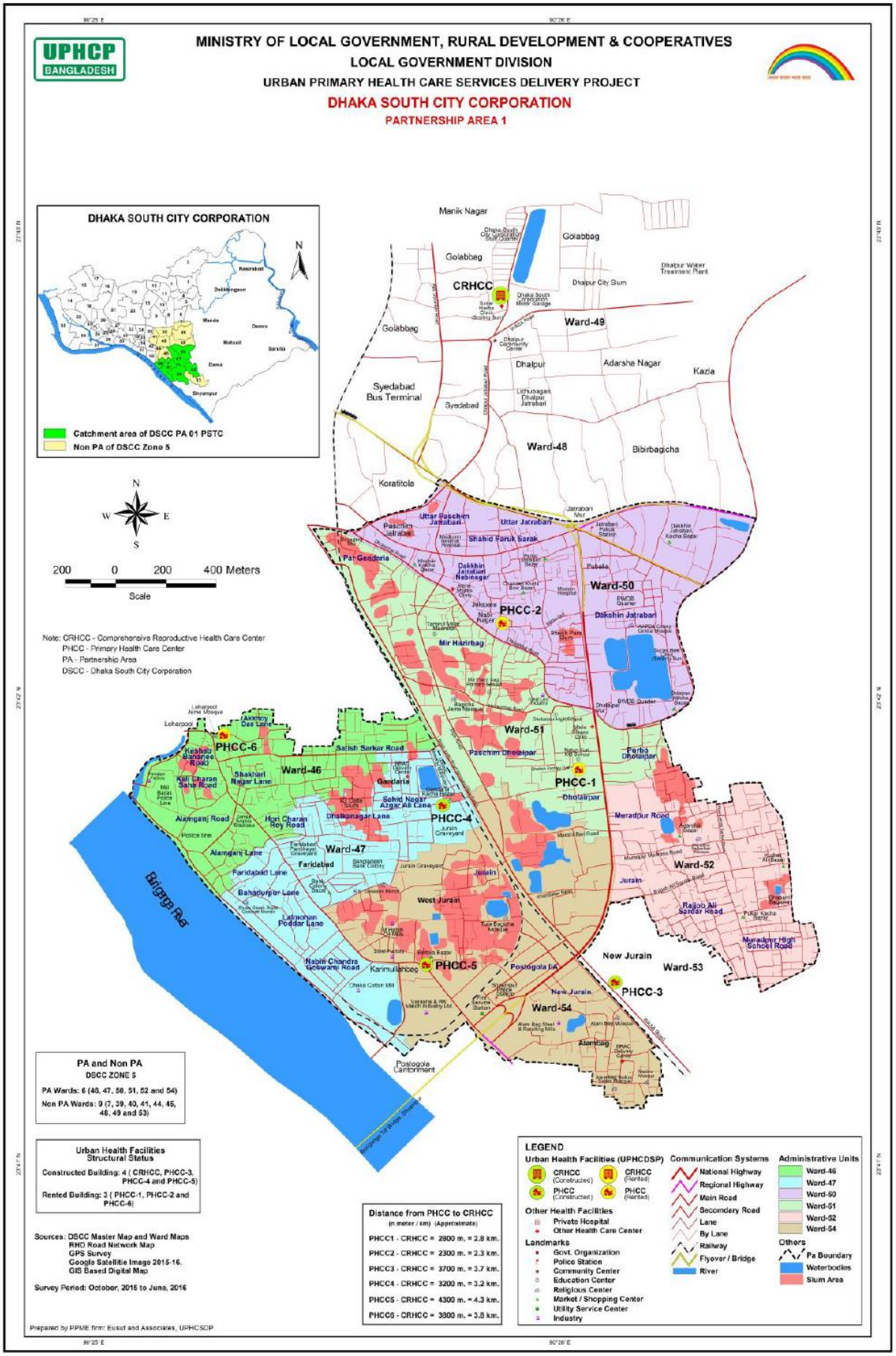
- ✓ Catchments area of PA – showing Wards/Mohallas
- ✓ Facilities locations of UPHCSDP – showing CRHCC and PHCC
- ✓ Other Health Facilities locations – showing Govt. Hospital and major other health centers
- ✓ Relevant Landmarks locations – showing Govt. Organizations, Education Center, Religious Center, 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
N
W
E
S
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
Manik Nagar
Golabbag
CRHCC
Dhaipur City Slum
Ward-49
Dhalpur
Adarsha Nagar
Kazla
Syedabad Bus Terminal
Syedabad
Ward-48
Bibirbagicha
Koratitola
Uttar Paschim Jatrabari
Uttar Jatrabari
Shahid Paruk Sarak
Par Gendaria
Dakkhin Jatrabari Nabinagar
PHCC-2
Dakshin Jatrabari
Ward-50
Mir Hazirbag
Ward-51
Paschim Dholaipar
Purbo Dholaipar
PHCC-1
Dholaipar
PHCC-6
Keshab Chandra Sen Lane
Satish Sarkar Road
Ward-46
Shakhari Nagar Lane
Kali Charan Saha Road
Gandaria
Sahid Nagar Azgar Ali Lane
PHCC-4
Alamganj Road
Hori Charan Roy Road
Dhalkanagar Lane
Meradpur Road
Ward-47
Alamganj Lane
Faridabad
Faridabad Lane
Bahadurpur Lane
Jurain
West Jurain
Ward-52
Rajab Ali Sarkar Road
Buriganga River
Lalmohan Poddar Lane
Nabin Chandra Goswami Road
Kanirulahcog
PHCC-5
Postogola Ltd.
New Jurain
Ward-53
PHCC-3
Ward-54
Alamtag
Postogola Cantonment
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 VII

Manpower Resources

69. 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 7.1.

Table 7.1: 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	2
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

70. 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 8.1). 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 VIII

Plan for the Next Quarter

71. The PPM&E firm has few activities of the last quarter that will continue through the next quarter (October-December 2016), few activities limited to the next quarter only, and few other activities that will continue further to the fifth quarter. The planned activities of the follow –up quarter (October-December 2016) as at table 8.1.

Table 8.1: 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		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Calendar Months >>>>>>>>>>>>	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
Inception Report																						
Quarterly Progress Report																						
Annual Progress Report																						
Qualitative Survey Report final																						
GIS Database and Mapping final																						
Semi-annual ISI Report-1st & 2nd																						
Health Facility Survey Report final																						
Training Evaluation Assessment																						
Annual Red Card Verification																						
Preparation of Final Report																						
Project Endline Evaluation Report																						

Legend

Planned
Actual
Intermittent