Urban Primary Health Care Services Delivery Project (UPHCSDP)

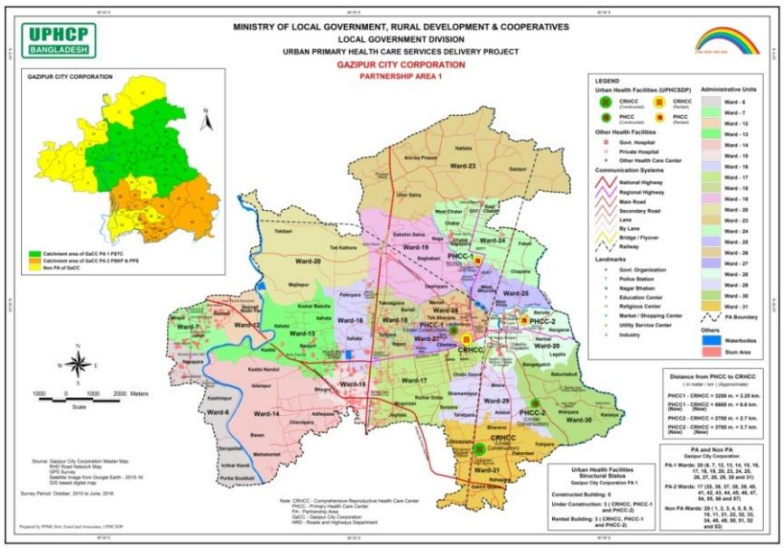
Local Government Division

Ministry of Local Government, Rural Development & Cooperatives

Quarterly Report

Fifth Quarter (October-December 2016)

Major Activities and Outcomes of the Project Performance Monitoring and Evaluation



Eusuf and Associates

Project Performance Monitoring and Evaluation Firm

January 2017

ABBREVIATIONS

ADB	-	Asian Development Bank
ANC	-	Antenatal Care
BMMS	-	Bangladesh Maternal Mortality Survey
BRAC	-	Bangladesh Rural Advancement Committee
CRHCC	-	Comprehensive Reproductive Health Care Center
DNCC	-	Dhaka North City Corporation
DSCC	-	Dhaka South City Corporation
FGD	-	Focus Group Discussion
FMIS	-	Financial Management Information System
FP	-	Family Planning
GIS	-	Geographical Information System
IDI	-	In-depth Interview
IP	-	Infection Prevention
ISI	-	Integrated Supervisory Instrument
LGD	-	Local Government Division
LQAS	-	Lot Quality Assurance Sampling
MDG	-	Millennium Development Goal
M&E	-	Monitoring and Evaluation
MMR	-	Maternal Mortality Rate
NGO	-	Non-government Organization
PA	-	Partnership Area
PAHQ	-	Partnership Area Head Quarters
PANGO	-	Partnership Area Non-government Organization
PHC	-	Primary Health Care
PHCC	-	Primary Health Care Center
PIU	-	Project Implementation Unit
PMU	-	Project Management Unit
PNC	-	Post Natal Care
PPP	-	Public Private Partnership
PPM&E	-	Project Performance Monitoring and Evaluation
PRA	-	Participatory Rapid Appraisal
QA	-	Quality Assurance
RTI	-	Reproductive Treat Infection
SC	-	Satellite Clinic
SIDA	-	Swedish International Development Agency
STI	-	Sexually Transmitted Infection
TFR	-	Total Fertility Rate
UHS	-	Urban Health Survey
ULB	-	Urban Local Body
UNFPA	-	United Nations Population Fund
UPHCP	-	Urban Primary Health Care Project
UPHCSDP	-	Urban Primary Health Care Services Delivery Project
VIPP	-	Visualization in Participatory Pregnancy

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 (PANGO) 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.

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 full fledged PPM&E consultant office at Gulshan -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 and 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.

C. Progress of Fifth Quarter (October-December 2016)

5. The Annual Red Card Verification report (1) is completed.

6. The ISI Monitoring report- Round II is completed.

7. The updated final GIS Maps of 25 PA-NGOs are uploaded in UPHCSDP website. PA and Non-PA wise data are being collected, sorted and updated for End line survey and GIS database mapping are in progress.

8. Monitoring of all on-going training programs including selective number of batches as convenient has been continuing.

9. Preparation for ISI Round III survey, Annual Red Card Verification (II) and End line Household survey is progressing.

D. Plan for the Sixth Quarter (January-March 2017)

9. Data collection for ISI Monitoring report- Round II1 and preparation of the report.

10. Data collection for Annual Red Card Verification (II) and preparation of the report.

11. PA and Non-PA wise data collecting, sorting and updating for End line survey and GIS database mapping are continuing. PA wise GIS database mapping will be web enabled in UPHCSDP website.

12. Preparation for End line Household survey.

13. Other activities will be continuing as per schedule.

TABLE OF CONTENTS

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.

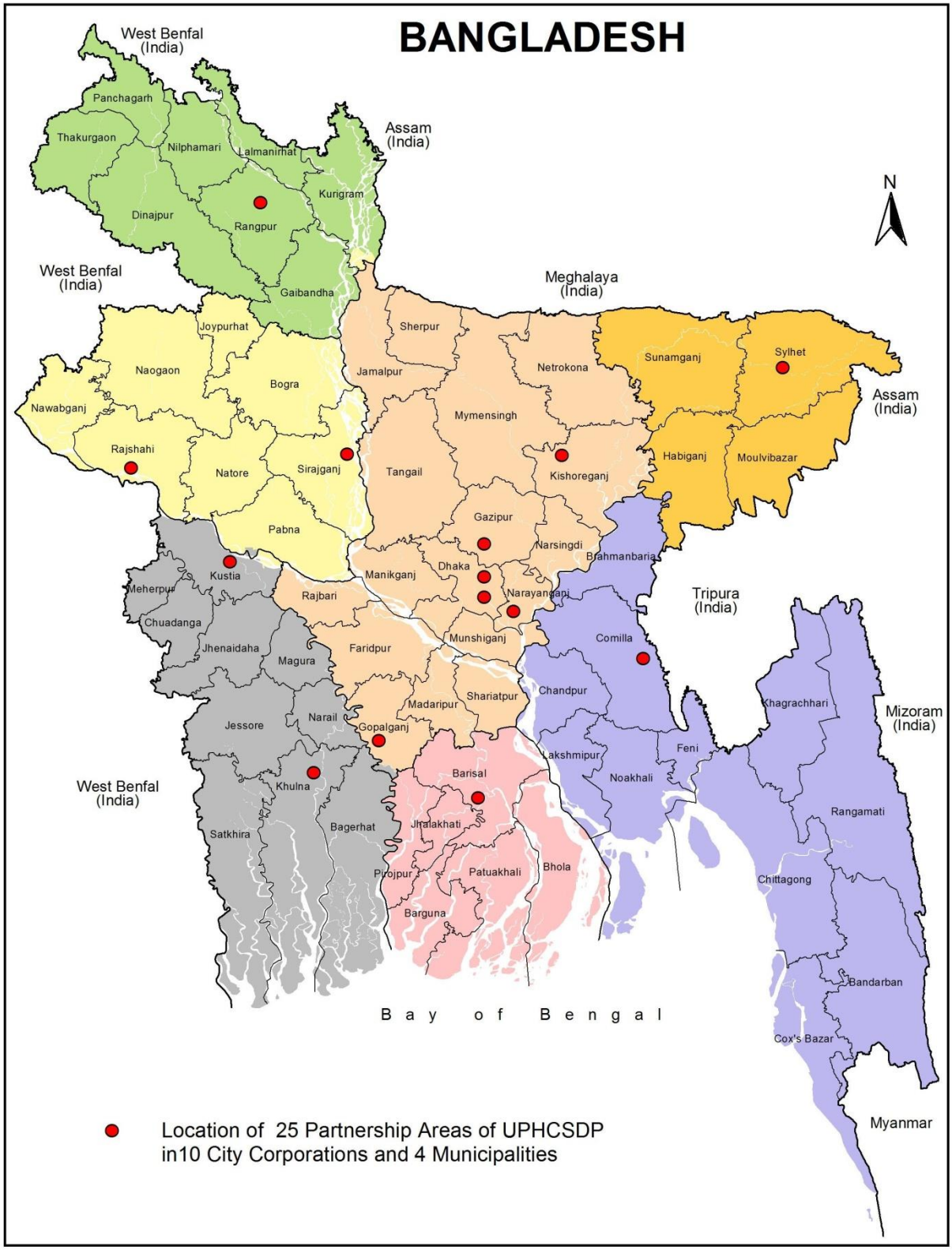
B. The Project

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 Agency (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 Population Fund (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
West Benfal (India)
West Benfal (India)
Assam (India)
N
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
Kustia
Meherpur
Chuadanga
Manikganj
Dhaka
Narayanganj
Rajbari
Jhenaidaha
Magura
Faridpur
Munshiganj
Comilla
Chandpur
Shariatpur
Madaripur
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

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

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

Annual Red Card Verification and Updating 2016

22. The Local Government Division (LGD), Ministry of Local Government, Rural Development & Cooperatives of the Bangladesh Government is implementing the Urban Primary Health Care Services Delivery Project (UPHCSDP) in ten city corporations and four municipalities. The project has started in July 2012 and is scheduled to complete in June 2017. The UPHCSDP is financed by the Bangladesh Government, Asian Development Bank (ADB), Swedish International Development Agency (SIDA), and the United Nations Population Fund (UNFPA). The project is delivering a package of essential services delivery plus services that include comprehensive emergency obstetric care. The target beneficiaries include the urban poor, particularly the women and children of the project area. The project is designed to serve at least 30% of all services to ultra poor and poor recipients free of cost including drugs, and for non-poor at lower costs than market price. The partner NGOs of the project has issued red cards to the ultra poor and poor for entitlement to get services free of cost.

23. The project engaged Eusuf and Associates as the independent Project Performance Monitoring and Evaluation (PPM&E) firm to assist project implementation through monitoring project operating performances including measurement of project impacts, outcomes and outputs. The present report, 'Red Card Verification and Updating 2016', is one of the seven agreed deliverables of the PPM&E firm. 3. The main objective and purpose of the red card verification and updating survey is to verify whether (a) the red cardholder households are residing at their registered addresses, (b) the red cards are issued only to the eligible poor beneficiaries, and (c) the PA NGOs verify and update the red cards at regular intervals ensuring that only the active red cards are maintained in the red card issue registers.

24. The PPM&E firm adopted different approaches for red card verification such as household survey and focus group discussion and developed specific data collection tools. Lot Quality Assurance Sampling (LQAS) technique was used to select households for survey. In the survey, all 25 partnership areas (PAs) were selected for survey and data collected from the sample red cardholder households. Secondary data was collected from master register and red card registers. The record of red cardholder household as of 31 December 2015 was considered for sampling and data collection for verification and updating.

25. In addition to household survey, 25 focus group discussions (FGD) were conducted (one in each partnership area) with three categories of stakeholders (service recipients, service providers, and community) with the participation of 372 persons.

26. Nineteen sample red card households were selected for survey and verification from all the red card holder households per partnership area using Lot Quality Assurance Sampling (LQAS) technique. Location and particulars of sample red cardholder households were collected from red card registers of Primary Health Care Centers (PHCCs). In all, 475 sample households were surveyed from the 25 partnership areas and addresses of all 475 sample households of red card holders are found correct. It is also found that there are red card holders in 362 surveyed households and in the remaining 113 households (24%) there are different discrepancies about the red card holders and issuance of red cards.

27. Among the 113 red card holder households, card holders of 37 households (7.9%) left addresses and their whereabouts are not known, 25 red card holders (5.3%) left the addresses and gone back to their villages, 11 card holders (2.3%) are not available due to demolition of their slums, 28 red cardholders (6.0%) though listed in the register, but did not receive red card yet, and 12 red card holders (2.5%) could not be found at the addresses and the people living at that addresses said that no one in those names lived at the address ever. It is gathered from the survey that the respective PA NGOs did not verify the presence of the red card holders for quite some time since issuing the cards. If there had been periodic verification Annual Red Card Verification and Updating of the red cards and updated the registers the discrepancies could have been totally avoided. Because, those who have left through voluntarily and involuntary migration (15.5%) could be

replaced by new red cards to eligible beneficiaries, 6.0% reds could have been delivered soon after the cards were issued, and the 2.5% cards had been issued to wrong persons could be recitified. Survey findings suggest that one out of every four cards are not actively used.

28. During the survey, 362 households having been found to live at their registered address of which 59.12% are ultra poor, 40.60% are poor, and 0.28% non-poor.

29. The beneficiaries participated in the focus group discussions opined that they were informed of the project services particularly about the free health care services including medicines for the poor through issuing red cards. The participants reported that field workers of PA-NGOs visit households to identify the poor and fill up forms. They also expressed satisfaction with the services provided especially the free health care services through red card. Fewer participants reported that they spent money for some tests and medicines that are not available in the centers. Few participants reported that they incurred cost for travel to reach the centers located far away from their home. In general, the participants reported shortage of medicines, lack of specialized doctors, pediatric complications, lack of X-ray and ultra-sonogram facilities.

30. Feedback of the focus group discussions of service providers indicate that PA-NGOs had personal communication and coordination and network with other health service providing organizations including Bangladesh Rural Advancement Committee (BRAC), Marie Stopes, Government Hospitals, and Medical College Hospitals for referring the critical patients. The participants listed several strengths of the project such as: free services to the poor, services at reduced cost to others, diagnostic services and medicine supply at lower cost, ambulatory services (free for red card holders), and counseling services. They mentioned some weaknesses such as: health facility in rented building, inadequate number of red cards, insufficient supply of medicine, inadequate number of field staff compared to area of operation, and insufficient training for service providing staff.

31. The community leaders reported in their focus group discussion that outreach workers discussed with them and the people on red card explaining the eligibility criteria for getting a red card and the provision of free services and medicines. The community leaders also informed that health service users are happy with the services and the service providers. They suggested to increasing supply of medicines and number of red card, extensive publicity of the project facilities and services in different forms to attract local people to the project health services.

32. The PPM&E experts recommend verification of red cards and updating by the respective PA NGOs on a routine basis and annual stock taking. The PA NGOs should ensure that only the active red cards are counted in the register upon updating and all services to the poor are planned and managed accordingly. All concerned including the UPHCSDP and the respective PA NGOs should appreciate the high rate of urban migration and the issue is addressed through regular verification and updating to ensure that the total number of only the active red cards be at least 30% of all services provided. Timely verification and updating of red cards increase the number of active cards and the scope of maximizing the use of the project health facilities and services.

SECTION IV

ISI Monitoring Report – Round II

33. The Government through the Local Government Division of the Ministry of Local Government, Rural Development & Cooperatives has been providing primary health care services in selected major city corporations and municipalities since 1998. Based on the success of the two earlier projects and on the backdrop of rousing demand for primary health care services particularly from the poor urban population the Government started the on-going 'Urban Primary Health Care Services Delivery Project (UPHCSDP)' from July 2012 in 25 partnership areas of 14 major cities (10 city corporations and 4 pourasavas). The goal of the project is to improve the health status of the urban population, especially the poor and particularly the women and children through providing primary health care services free of cost to poor and at low costs to the non-poor.

34. The Project Performance Monitoring and Evaluation (PPM&E) firm of the UPHCSDP, namely Eusuf and Associates, regularly monitor project outcomes and impact. One of the major monitoring activities is half-yearly performance monitoring in each of the 25 partnership area using same standard Integrated Supervisory Instrument (ISI) developed jointly by the project and the donors. The ISI monitoring is conducted in January and July every year covering overall performance of past six months. The present ISI Monitoring - Round II covered the period January-June 2016 of all 25 partnership areas (included all 25 partnership area head quarters (PA HQs), 25 comprehensive reproductive health care centers (CRHCCs), 113 primary health care centers (PHCCs), and 226 satellite clinics (SCs). The performance of these centers are assessed in terms of the quality and quantity of services and management of the health facilities and service delivery to the beneficiaries over the previous six months

35. In quantitative analysis CRHCCs have achieved 100% and more of their targets in five types of services provided during the assessment period of ISI Round II. The under five child visits in the CRHCCs is the highest (111%) is amongst all services followed by Caesarian Section (110%) and PNC visits (108%). Achievement less than 100% is found in services like couples accepting longer acting and permanent methods (95%), RTI/STI visits (89%) and adolescent visits (86%).

36. It is found that PHCCs have achieved more than 100% of their targets in two types of services provided during the assessment period of ISI Round II. Services for eligible couples continuing a modern method of contraception or to switch over to another method by the PHCCs is the highest (130%) amongst all services followed by diagnostic services (106%). Achievement less than 100% is found in services provided for ANC visits (94%), eligible couples accepting a modern method of contraception (72%), and children receiving complete vaccination at age 9-15 months (68%).

37. The service for client visit is the highest (97%) in satellite clinics, followed by holding of clinics (95%), and clients visited for continuing FP methods (87%). Conduction of health education sessions is found as the lowest (74%).

38. It is found that overall percentage of ultra poor, poor and non-poor service recipients are respectively 49.69%, 48.63% and 1.68%. It is also found that among the red card holder patients received services for normal vaginal delivery and caesarean section delivery are respectively 68% and 72% of all such service recipients.

39. Standard infection prevention (IP) practices are generally followed in all CRHCCs and PHCCs. Presence of physicians, nurses/ paramedics/ midwives, counselors, and receptionists in the health is satisfactory and patients' have easy access to them. It is found that members of 93% surveyed households are familiar with "Rainbow Clinic" as a quality health service center that provides services free of cost to the ultra-poor and at reasonable costs to the non-poor.

40. 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.

41. Average performance of PA HQs ranged from 80 to 130 points (average 114.8 points) and that of the CRHCCs vary from 125 points to 250 points (average 209.8 points). On the other hand the average performance of PHCCs is within 122 to 450 points (average 345.2 points) and that of Satellite Clinic range from 74 to 169 points (average133.4 points). Overall performances of all 25 partnership areas in terms of quality, quantity and management of the service vary from 418 to 987 points (average 806.2 points) out of total 1,000 points.

42. The overall performance of the partnership areas manifests the performance of the project. The overall performance found in the ISI Round II (Jan-Jun 2016) is 80.6% compared to 73.8% found in ISI Round I (Jul-Dec 2015) indicating an increase of 6.8% per annum. Overall performance of 22 partnership area is above 70% (including 14 partnership areas having achieved above 80% points) leaving only three partnership areas below 70% that signifies excellent achievement of the project as of June 2016.

43. The overall performance of the project can be further improved partly by motivating the partnership area NGOs to set realistically higher achievement targets every half-yearly with approval of the PMU.

44. While setting performance targets, the capacity of the partnership area NGO and its existing achievement level, potential of the partnership area in respect of population and health seeking behavior of the people, incidence of poverty as well as the diseases requiring primary health care services, and existence of health care facilities in the catchments area should be considered. The targets so set should be balanced and agreed that can be achieved.

SECTION V

Training on Gender Mainstreaming Health Service Delivery for PMU, PIU, PA NGO Officials

45. Training on Gender Mainstreaming Health Service Delivery sponsored by the Urban Primary Health Care Services Delivery Project (UPHCSDP) was held in three batches at Catholic Bishops' Conference of Bangladesh (CBCB), Dhaka for the PMU, PIU, and PA NGO Officials. The training was organized by the 'Naripokkho'. Naripokkho is a membership-based, women's activist organization working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice. The duration of training was for 3 days and it was conducted in three batches in the same venue. The first batch of the course was held from 12th to 14th November, second batch from 15th to 17th and third batch from 19th to 21st November 2016.

1. Objectives of the Course

46. At the end of the course the participants will:

- have clear conception about the gender mainstreaming in the health service delivery
- have better understanding about disparities among different sections of the society in the health sector
- be able to involve themselves in ensuring need based health service
- get some idea about different aspects of women's health

2. Participants

47. Participants in the course comprised of Project Management Unit (PMU), Project Implementation Unit (PIU)) and PA NGO officials of UPHCSD Project. Number of participants in each batch was 30.

48. Types of participants included, Sr./Program Officers of the PMU, Program Officers and Monitoring & Quality Assurance Officers of the Project Implementation Unit (PIU) of the 14 City Corporations and Municipalities under the project, Project Managers, Clinic Managers, Family Planning Coordinators and Counselors of PA NGOs.

3. Course Contents

49. Major contents of the course were:

- Sex and Gender
- Economic condition and social status of women
- Health rights of women
- Gender sensitivity and accessibility of women in health service systems
- Easy availability of health service and creating congenial environment for receiving health services
- Basic facilities of Hospital and probable acts for ensuring quality services
- Health services for women affected by act of violence
- Removal of barriers to receive right based and standard health services
- Different health related policies of the government
- Programs and initiatives of the government in the health sector
- Actions for creating accountability of service providers

4. Findings of the Monitoring

- *Venue:* Catholic Bishops' Conference of Bangladesh (CBCB) at Asad Avenue, Dhaka was used as the venue for all the three batches of training on 'Gender Mainstreaming in Health Service Delivery' facilitated by the **Naripokkho**. The venue was easily accessible to the participants. Training room was spacious, having sufficient light and fully air-conditioned.

- **Seating Arrangement:** Training room was designed as per requirement of a participatory training. It was U-shaped, having comfortable chairs. Room was decorated with some posters displayed on the wall.

- **Resource Persons:** In the course very limited number of Resource Persons (four/five) were used, all of whom were from the Naripokkho. In each batch, there were changes of some resource persons, however, Course Coordinator, remained static.

- **Training Materials/Tools Used:** In most of the sessions Multimedia was used for presentation. Besides, VIPP cards, posters and handouts were used.

- **Training Methods**: To make the training useful and attractive Resource Persons/trainers mostly used group work followed by presentation and discussions.

- **Quality of Presentation and Nature of Participation:** Trainers of the course were all members of the women's activist organization and regular trainers. They were found quite comfortable to present their respective topics in a professional manner. Sessions were made highly participatory by the trainers.

- **Evaluation of Participants:** Pre-training evaluation was done to evaluate the level of knowledge of the participants using a structured question paper during the opening day of the course and a post training evaluation was done on the closing day using the same set of question paper to measure the improvement in the level of knowledge of the participants.

50. To receive feedback from the participants about the course, participants of all the three batches were interviewed on the last day of the training. Combined feedbacks were as follows:

- Relevancy of the Course: All the course participants said that the course objectives were 'Relevant' to their profession. All of them felt 'Satisfied' with the contents of the course.

- **Relevancy of the Training Materials Used:** All the participants could mention the training materials used in the course. They mentioned Multimedia, VIPP Card and Posters. They expressed that the training materials used were 'Relevant' with the course content.

- **Training Method and Nature of Participation:** Participants mentioned that, the training methods used by the trainers were mostly group work, presentation and discussion. All the participants stated that the extent of participation in the group works were 'Very Good'. They also mentioned that the degree of participation in the training sessions were 'Good'.

- **Overall Impression about the Course:** Participants of all the three batches expressed their liking for the course. As regards organization and management of the course, all of them mentioned 'Good'.

- **New Knowledge and Skills Acquired:** All the participants mentioned that they acquired new knowledge after attending the course. When asked to mention some of the new knowledge gained, most of the participants mentioned, 'Different health related policies of the government'.

5. Comments and Suggestions

- Participants expressed their satisfaction with the course, as 'Violence Against Women' being one of the components of the project was highly relevant to their job.
- Resource persons being women's rights activists and regular trainers were quite proficient in handling the experienced participants.

- Resource persons applied participatory method of training in such a way that the participants were kept fully engaged throughout the day. However, to some of the participants continuously conducting sessions throughout the day by some speakers was monotonous.

6. Concluding Remarks

51. Participants of the course were from different levels of the PMU, PIU and PA-NGOs of the project. They appreciated the contents of this course and suggested that intensive training on this topic should be given to front line staff of the PA-NGOs, particularly, Counselor, Supervisor, FWA and FWV. They were also satisfied with the overall management of the course.

SECTION VI

FEATURES OF GIS MAPS

52. The GIS map of each of the partnership area consists of the following features:

a. Partnership Area-PA Final Map showing Administrative Units
- City / Municipality Boundary
- Ward Boundary
- Mohalla Boundary (only for DNCC and DSCC)
- PA Boundary

b. Urban Health facilities (UPHCSDP)
- CRHCC- Comprehensive Reproductive Health Care Center
- PHCC-Primary Health Care Center

c. Other Health facilities
- Govt. Hospitals (Sadar Hospital, Govt. Medical College Hospital, MCWC and Others)
- Private Hospital (Major Hospital and Private Medical College and Hospital)
- Other Major Health Care Center (Major Private and NGO Health Care)

d. Landmarks
- City Corporation , Municipality, Police Station and Govt. office
- Utility Service Center – Fire Service, Water Pump/Tank and Electric Power House.
- Education Center – School, College, University and Madrasa
- Social Center– Hat, Bazar, Market, Park, Theme Park, Community Center, Club, Eidga, Graveyard, Play Field, Open Space, Ghat, Railway Station, Bus & Launch Terminal and Airport.
- Religious – Mosque, Mazar (Shrine), Temple, Church and Tomb.
- Industrial – Garments, Jute, Textile, BSCIC Area and others.

e. Communication

f. +

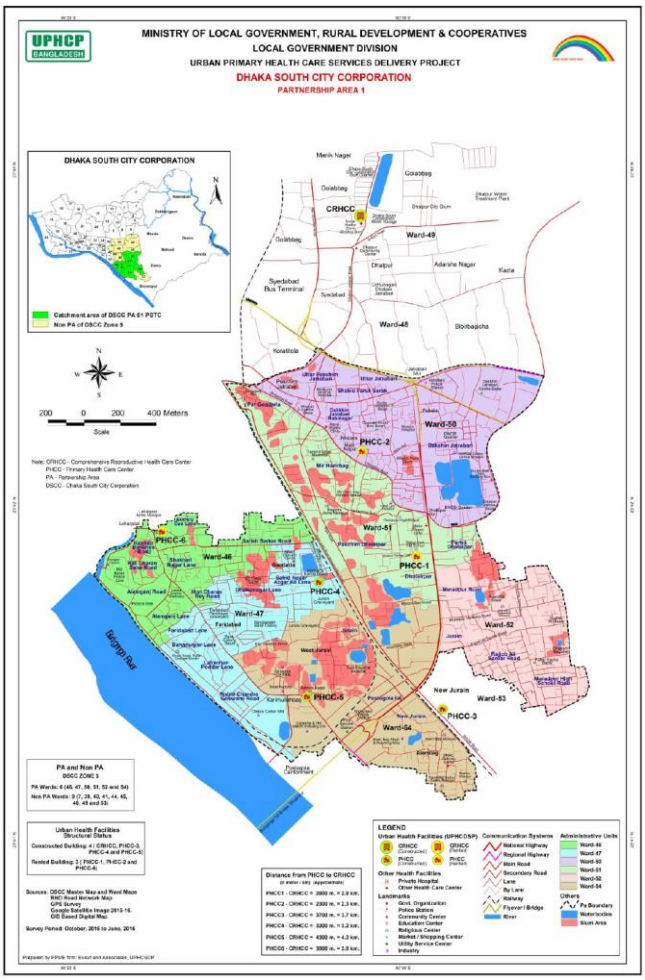
Other features
- Slum Area – Dwelling place for poor and ultra poor.
- Water-bodies – Pond, Ditch, Very Low land and Water logged Area

g. Distance: by Road (in meter/km.) (Approximate)
- From PHCC to CRHCC

h. PA and Non PA within City and Municipality
- Catchment Area / Services Delivery Area of PA
- Non Services Delivery Area of Non PA

i. Structural Status of Urban Health Facilities of PAs
- Constructed Building
- Under Construction Building
- Rented Building

A sample of final GIS Map of Partnership Area (PA)



A. Deliverables

53. The final GIS Maps have been prepared incorporating all suggestions from the PA NGOs, PMUs and PIUs. The maps are available in UPHCSDP website as JPEG format. The requirements are given below:

- GIS database and Mapping of 25 Partnership Areas will be Web- enabled (in progress)

Future plan as per PMU's requirement

- GIS database and Mapping will be linked to the HMIS, ISIs and End line surveyed data
- PA and Non-PA wise GIS Spatial and attribute data would be used for analytical maps and Google Earth kmz file
- The GIS database and mapping will be updated and developed by end of the project.

B. Conclusion

54. GIS database produces not only Static Map also has power to generate Dynamic, Web-enabled and Inter-operability, analyzing and modeling, planning, manipulating and managerial decision. GIS based Spatial and Non-Spatial data will be linked to HMIS and used on Google Earth. Health facilitators and decision makers can oversee the Partnership Area and location of urban health facilities using GIS database and PA's coverage map for taking necessary steps to review their catchment area.

SECTION VII

Manpower Resources

55. 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 5th QTR**
Team Leader (Performance Monitoring & Evaluation Specialist)	Prof.Dr.Md.Nurul Islam	22	3
Public Health Management Specialist	Dr. Md. Alamgir Hossain	14	3
Sociologist	Mr.Kazi Bazlul Karim	20	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

SECTION VIII

Plan for the Next Quarter

56. 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. The end line survey and project impact study due to take place after the close of the project in three months (20, 21& 22th (April- June months 2017).

57. The PPM&E firm has few activities of the last quarter that will continue through the next quarter (January- March 2017), few activities limited to the next quarter only, and few other activities that will continue further to the sixth quarter. The planned activities of the follow –up quarter (January- March 2017) as at table 8.1.

Table 8.1: Planned Activities of Quarter 6

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 & 3rd																						
Health Facility Survey Report																						
Training Evaluation Assessment																						
Annual Red Card Verification																						
Preparation of Final Report																						
Project Endline Evaluation Report																						

Legend

Planned
Actual
Intermittent