Sida Evaluation 07/39

Swedish Support to the Menstrual Regulation Program of Bangladesh

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Asia Department

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Dr. Z A Tahmina Sarker Nazme Sabina

List of Acronyms

ADCC	Assistant Director Clinical Contraception
AFLE	Adolescents Family Life Education
ANC	Ante Natal Care
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BWHC	Bangladesh Women's Health Coalition
BAPSA	Bangladesh Association for Prevention Of Septic Abortion
CCMRA, B	Coordination Committee for MR Agencies in Bangladesh
CT	Copper-T
D&C	Dilatation and Curettage
DFP	Directorate of Family Planning
DDFP	Deputy Direction Family Planning
ESP	Essential Service Packages
FWA	Family Welfare Assistant
FP	Family Planning
FPI	Family Planning
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
HIV/AIDS	Human Immunodeficiency Virus/Acute Immunodeficiency Syndrome
HNPSP	Health Nutrition and Population Sector Program
IRG	Iso-Resource Group
IP	Infection Prevention
ISO	International Organization for Standardization
IUD	Intra Uterine Device
MIS	Management information System
MR	Menstrual Regulation
MCH	Maternal and Child Health
MFSTC	Mohammadpur Fertility Services and Training Center
MO-MCH	Medical Officer-Maternal and Child Health
MO-FW	Medical Officer-Family Welfare
MOHFW	Ministry of Health and Family Welfare
NIPORT	National Institute of Population Research and Training
PNC	Post Natal Care
RH-CH	Reproductive Health – Child Health
RTI/STI	Reproductive Tract Infection/Sexually Transmitted Infections
TT	Tetanus Toxoid
SACMO	Sub-Assistant Community Medical Officer
SBA	Skilled Birth Attendant
Sida	Swedish International Development Cooperation Agency
SRH & R	Sexual and Reproductive Health and Rights
TBA	Traditional Birth Attendants
UHFPO	Upazila Health and Family Planning Officer
QOC	Quality of Care
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection by Acetic Acid
VHSS	Voluntary Health Services Society
WHO	World Health Organization

Executive Summary

In Bangladesh, 14% of maternal death occurs due to unsafe abortion. Annually around 730.000 pregnancies are terminated in Bangladesh. Menstrual Regulation (MR) is a recognized interim method of establishing non-pregnancy for a woman who is at risk of becoming pregnant. It is nationally approved procedure and performed by skilled providers during the first 6-10 weeks of amenorrhea.

Sida has been supporting the MR program as part of its parallel funding to the HNPSP through NGOs. The NGOs are: Bangladesh Association for Prevention of Septic Abortion (BAPSA), Bangladesh Women's Health Coalition (BWHC), and Reproductive Health Services, Training and Education Program (RHSTEP). They deliver and promote sexual and reproductive health and rights (SRHR) services and capacity building with a focus on MR. The Swedish financial support for 2004-07 was explicitly linked through unit costing to results and performance based targets.

Sida considers extending financial support to the NGOs until end of the HNPSP. The evaluation is planned in the project and its findings will assist Sida and partner NGOs to ensure improvement of the program. The major objectives of the evaluation are:

a. Analysis of target achievement according to the project documents;

b. Assess status of coordination mechanism of the MR program;

c. Analysis of basic performance elements as defined in the MOU and the unit costs;

d. Analysis of the service delivery from the poverty perspectives;

A two-member team of consultants (a public health specialist and a Health Economist) was assigned by the SIDA to perform the evaluation. Seven sites were identified based on one year performance taken randomly and information was collected from sites using a set of tools. Performance assessment was considered 30 months period out of 36 months.

Methods of the evaluation included review of relevant documents, interview of officials of the Directorate of Family Planning, development partner (Sida officials), NGOs leaders providing MR services, professional body, managers, service providers, headquarter staff of three NGOs including NGO management with committee members. The methods also included observation of clinic and field activities, and review of records. Exit interview of clinic clients, group discussion with married women and adolescents at the community level, male and female students at the schools and interview with school authority are also part of the methods.

It is observed that all the three NGOs have performed close to their targets set; some targets are overachieved. Several factors influenced achievements. Those include physical infrastructure, location of clinic, availability of appropriate and skilled human resources, cooperation of the government counterpart, BCC strategy of individual organization targeting appropriate groups, quality of care, effective liaison with the Directorate of Family Planning for training program, monitoring and supervision system of individual organization including medical technical supervision, record keeping and reporting. Factors that hinder achievements are mainly weather conditions, natural calamities like, flood and political unrest sometimes put barrier to achieve some of the element of the program. Entrance of other service providers in the working area is a challenge to some clinics of the NGOs.

The evaluation found that NGOs are capable of performing MR services, MR training and other reproductive health services. Some activities are very important to play a role in dissemination of

information related to maternal mortality and unsafe abortion through the grass-root level public sector health staff by organizing orientation on the issue to them. Some areas have scope for improvement. Those are: developing a uniform full blown MR curriculum, trainee follow up as part of training program, refresher and some basic training for clinic staff including clinic manager, appropriate BCC strategy and activities, complying with national standards and clinical guidelines on health and family planning including clinical guideline on MR, updating existing guideline that was developed by NGOs, improving environment for interpersonal communication at clinic level, use of appropriate human resources and all other components of quality of care.

It is recommended that NGOs should follow guidelines to provide quality services in all aspects and assess their strengths and opportunities to expand the good practices and program components to other places.

Coordination among MR services providing NGOs is very important as some decision and action should be taken on emerging issues. Strengthening of the coordination body of NGO such as Coordination Committee for MR Agencies in Bangladesh (CCMRA, B) should be proactive in bringing the MR NGOs in a platform and coordinate activities among themselves. High level government representative should be involved in the CCMRA, B meetings for ownership of this national program. MR Consortium is a functioning coordinating body among the Sida supported NGO. Annual performance review of Sida done yearly in presence of partner NGOs is an effective way of coordination.

NGOs introduce service charge or user fee for sustainability and cost of the organization. The money accrued from service charge is deposited into a separate account of specific NGOs. They also have full or partial exemption rules, and the basic rule is that none shall be denied services because of inability to pay the stipulated fee.

At the clinic level, the counselor or assistant counselor of the clinic is primarily responsible to identify the poverty status or socio-economic background of a client by asking information about income, expenditure, household member composition, asset, appearance, and area of residence. Ultimate provision of free service depends on 'best judgment' of herself, clinic manager, medical doctor, and for RHSTEP clinics, the Technical Advisor as well. However, the number of poor people treated in the clinics is not incorporated in the current reporting system of the MIS of NGOs. The NGOs should establish a specific strategy or mechanism to serve a fixed proportion of poor and ensure safety net for the poor.

The service charge of MR is based on the pre-medication: higher charge for with pre-medication and lower charge for without pre-medication. According to the service providers of all NGOs, clients of lower socio-economic status can not afford the price of MR with pre-medication, so they prefer MR without medication which causes pain. However, if any client is unable to pay charge for MR without pre-medication, she is partially or fully exempted. It is recommended that the delivery of MR services should not be differentiated on the basis of price and pain. The clients should be treated (for example, uniform medication for pain control) equally regardless of their ability to pay. The NGOs should take a strategy to provide 'with pre-medication' services to all clients if there is a practice exists of providing pre-medication for MR.

The reasons for selecting the NGO clinics are: cheaper services than private alternatives; maintaining confidentiality; high level of previous client satisfaction; geographical location of clinics. However, full fee exemption practice in the clinics is not known to all community. The field workers of the NGOs should ensure the community regarding important issues, such as, practice of exempting people who can not afford the fees, referral system, etc.

The strength of unit cost is that performance of a service can be measured as how much is spent to provide one unit of specific service. However, it does not consider the inflation rate incurred over the

years. Moreover, there is a need of revisit of unit cost of several IRG categories such as, RTI/gynae interventions, safe delivery, child health and maternal health. All NGOs should have a clear conception regarding the reimbursement mechanism, possible areas of utilization from income or service account, etc.

At the centre level, the NGOs can take several steps: a) create an emergency account for crisis management; b) revisit service charges specifically in the urban setting in line with similar services given by different NGOs and/or funded by other agencies; and c) explore cost-containment strategy.

Sida can also play an important role to strengthen the support as well as performance of the program during next phase. These are: a) to ensure poor-focused services; b) to emphasis on quality of care of services and MR training; c) to revisit unit cost of several categories and explore other funding options; and d) to ensure uniform financial and performance reporting system of NGOs.

1. Introduction

In Bangladesh, complications from unsafe abortion is one of the leading causes of maternal mortality. About 25% of the pregnancies are reported to be unwanted.[1] The World Health Organization estimates 14% of maternal death occurs in South Asian countries including Bangladesh due to unsafe abortion[2]. Maternal mortality ratio in Bangladesh is 3.8/1000 live birth (WHO statistics 2000) It has been estimated that annually 730,000 pregnancies are terminated in Bangladesh (262,000 induced abortions plus 468000 MRs).[3] Contraceptive prevalence rate in the country is 54% (47% modern methods) among the eligible couple.[4] There is unmet need of contraceptives and also due to method failure unwanted pregnancies results and many among those seek to terminate pregnancy. Using manual vacuum aspiration menstrual regulation (MR) is 'one of the safest medical procedures when performed by trained health care providers with proper equipment, correct technique and applying universal precautions for infection control'. MR is a recognized interim method of establishing non-pregnancy for a woman who is at risk of becoming pregnant. Whether or not she is in fact pregnant is no longer an issue[5].

Sida is supporting the MR program being implemented by NGOs as part of its parallel funding to the HNPSP of the Ministry of Health & Family Welfare in Bangladesh. From Swedish support, three NGOs, Bangladesh Association for Prevention of Septic Abortion (BAPSA), Bangladesh Women's Health Coalition (BWHC), and Reproductive Health Services, Training and Education Program (RHSTEP) deliver and promote sexual and reproductive health and rights (SRHR) services and capacity building with a focus on MR.

The Swedish financial support was explicitly linked through unit costing to results and performance based targets. The major objectives of the evaluation are:

a. Analysis of target achievement according to the project documents;

b. Assess status of coordination mechanism of the MR program;

c. Analysis of basic performance elements as defined in the MOU and the unit costs;

d. Analysis of the service delivery from the poverty perspectives;

Methodology

A two-member team of consultants (a public health specialist and a Health Economist) was assigned by the Sida to perform the evaluation (ToR attached in appendix 1). Data was collected from seven sites using a set of tools. Data collected was considered for 30 months (July 2004–December 2006) out of 36 months. The current project period started in July 2004 and will be completed in June 2007. During the sites visit GOB counterparts at different level were met and discussed about services provided by the NGOS. At least one full day was dedicated for one site.

[1] Post Abortion Care: Technical Standard and Service Delivery Guideline-Developed by the Directorate of Family Planning and EngenderHealth BCO, June 2002

[2] Post Abortion Care: Technical Standard and Service Delivery Guideline-Developed by the Directorate of Family Planning and EngenderHealth BCO, June 2002

[3] Bangladesh National Strategy for Maternal Health, October 2001

[4] Bangladesh Demographic and Health Survey 2004

[5] The Institute of Law Report 1979

The evaluation has been done using the following methods:

a. Review of relevant documents (Listed in appendix 2)

b. Interview of officials of the Directorate of Family Planning

c. Interview with Development Partner (Sida officials)

d. Interview with NGOs leaders providing MR services

e. Interview with professional body

f. Observation of clinic and field activities and records

g. Interview of Managers, Service Providers

h. Interview of clinic clients, married women at the community level, adolescents, school authority

i. Separate discussion meetings with headquarters staff of three NGOs including NGO management with committee members

All the persons interviewed are listed in appendix 3)

Method sample selection and process of data collection

Based on high and low performances, two clinics were identified for BAPSA two clinics for BWHC. For RHSTEP, selection criterion was based on high, medium and low performances and three clinics were selected. High/medium/low performance was determined considering performances of MR done by individual organization during the project period. Selection of sites was consulted with individual NGOs.

Based on above criteria seven clinics were selected. Those are

Name of NGO	Sites identified	Performance
BAPSA	1. Model Reproductive Health Clinic-1, Mirpur	1. High
	2. Model Reproductive Health Clinic-5, Gazipur	2. Low
BWHC	1. Polash Clinic	1. High
	2. Zokiganj Clinic	2. Low
RHSTEP	1. RHSTEP Clinic at Khulna Medical College Hospital	1. High
	2. RHSTEP Clinic at Sylhet MAG Osmani Medical College Hospital	2. Medium
	3. RHSTEP Clinic at Bogra Shahid Ziaur Rahman Medical College and Mohammad Ali Hospital	3. Low
Total	**7 sites**	

2. Analysis of Performances and Target Achievements

2.1 BAPSA

Bangladesh Association for Prevention of Septic Abortion (BAPSA) formed in 1982. Its mission is to improve the reproductive health and wellbeing of the society through providing quality reproductive health services and create an enabling environment for improving the quality of life of the underserved and rural population.

BAPSA has been implementing its project "Reproductive Health Care Services and Prevention of Unsafe Abortion and Complication Management". The project is being supported by Sida since July 2004.

The organization has total six clinics under this project: three urban clinics in Dhaka, one in Gazipuir, one rural reproductive health clinic at Begumganj, Noakhali, one miniclinic at Kamrangir Char in Dhaka and one adolescent health mini-clinic at Duaripara, Mirpur in Dhaka.

Services offered

At HQ level

- Training. Refresher-FWV/Paramedic
- Maintaining liaison with the Directorate of Family Planning and NGOs in organizing Training
- Monitoring MR Kit distribution
- Monitoring QOC of MR services
- BCC: Orientation of FP frontline Worker of Family Planning Directorate
- Publishing MR Newsletter quarterly

At Clinic/Branch level

- MR Counseling & MR Perform
- Post MR Contraception
- Management of Abortion Complication
- MR BCC
- Adolescent SRH & R BCC
- RTI/Gynecological Interventions
- ANC
- PNC
- Family Planning Services
- Child Health/Maternal Health &, LCC

Mode of service delivery at clinic/branch level

- Clinic based services
- Community based program

Human resources

BAPSA has different staffing pattern at different level of service delivery outlets based on need. There is a Project Coordinator position at Begumganj center but other centers have no such position. Medical Officer of a clinic is supposed to be clinic manager who is responsible for clinical services as well as administrative matters. Some key positions are vacant like doctor, Field Supervisor at some centers. Number of Service Promoters ranges from 3-6 based on area coverage. In adolescent program at Mirpur there is a position of an Adolescent Health Supervisor and three health Educators. Position of Pathology in-charge is based only at HQ clinic where training of service providers is being conducted.

At headquarters level there are two Monitoring Officers and two Assistant Monitoring Officers. A Training Coordinator based is responsible for training activities. An Office Manager and a MIS Assistant also are based at HQ. Director of BAPSA look after overall program activities and also develop programs and an Advisor provide supports to programs. It was observed that there is nobody as medical technical supervisor at headquarters level who can oversee the clinical activities in-depth and can provide support to the program.

Staff development plan is another issue that BAPSA needs to consider. Some clinical staff in fact need refresher training focusing on attitudes, counseling and technical issues. Clinic Assistants at some places have little idea on infection prevention practices. Waste disposal is another important element of IP practices that is neglected due to lack of awareness of support staff that needs supervision.

Recommendations

Ensuring quality of care

BAPSA should consider appointing a medical technical personnel with some public health experience as Monitoring Officer (Clinical) who can oversee all branches' clinical activities specially relating to quality that encompasses: ensuring enabling systems (policy, strategy, resources etc.), infrastructure, exercising policy guidelines and service protocols, access to information and services, affordability, technical competence of providers, interpersonal communications, appropriateness of services, comfort, safety of clients as well as of clinic staff, privacy and confidentiality and continuity of services offered through clinics. Other monitoring officers can look into the quality of field services especially BCC related issues and organization of field services. The funding agency may consider the matter of technical assistance by a medical technical professional in BAPSA HQ team in subsequent phase of the program.

Performances

Performances achieved during July 2004 to December 2006

Sl. #	IRG #	Component	Target	Achievements	Percent achieved %
1	1.a	Training. Refresher-FWV/Paramedic	130	96	74
2	2a	MR Counseling	21670	18976	88
	2a	MR Perform	20122	17840	89
	2b	Management of Abortion Complication	1596	1804	113
3	3	Post MR Contraception	19346	16669	86
4	4a	MR BCC	277476	300691	108
	4b	Adolescent SRH & R BCC	49968	59251	119
	4c	MR Newsletter	130000	78400	60

5	5A	RTI/Gynecological Interventions	36116	35089	97
6	6b	ANC	10583	12738	120
		PNC	6230	4862	78
		FP	22584	26262	116
7	7	Child Health/Maternal Health LCC	39604	78621	199
8	Non-IRG	Maintaining liaison & Organizing Training	1325	2527	191
		Monitoring MR Kit distribution	843	711	84
		Monitoring QOC of MR services	761	537	71
		BCC: Orientation of frontline Family Planning Government Workers (FWA, FPI)	5500	4112	75

Source: BAPSA Annual Report2004–2005& 2005–2006 and 6 monthly report July–December 2006

Analysis of performances

There are some components that are fully achieved, some are overachieved some are closely achieved to target set. After discussing with service providers, clients and headquarters officials it is understood that following factors influenced achievements:

Recommendations

Child health/maternal health/LCC and Liaison contact targets and other elements of services that are being overachieved, need to revisit and to put realistic and achievable figures during planning for subsequent phase. This needs a planning exercise in the organization bringing all level of staff and consult with them.

Favorable factors of achievements

- Attendance of Trainees has been within satisfactory level. Probably it is due to issuance of additional 25% call up notices than the desired number of trainees
- District level Authority of FWVs are personally communicated over telephone as reminder
- Token given for client satisfaction and easy client flow
- Good behavior of clinic staff
- Less waiting time at clinic
- Greetings at clinic by service providers
- Good relationship with GOB in getting supply of equipment and commodities
- Marketing strategy: BCC at community level & referral card distributed to local pharmacies

Barriers of achievements

- Number of trainees are less due to their physical condition like pregnancy, other illnesses
- Gap in dissemination of information to target group
- During the month of Ramadhan there is less client load
- Weather conditions (Rainy season, flood)
- Seasonal drop of performance (July–Aug)
- Political program hampered client movement
- Entrance other providers in the market

Critical observations and recommendations on performance elements

Service delivery

It is observed that clients are dealt with different standards of services according to different payment structure (details are in chapter-IV). Cost of MR, provided with pre-medications to relief pain are much more than normal MR. Cost of medicines that are being used for pain control (list of medicines that are being used for pain control in appendix 4) are not that expensive. The MR procedure is painful to certain clients who are not able to provide additional cost of painkilling medicines to be provided before MR. It is also observed that there is no uniformity of medicines given (painkillers alone or given with tranquillizer) clinic to clinic.

Service providers are following clinical guidelines and following the standard of performing MR within stipulated time. The clinical guideline is developed by BWHC few years back. Sometimes they perform MR on bigger size of uterus that is not supposed to be done. Clients are asked to do laboratory tests if needed, e.g if the client having history of jaundice and icteric, serum billirubin is done, urine for routine examination is done if there is problem and hemoglobin is done if a client found anemic. Blood grouping is rarely being done. Charges for laboratory tests are collected from clients. Some clinics are performing pregnancy tests routinely. At some places clients are referred to nearby diagnostic centers for doing laboratory tests as there is such no facilities in that clinic. Emergency medicines are found and kept in the procedure room. Some clinic does not care to keep the emergency medicines in good place and in an organized manner. Label on the emergency medicine box/tray with dates of expiry so that they can have a look at a glance to check is also not found to some clinic. Torch light is not available in a mini-clinic where load-shedding is a regular matter and performing MR in that clinic is not easy as the procedure room is very dark without artificial light. Charger light does not serve the purpose as the clinic staff referred its availability in the clinic for the purpose in case of load-shedding.

Pre and Post MR counseling are sometimes inadequate. Opportunity to counsel husband is also missed in some cases although it is an important element of counseling of MR services; moreover, counseling on post MR contraceptives are done during that time. Advices are given during discharge after MR and provided with a pictorial brochure. Breech of privacy during counseling was observed.

Recommendations

There must be uniformity in pre-medication for all types of MR clients irrespective of economic status. Post-MR medication could vary as it depends upon the conditions of uterine cervix and case by case. Unhealthy condition of cervix of uterus need appropriate medication and treatment should not be limited to clients; treatment of husband needs to be provided for some cases. It is recommended to standardize & revise clinical guideline that include all the aspects of MR, Post MR services, follow up and complication management and include additional chapters on RTI/STI, IP practices and other related issues under the reproductive health. Training of staff on those issues after update must be provided.

Blood grouping should be done before MR to screen negative blood group. There could be client who is having her first pregnancy (Primae-gravida) or women having one child willing to perform MR. They are supposed to bear pregnancy willingly in future after some gap. So all facilities should have blood grouping facilities and do it routinely. If negative blood group is found the client needs to be provided with immunoglobulin after MR. The clinical guideline must explain the issue and training must focus on it in future. Some clinic practices doing pregnancy test mandatory before MR which should not be in practice and that confirms pregnancy and against the legal issue of MR. All the NGOs under this project should have a uniform standard operative procedure (SOP) and guidelines so that standard o services would not vary across the clinics and across the NGOs. Related government authority could take the initiative to revisit the set of standards being used by the NGOs concerned. Internal monitor

ing and supervision is also a necessity. Privacy and confidentiality must be maintained for quality assurance in reproductive health care facilities.

Training conduction

BAPSA has been conducting 6-day MR Refresher Training. The organization has been using the curriculum that is developed by three NGOs which is mere a compilation of schedule and service delivery manual. It is not a set of curriculum. It does not have trainers' manual and as such, training standard varies across the NGOs and within a NGO as training classes are being conducted by different resource persons (government resources like FWVTI Principal and Program personnel of RH-CH Directorate of DGFP office and others). Practical sessions are conducted in the clinic of BAPSA at the same premise of class room training venue. BAPSA has accommodation facility for trainees at headquarters. Necessary equipments of training conduction are available in the classroom and client load of MR for trainees are sufficient for practical training conduction. Didactic part of training puts additional efforts on counseling session. Handouts related to septic abortion are distributed to the trainees in addition to the service delivery manual of MR. Trainee follow up of BAPSA trained trainees has not yet been arranged although it is a component of training.

Number of trainees is getting lesser day by day as a number of FWVs have gone into retirement and few others left their job. *It is to be noted that GOB has suspended recruitment of FWVs.* Medical Officer-MCH recruitment is also stalled.

Recommendations

Ministry of Health & Family Welfare should consider acceleration of the process of recruitment of MCH and family planning clinical service providers and their training. Pre-service training of FWVs needs 18 months and after placement at different posts, in-service training is being arranged. All the process need close to two years. *So the MR training institutions have to wait until then for organizing & conducting Comprehensive course for FWVs specifically.* During this period of gap alternate cadre can be thought out and that could be Nurses of UHFPOs and District Hospitals and other potential cadres but not SBAs as they are not trained to provide intra-uterine procedures[6]. Refresher courses also need to have a standard that how often it would be offered to update trainees. It is known that NIPORT has been reviewing its FWV curriculum that has opportunity to revisit the module on MR so that newly recruited trainee FWVs get hands on training on MR procedure.

A standard set of MR training curriculum that is available from many sources could be adapted for the NGOs in our country perspective. Curriculum must be uniform across the MR training institutions in next phase. An ISO certification of MR training should be introduced with strict follow up and re-accreditation at regular intervals to ensure quality of care and standard of service delivery[7]. MR training should also be introduced by government training organization like MFSTC. Private or other NGO participants should be considered in the training as more the service providers on MR are available; more prevention of unsafe abortion could be achieved. At the same time BCC on contraceptives use, thereby prevention of unwanted pregnancies should be focused in the training so that service providers would be unbiased to MR Service. Trainee follow up should be done as part of the training activities.

[6] Recommendation by leaders of Reproductive Health community in Bangladesh
[7] Recommendations in MR Newsletter March 2006

MR newsletter and distribution

BAPSA has been publishing the MR newsletter in two versions: English and Bangla. Purpose of publishing the newsletter[8] is:

1. To sensitize public opinion on the consequences of septic abortion
2. To provide updated knowledge and technical guidance to the service providers in order to facilitate improvement of quality of services
3. To highlight MR training needs among the potential providers of MR

The newsletter sometimes comes out four-page volume but usually it is two-page volume. Contents of the newsletter is target group oriented as it publishes articles that attract technical personnel but sometimes it publishes elaborated reports that cover the entire edition. It also publishes other areas of reproductive health during the project period like adolescents health related issue, violence against adolescent and other issue related to BCC activities and Infection Prevention procedures in MR services. Regarding the title of the newsletter, renowned reproductive health professionals suggested to keep the title of the newsletter as it is. Field level personnel expressed usefulness of the content of the newsletter that provides them updated information related to MR and some other reproductive health issues, however, they do not share the newsletter to common people as stigma is attached to MR. BAPSA sends the newsletter to reproductive health service providing organizations and individuals at home and abroad according to a list of recipients prepared by BAPSA.

Recommendation

MR newsletter should have an editorial board that should provide assistance to publish the newsletter in time. Editorial board should decide the contents and design of the newsletter and updating list of recipients. There could be a readers' corner to have opinions/remarks on published issues. BAPSA must ensure reaching the newsletter to the MR and reproductive health services providing individuals/organizations in country and abroad and then to other stakeholders. In the meeting of CCMRA, B the issue could be discussed for proper direction/suggestion by the member organizations.

Training liaison

Government doctors and FWVs/SACMOs training liaison is done by BAPSA. BAPSA has been nominated to prepare a training database of the DFP clinical service providers (FWVs and SACMOs, MO-MCH and MO-FW) in the country. Accordingly, the providers who did not receive Comprehensive or Refresher training and interested to have the training are selected primarily and a list is made. The list is sent to the office of the Director-MCH services and the Line Director (RH-CH) where verification and final selection of the list is done. The list is then sent to the Directorate of Family Planning for issuing call-up notice for the trainees to be trained. After issuance of call up notice it is communicated with RHSTEP and BWHC. Moreover, DDFPs are communicated personally to ensure attendance of trainees in time; although they officially receive a copy of call up notice from the Directorate. Trainees get conveyance from the GOB and per-diem from NGOs (Sida fund). Training is monitored by FP Directorate. At many places resource persons from at level (DDFP, ADCC, Civil Surgeon, UHFPO and also national level officers) are requested to conduct sessions.

[8] Annual Report of BAPSA 2005–06

Suggestion by BAPSA

- Inclusion of conveyance in Sida budget
- Inclusion of other cadre of service providers in training on MR such as, Nurses of Upazilla Health and Family Welfare Center. So service could be made available through skilled service providers during the vacuum period of non-availability of FWVs
- Any Refresher training should be within every 3 years

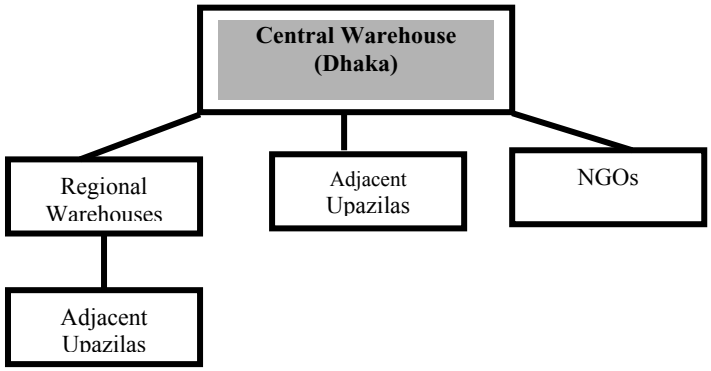
Recommendations

Family planning wing of the MOHFW should take immediate initiatives to recruit family planning service providers at clinic levels. MOHFW could also consider extension of services of capable and willing FWVs who are retiring and under LPR. Health policy makers at national level should consider the issue with priority basis. CMMRA, B can play its role in the prevention of unsafe abortion to influence the GOB for its timely initiatives to prevent shortage of GOB service providers.

MR kit distribution monitoring

BAPSA ensures continuous supply of MR kits in the supply chain system. BAPSA officials visits the stores and if there is any shortage of supply then ask the store officers to send indent to get supply from upper chain. In this way MR kit supply situation has been improved. During the project period BAPSA has undertaken this activity to visit stores mentioned in the supply chain down to providers at Union level and ensure supply. Non-achievement of visit is due to unavailability of Store Officer or closure of the store during the visit.

Equipment supply channel



Monitoring QOC of MR services

Monitoring quality of care issues of MR services are limited to services provided by FWVs at their union level clinics[9]. Followings are issues considered to assess quality of care of services:

- Status of having basic and refresher training
- Currently providing services or not
- Problem faced in providing services or not
- Problem facing in getting supplies of equipments

[9] Annual Report BAPSA 2004–2005

- Finding causes of rejection
- Post MR contraception
- Checking record keepings on MR
- Availability of medicines
- Use of MR syringe: how many MR done by a syringe

Recommendations

It is a very good initiative to monitor GOB service facilities at the union level. This type of activities should be continued and should include other areas of QOC in phasing in manner.

BCC activities

Strategy

- BAPSA has service promoters at the community level to register eligible couples and educate married women of reproductive age on MR and other reproductive health issues.
- Adolescent program at Mirpur in Dhaka has school program and group education are being conducted. Adolescent health related BCC materials have been developed during the end of last year (2006) that could be used during the successive project period
- BAPSA has developed several BCC materials jointly with other two NGOs. A take home pictorial as education material are being distributed to post procedure MR clients. (listed in appendix 5)

Orientation of frontline family planning government workers (FWA, FPI) on MR

This is an excellent step to orient GOB frontline workers with information on causes of maternal mortality, prevention septic abortion and messages on MR. They are frontline workers and are able to transmit those messages to the community people. So far 50 such union level orientation program has completed. It is a one-day orientation workshop (schedule of orientation is in appendix 6). According to BAPSA, the orientation includes a pre-test and post-test. There are 12 questions in the test and it needs at least half an hour to complete pre and post test.

Recommendations

All the adolescent in a household must be brought under the health education program. Field log book should be revised and staff should be oriented accordingly. Excluded groups should also to be targeted for BCC activities. Field worker orientation workshop schedule should be revisited for time management of the inaugural and working sessions as designed. All the upazilas should be brought under this activity and should not be limited only to FP workers but also to health wing grass-root level workers. Other channels of transmitting MR and RH messages are local Union Parishad female members and relevant groups.

Excluded groups at some places

BAPSA has a field log book does not encompass the industrial workers who are mostly garments workers in the surrounding area and most of them are young and adolescents. According to clinic staff, there is need of female garments workers for clinical services as they are found to visit clinic beyond the clinic time.

Recommendations

There should be a strategy how to include those important groups under the BCC program and to promote the clinical services. An extended time of clinics for those places could be considered to

adjust/match their off times to ensure their access to clinical services. Female and Male workers at work site need to be approached using different strategies to address demand side. Supply side has to be ensured by BAPSA in an efficient manner.

Reporting

BAPSA sends reports using MIS-3 format to:

- UFPO office
- DGFP office
- MIS Director
- DDFP
- Additional Secretary MOHFW

Sida gets performance report along with financial report directly from HQs based on IRG category. It is very interesting that BAPSA has non-IRG category of BCC activities which is an important component but it is merged with overhead costs (discussed in chapter v).

Future plan of BAPSA

- MR Newsletter concern: Need to form Editorial body, to have recommendations on its content from CCMRA, B
- Possible geographical expansion to Chittagong Hill Tracts along with other two organization and with support from GOB counterpart
- VIA test to screen cervical cancer is a probable clinical service expansion
- Expansion of orientation program of health & family planning frontline workers. FWVs also need to have orientation on MR-BCC
- HIV/AIDS prevention program to be merged with adolescent health activities

2.2 BWHC

Bangladesh Women's Health Coalition (BWHC) is a national NGO established in 1980. It has been emerged as an innovative health organization in the field of women's health. BWHC operates 30 static clinics and 86 satellite clinics in rural and urban settings supported by multiple donors. Its *Vision is Equality of Women in a just Civil Society.* Its *Mission* is to work with the underprivileged and marginalized women, children and adolescents through health oriented development interventions, with prime focus on reproductive health services and action oriented community education. The organization has been running 'Reproductive & Sexual Health Program through MR services and Training, Essential Service Package and BCC' project funded by Sida and CORDAID[10]. BWHC has been implementing Sida funded program at seven places: sadar upazila of Narayanganj district, sadar upazila of Tangail district, Polash upazila of Narsingdi district, Shaghata upazila of Gaibandha district, Lohagora upazila of Narail district, Zokiganj upazila of Sylhet district and Chouddagram upazila of Comilla district.

Mode of service delivery

- Clinic based program
- Community based program

[10] BWHC Annual Report 2005

Services offered

At Clinic/Center level

Clinic based services include

- Family planning
- Menstrual regulation (MR)
- Safe Motherhood
- RTI/STI/HIV/AIDS
- Adolescent health
- Integrated Management of Childhood Illnesses
- Basic curative care for adults
- Basic laboratory tests
- MR training for GOB FWVs

Community based services include

- Behavior change communication on reproductive health and relevant social issues
- Adolescent program for school and non-school going adolescents
- Involving and skills building of community health volunteers (CHVs)
- celebration of national and international days
- community mobilization
- Involving local Advisory committee and support groups

Performances

Performances Achieved during July 2004 to December 2006

BWHC

Sl	IRG	Component	Target	Achievements	Percen Achieved %
1	1	MR Training			
	1.a	Training. Refresher-FWV/Paramedic	300	213	71
	1c	Training. Comprehensive FWV/Paramedic	240	217	90
2	2	MR			
	2a	Menstrual Regulation (MR)	11128	12541	113
3	3	Post MR Contraception	10561	11657	110
4	4	BCC			
	4a	MR BCC	362792	450717	124
	4b	Adolescent SRH & R BCC	32341	37745	117
5	5A	RTI/Gynecological Interventions	19022	37789	199
6	6	Safe Pregnancy			
	6a	Safe delivery	10318	10661	103
	6b	ANC	20016	26447	132

		PNC	3528	4710	134
		FP	28008	56437	202
7	7	Child Health	93088	115444	124

Analysis of performances

There are some components over achieved some are close to target set. Training is a component that is not achieved satisfactorily. The cause behind this is not showing up of trainees during scheduled time. It was found that at one place only two FWVs have taken part in a batch in the month of February '07. BWHC need to revisit the set targets those are over achieved during the project period.

Favorable factors of achievements

- BWHC has reputation in the local areas as "Coalition clinic" for long time
- At some center there are many factory/industrial set ups and headquarters of public offices so client load is high
- High population density at some places
- Well managed BCC activities and innovations at community level.
- People also get services who do not live in catchment areas (non-community clients)

Barriers of achievements

- Number of attendance of trainees are less due to their physical condition like pregnancy, other illnesses
- Sometimes FWVs without fresher training called up for fresher training so BWHC has to communicate with BAPSA. They are provided with refresher training without comprehensive training. This is happened as the upazila level MIS could not inform about the actual training status of FWVs that needs more searching by BAPSA as the training coordinating and liaison NGO.
- Weather conditions (Rainy season, flood)
- Political program hampered client movement and school program
- Examination also hampers school program, schools do not allow more than 2 day a week
- Target set are high
- Staff turn over
- Budget for meeting and orientation is less
- PNC is less as there are other service providers

Critical observations and recommendations on performance elements

Human Resources

BWHC has several projects operated through same service outlets and different project staff are available at a center. Sida supported human resources include at the clinic and field level are listed in the box below.

At the Headquarters level there are Directors and Managers to support each category of program and included medical technical professionals. They are also attached to other activities of the organization e.g. training.

Staff pattern of BWHC

1. Center Manager	9. Adolescent Organizer
2. Medical Officer	10. HIV/AIDS & Social Mobilizer
3. FWV Training Supervisor	11. Adolescent Educator
4. Asst. Accounts cum Admn. Officer	12. Community Health and Social Worker (CHSW)
5. MIS Assistant	13. Community Health Volunteers (Get some honorarium)
6. Paramedic cum Counselor	14. Clinic Assistant
7. Paramedic cum Lab. Technician	15. Cleaner
8. Receptionist	16. Other support Staff

Recommendations

Staffing at headquarters and at center level seems fine. At clinic level medicine disbursement should be made by clinical staff. Non-clinical staff can provide the service if having formal training on medicine disbursement. Medical technical persons based at HQs need to be more proactive in program monitoring, supervision and feedback mechanism. Updating knowledge of professional clinic staff as well as clinic assistants need to be considered as there is concern of quality assurance of clinical activities. BWHC should have a proper need based staff development plan from headquarters level down to branch level.

Training conduction

BWHC has been conducting comprehensive and refresher training on MR for FWVs of government sector. Very occasionally it provides training to service providers of private clinics. Training are being conducted by four FWV training Supervisor at four centers whose background is FWV. They have experiences of conducting training more than 12 years. Lecture classes are conducted by government resource persons, by clinic doctor and by others. It is found at one place that lecture session on counseling has not been provided by the center and the trainees are directly brought to practical session of counseling observation. The same curriculum (schedule & manual) has been shared by all the three NGOs. At some center participants of Fresher and Refresher training was very unsatisfactory during February 2007. This is not cost effective as honorarium for external resource person is same for two-person batch and four or six-person batch. Sometimes more than one session in a course is taken by external resource persons.

Recommendations

Some theoretical knowledge on each subject is necessary for trainees before putting them to practical session for skills development. Recommendations on curriculum are common for all the three NGOs as described in BAPSA training conduction paragraph. All the three NGOs should target to get at least three to four participants in each batch of training. Communication could be made with concerned DFP officials at district level under whom the FWVs work and get call up notice, would be helpful to have satisfactory attendance.

Service Delivery

Service charge and registration

BWHC clinics have master register where all the clients are being registered when they arrive in the clinic. Token is given to each client for maintaining serials. It is very surprising that in one clinic a male guard was providing tokens which are marked on service basis & he asked the client the reason which she has come for. This is totally unacceptable for a MR client and the headquarters of BWHC should look into the matter and take necessary measures.

MR services and quality of care

Clinics setup does not allow privacy and confidentiality during counseling. Pain management varies from clinic to clinic; at one center 2 tablets of antispasmodic (Hyoscine butylbromide) are being given 30 minutes before MR. At another center Injection Diclofenac Sodium is given intramuscular to all clients before procedure to manage pain during MR. Antibiotics and iron tablets are being given routinely. Pain management by injection is mandatory at that clinic and the service charge for MR is fixed for any client. Emergency medicines are found and kept in the procedure room. It is observed that the standard of medication varies across the clinics of an organization and varies across the three organizations supported by Sida.

At one place it is found that paramedic refers clients of MR to government FWV. The consultant team found very little performance of MR at that clinic. Autoclaving procedure at some clinics is not correct. BWHC has introduced a new technique to dispose off liquid clinic waste (blood and products of uterus). A cement pit is constructed close to the main hole of safety tank of the clinic and connected with it by a closed drain constructed.

Recommendations

Counselor must maintain privacy during counseling and we recommend for all the three NGOs to attach door closure (if possible) with doors of counselor/counselor cum paramedics' room. Counseling space must not be shared with space of other services that is only partitioned by half wall and having a curtain. There must be uniform guideline from the NGOs' part about pre and post medication of MR. Uniform charge related issues are discussed in chapter IV. If the paramedic is not confident to perform MR then she should have refresher training. Opportunity for contraceptive counseling at PNC contact should not be missed as it is found in a clinic. Clinical furniture needs to be upgraded. All clinical staff need refresher training on infection prevention procedures. Cross referral among the sister organization should be a practice if the client is not manageable by clinic paramedic; government FWV has the same regulation of doing MR regarding size of uterus. Referral to a center where doctor can take the responsibility of doing MR more than 8 weeks should be preferred than referring to same category of provider as per national guideline and service protocol.

BCC activities

MR BCC

BWHC has divided its working area in three zones. Each zone has four community health volunteers (CHVs) who are provided with honorarium by BWHC and they are supervised by BWHC field staff. Community health volunteers formed groups and group education are being provided. Group leaders also have responsibilities to educate others. Each CHV conducts one session /day. One group becomes educated about all the messages related to reproductive health, MR and other issues within 3-month cycle. Community Health and Social Workers (CHSW) oversee the field BCC program. It is observed

at the community that women know about MR but they do not like to share their experience as it is still a matter of stigma. There is a need to aware community people about the availability of Emergency Contraceptive Pill (ECP) and its proper use. BWHC has developed MR BCC Flip-chart that is being used by the educator for conducting group sessions.

Adolescent SRH & R BCC

Adolescent program is school based and community based. There are boys' and girls' school. BWHC provides them a note book to write notes during education sessions. At the community level, peer educators are developed in each zone they transmit messages to the group formed by them (20 members/group). One peer educator holds 4 sessions per month. They have registers and topics are same as in AFLE curriculum of VHSS developed in March 1994. There are separate groups of boys and girls. In spite of some constraints, BWHC met the target. BWHC has adolescent-friendly health services at some center. To ensure TT immunization it sends medical team to identified girls' schools where they provide TT at specific time and SRH& R education.

Recommendations

BWHC need to review/adapt the AFLE curriculum if any updated information required to be added.

Safe delivery

Safe delivery component of BWHC includes involvement of Traditional Birth Attendant (TBA) in the community. Forty such TBAs were identified from each zone of the project site and divided into two groups for training. There is one training for a group per year. It is five-day training conducted by BWHC at local level. Follow up training for 3-day is done within next 6 months. There is also orientation meeting for a group quarterly. Selection criteria of TBAs to be trained are:

- Age between 30–69 years
- Having experience of conducting at least 10 deliveries
- Willing to get the training

There are lecture classes for TBAs and guidelines are sent from HQ of BWHC. Video CD also used as training material. BWHC developed curriculum 'Shomaj Vittik Kormosuchi Shakier' in 1999. That curriculum is being followed. Safe delivery kits are supplied to trained TBAs after training free of cost. Supervision of TTBAs' activities is done by CHVs and other community based workers of BWHC. TTBAs perform safe delivery at the community levels and refer to Upazila health center if find any complication. They also perform delivery beyond BWHC's selected zones. They transmit messages on MR and other reproductive health issues to the community people.

Monitoring, supervision & reporting

BWHC has comprehensive checklists for clinic & field activities. COPE as a local level planning and management tool was exercised once at two places but follow up COPE has not yet done. Reporting is done to local Upazila family planning office, DDFP and to BWHC HQ

Staff need (according to local level staff)

- Formal training on counseling
- Waiting room for clients
- Provision of Pure Water supply in the clinic should be ensured
- Delivery care at clinic level by Nurse-midwife
- Clinic management training for center manager

Expansion

BWHC would like to expand its services geographically and also programmatically. Geographic expansion is a possibility under a joint program funded by Sida in Chittagong Hill Tracts with other two sister organization with collaboration of GOB counterpart. BWHC also like to introduce a pilot project where the theme will be using older population in health promotion (BCC). It also would like to introduce VIA test to all its centers. If BWHC goes for any programmatic expansion within the ongoing project, there is need to assess feasibility first and proper training before introduction of any services.

2.3 RHSTEP

Reproductive Health Services, Training and Education Program (RHSTEP) is former MRTSP (Menstrual Regulation Training and Services Project) established in 1 October 1983 as a special project of the Family Planning wing of the Ministry of Health & Family Planning that become a very successful program. Considering the need of wider range of services under the reproductive health, MRTSP stepped forward to include most of the reproductive health services and changed its name to RHSTEP and currently it has been providing RH services through 18 clinics throughout the country. Thirteen clinics are located in Medical College Hospitals four in District hospitals and one Maternity clinic located in Dhaka providing outdoor services.

RHSTEP does not have any Vision and Mission statement. Its goal is to contribute towards reproductive health status of women and adolescent and to build up trained people thereby training professional for better services & thereby supporting national health program in reducing maternal mortality and morbidity & other reproductive health problems in Bangladesh. It has eighteen program objectives. The priority areas of reproductive health care under the current project are:[11]

1. MR Training
2. MR Service
3. Reproductive health care education
4. Adolescent health care education
5. Family Planning services
6. Safe Motherhood
7. Prevention of unsafe abortion
8. Management of complication of unsafe abortion and reproductive complications
9. Prevention and management of RTI/STI
10. Screening of infectious diseases including Cervical cancer screening by collecting and testing Pap's smear
11. Education program on health and nutrition in communities, adolescent group in schools and clients in the clinics
12. Prevention of HIV/AIDS
13. Research on present perspectives

[11] Annual report RHSTEP July 2004–June 2005

Mode of service delivery

- Clinic Based
- Satellite clinics along with community education and school program

Human resources

RHSTEP has two medical officers at each clinic designated as Trainers. At three places, designation of one trainer out of two is given as IP Coordinator. Doctors (Trainer plus IP Coordinator) provide services and also training during training courses are going on. According to the headquarters, the doctors whose designation is IP Coordinator oversee clinical activities of the organization. But they are not headquarters' staff. All the fifteen training center have two trainers whose background are medical doctor.

Staff positions at clinics

1. IP Coordinator	8. Nurse
2. Trainer	9. Field Worker
3. Counselor	10. Cleaner
4. Asstt. Counselor	11. Maid
5. Administrative Officer cum Accounts Officer	12. Messenger
6. Lab Tech/Medical Asstt.	13. Guard
7. Paramedic	

RHSTEP headquarters has no medical technical monitoring officer or supervisor who can oversee all the 18 clinics' activities in a systemic way. There are vacant positions[12] of Field Workers at ten places; at four places there are part-time Field Workers and at Maternity clinics there are two Field Workers. At some places Paramedic (11) positions are also vacant. It is understood by observing the activities that either the Paramedic or the Field Worker is transmitting messages to the community served. But the vacant positions raised the concern about viability of community outreach activities.

Administrative Officer cum Accounts Officer at some places depends on clinic staff and not able to explain many things. They are also dependent on Technical Advisors (TA: a Gynecologist) and Project Advisors (PA: Director of medical college hospital or Superintendent of Sadar/General hospital) who hold the position on honorary basis. It is well-known that TA and PA are very supportive to RHSTEP program and doing their best to solve problem if any arises. For other staff RHSTEP has definite staff development plan and implementing accordingly.

Recommendations

If any staff position is not needed (based on current experience) it should be removed from the project next phase. It should be decided which category of staff is supposed to announce organization of satellite clinic on the following day and who will educate clients at clinic and at the satellite sessions.

As a regular Administrative Officer of the organization, the Administrative Officer cum Accounts Officer should have knowledge on clinic management and must visit the clinic day to day to check many issues which are possible by any non-medical person. They should have training on general clinic management.

[12] Staff list with vacancies prepared by RHSTEP

Ensuring Quality of Care

Privacy, confidentiality, safety and indiscrimination are elements in quality of care. Analgesics (pain killer medicines) provided to clients before MR varies from clinic to clinic. Counseling rooms are not complying for audiovisual privacy. At some clinics autoclaving procedure is not correct and general cleanliness to some extent is missing.

Recommendations

RHSTEP should consider resetting/renovating counselors' and service providers' room for maintaining privacy and confidentiality though most of clients in the country are not aware about clients' rights. All the NGOs should respect and comply to ensure clients' rights. Autoclave training should be given as refresher training to all clinic staff in presence of doctors. Doctors can oversee the activities of Procedure room/OT at the beginning of each day and at the end of day.

Performances

Performances Achieved by RHSTEP during July 2004 to December 2006

Sl #	IRG #	Component	Targets	Achievements	Achieved in %
	1c	Comprehensive Training for Paramedics/FWVs/Nurse/ Medical Assistant	500	447	89
		Government deputed	375	407	109
		Private: FWV/Paramedics/Nurse	125	40	32
1	1.a	Training. Refresher-FWV/Paramedic/Nurse/Medical Assistant: Government deputed	375	482	129
	1b	Comprehensive MR Training to Doctors	780	703	90
		Government deputed	302	64	21
		Internee doctors	455	558	123
		Private doctors	125	81	65
	1d	Follow up of MR trained Providers	160	226	141
2	2a	MR Services			
	2.1	MR Counseling	162500	156013	96
	2.2	MR Perform	155000	145157	94
	2.3	MR follow up clients	75000	51757	69
	2b	Management of Abortion Complication (D&C, Post abortion complication management, Referral, CT removal etc)	5000	4132	83
3	3	**Post MR Contraception (Pill, IUD, Injection)	155000	237253	153
4	4a	MR BCC	189500	389834	206
	4b	Adolescent SRH & R BCC	150000	143887	96
5	5a	RTI/Gynecological Interventions	1250	7785	623
	5b	Cervical Cancer Screening and diagnosis of other uterine diseases by Pap's smear test	10000	28755	288
6	6a	Safe delivery	60	29	48
		ANC	10000	12765	128
		PNC	350	364	104
		FP		53918	
7	7	Others: Child Health/Maternal Health	12500	28598	229

Analysis of performances

There are few components fully achieved, some are overachieved and some are close to target set. Pap's smear achievement is very high and it is encouraging that women are coming for the test. After discussing with service providers, clients and headquarters officials it is understood that following factors influenced achievements:

Favorable factors of achievements

- Al the clinics are in government hospital premises
- Satisfied clients bring other clients
- Choice of services
- Cervical Cancer screening created tremendous responses among the women

Barriers of achievements

- Training of government deputed doctors is not satisfactory. Cause of poor attendance is mainly their personal reasons
- Few activities are very new such as safe delivery
- Political program hampered workshop

Critical observations and recommendations on performance elements

Service delivery

Registration is being done by the Assistant Counselor and she writes all the information on individual case sheet and issue client card and then send client to Counselor. Counselor after counseling on MR and contraceptives sends the clients to clinic doctors who are supposed to perform MR. After the MR the clients are being counseled Post-MR for contraceptives and prescription is given to buy medicine from the clinic or outside. At some places contraceptive supplies are not available for couple of months due to problem in administrative procedure to extend clinical permission from the DFP. Due to nationwide crisis of injectable contraceptive, it is also not available in the clinics of RHSTEP.

Master Register is not in use at the clinics visited. Master register is supposed to be the key register where one can have information at a glance about the clinic performance in a day at any point of time. Registers found are service based individual registers, e.g. MR register, contraceptive register, medicine register, Pap's smear register, general health register, adolescent health treatment register, school BCC and treatment register. MR is being done under pain killers at each clinic but sometimes no pain killer is given and that is named as Normal MR. This is termed by each NGO. Analgesics that are given to clients as pre-MR medication vary form clinic to clinic of RHSTEP. Dilation & curettage (D&C) is always done after providing analgesics. It is always done by doctors. Post-MR-contraceptives are being provided to clients as counseled during pre-procedure counseling. Counselors are missing the opportunity to counsel husbands of clients who sit outside at male waiting place. They are given leaflets regarding MR. Antibiotics are given routinely and vary from clinic to clinic and based on doctors' choice. Emergency medicines are found and kept in the procedure room labeled with expiry dates on the tray. Complicated case are referred to gynecologist of medical college hospital or sadar hospital where it is housed.

MR BARTA the Bangla version of MR newsletter is being received by Counselors and Trainer Doctors

Recommendations

RHSTEP can introduce Master Register to all its clinic for own convenience. Any administrative procedure to get contraceptive supply should be initiated as early as possible. If there is nationwide

crisis of any contraceptives, NGOs should arrange purchasing of that from SMC from its own fund. It is observed that clients are paying the cost of contraceptive injection of SMC at sister NGO clinic. BAPSA produced pictorial would be helpful if clients' husband could not be reached as the pictorial has pictures what to do or not after MR. Medication standard should be uniform across clinics.

Pap's smear

Counseling for Pap's smear is being done by the counselors while counseling for MR. Clients of MR usually have tremendous psychological pressure and at that time anything the providers advice clients usually do not oppose if she has financially solvent. At the same time many clients do not come in the clinic with enough money. Moreover, expert's opinion is: it is better to get smear at least after two weeks post-MR as cytological changes during amenorrhea mislead if the smear is taken during MR.

Recommendations

Clients can be counseled about Pap's smear and its benefit and can be advised to do it while coming for follow up. Cervical cancer screening by Pap's smear is a pilot activity and need to have an evaluation at the end of project period for any expansion of the activity.

Training conduction and recommendations

Except government doctors' training, RHSTEP has achieved training conduction satisfactorily. Curriculum is same as being used by other two NGOs. RHSTEP's strength is that it is housed in tertiary and secondary level public hospitals so specialist gynecologist who is Technical Advisor conducting sessions that are required to be conducted by a gynecologist; especially for the comprehensive training for doctors. Training aid (Pelvic model and video cassette) is available and classrooms are equipped with chalkboard. RHSTTEP conducting training through its fifteen centers.

RHSTEP plans to offer training for doctors of private medical colleges in future. Currently Internee doctors are not being placed for MR training at RHSTEP clinics as they are having different duty schedule in the logbook. During in-service training internee doctors have 7-day placement in family planning clinic at outdoor but in reality they have very little to learn as client load are less at those clinics. There are little opportunity to observe counseling and any contraceptive procedure like injecting Depo-Provera. Little surgical permanent methods are being done by these FP clinic. In-Service Training (IST) Department of DG Health Services may revisit the schedule so that internee doctors have exposure to MR management from their early professional life. They will be posted at different remote government clinical setups after in-service training, so they need to know how MR is performed. If they can have training at RHSTEP on MR, they will have opportunity to exercise their training experience at work.

RHSTEP planned to organize and conduct a workshop for its Project Advisors and Technical Advisors but it could not be done due to unavoidable circumstances. RHSTEP has been planning to conduct the workshop before the end of the project period. Such workshop will enhance common understanding among different branches for uniform activities.

BCC activities

Clinic level: Paramedic conducts BCC sessions in the clinic. Message transmission is an activity where concentration of receiver is very important. BCC sessions in clinic level are being organized but clients could not concentrate as the paramedic delivers many messages in one session. Clients and their attendants may find difficulties to capture all the messages delivered. There are posters on MR hanging on the walls of each clinic. Some take home printed materials also developed and being distributed to clinic clients.

Outreach clinics: Service providers from the clinic go to community to provide medical services through satellite clinics. Family Welfare Centers (FWCs) are also being selected for conducting satellite clinics sessions. Through these clinics many clients who come to get other services received MR and reproductive health related messages. There are also 3 monthly BCC activities at field level involving WRA. List of topics are with the Field workers. The topics include:

- Safe Motherhood
- Family planning methods (Long acting methods are emphasized)
- Prevention of unsafe abortion and post abortion care
- Immunization
- Adolescent reproductive health care
- Prevention of RTI/STI/HIV/AIDS
- Screening of cervical cancer
- Reproductive rights
- Gender equality and women empowerment

Channels for marketing services and BCC

- Personal contact to doctors of Upazila health complex and other doctors to refer clients to RHSTEP
- Satisfied clients brings other clients
- Distribution of printed BCC materials to clients and attendants
- Display of signboards and billboards at public places
- Advertisement on TV through local cable operators (running subtitle)

Adolescent: School program

Adolescent health program includes Health Education followed by general treatment. So far one visit per school is made and there are no follow up visit. There is overlapping of efforts at some school as Directorate of Education also implementing RHIYA project to one school so it is not possible to understand source of knowledge gained by the students.

Worksite BCC and health care services

According to RHSTEP headquarters, the Maternity clinic in Dhaka has a medical team comprising of a male Medical Assistant and a female Paramedic, visit nearby seven garments factories around Mirpur twice in a week. They provide information on reproductive health issues and treatment to the garments worker. The factory authority provides space and given time schedule to RHSTEP for visit.

Recommendations

One specific message should be given in each session as client does not sit for long time so sessions should be short. BCC messages at worksite to young adults and adolescents should be expanded in next phase after assessing success of the garments industry.

Schools should be revisited at least three times in a year to cover all the health related topics along with advice for TT and availability of other treatment facilities.

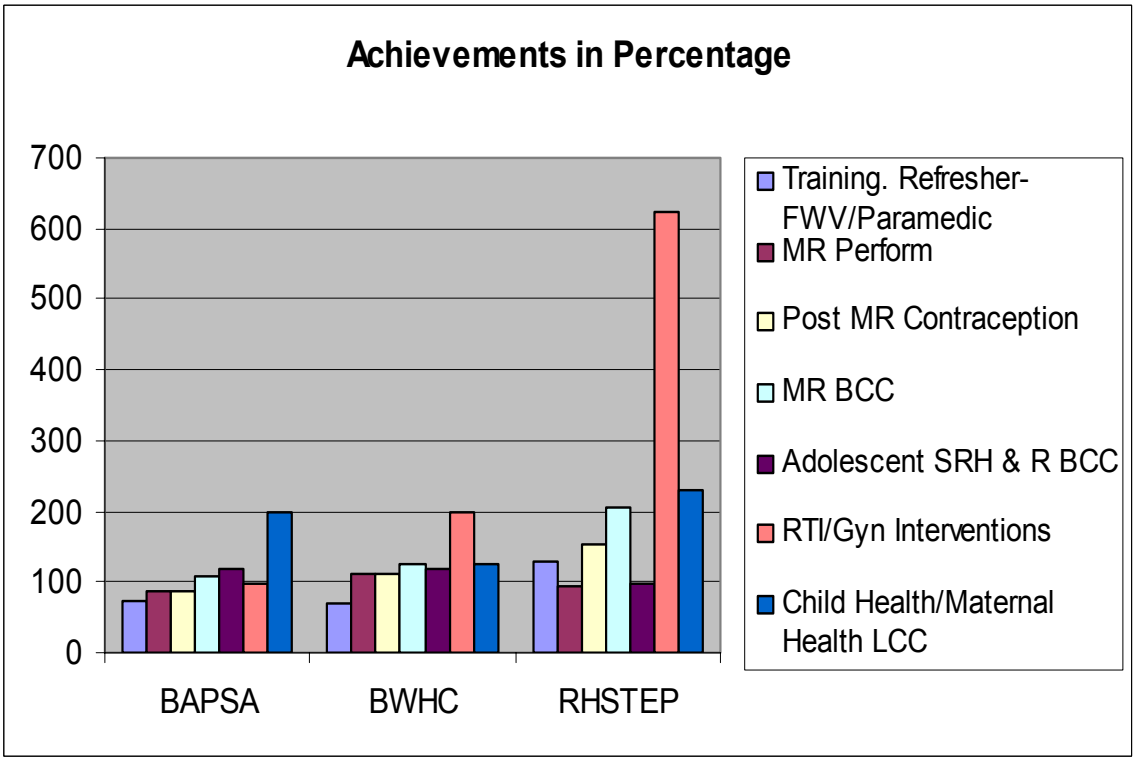
Reporting

Reports are sent on monthly basis to TFPO, DDFP and HQ of RHSTEP

Future plan of the organization

- Clinic management training to be offered to the Administrative Officers
- Redesign of BCC program
- Offer RTI/STI training to other providers
- Offer training to private medical college internee doctors and other medical officers
- Introduction of HIV/AIDS and VCT to all centers by separate team
- Introduction of VIA test in all clinics
- Exchange visits among the sister NGOs to observe others' program implementation and activities
- Sharing BCC materials of others

Achievements of NGOs' program* in 30 months



* BAPSA has 4 Clinics and 2 Mini Clinics, BWHC has 7 clinics and RHSTEP has 18 clinics supported by the project

3. Analysis of Status of Coordination Mechanism of MR Program

3.1 Coordination and Collaboration with GOB

The project is a parallel funding of HNPSP of the Ministry of Health and Family Welfare. As such all the activities have been implemented by the NGOs need collaborative efforts from GOB counterpart specifically Directorate of Family Planning (DFP).

- BAPSA is coordinating the project activities with the government regarding training. BAPSA identify and list potential GOB service providers in the FP wing of the MOHFW, then putting forward the list for selection by the Directorate and issuance of call up notices. Finally, communicating call up notices with sister NGOs (RHSTEP and BWHC). Government provides conveyance and Sida funded NGOs provide per-diem to the trainees.
- Training sessions are conducted by professional personnel from the Family Planning Directorate along with NGOs
- Training is monitored and supervised by the ESP (RH-CH) unit of DFP
- BAPSA monitors MR kit supply situation from Upazila store level upto Central Warehouse. Any problem at supply chain is immediately brought into notice to Director MCH so that difficulties can be solved as soon as possible. This to mention that GOB is responsible for procurement of MR kit
- BAPSA conducts Orientation program for frontline FP and health worker on Prevention of Unsafe Abortion that focuses MR issues
- GOB approves area of work for three NGOs
- GOB developed approved BCC material are being used in the NGO program
- Reporting to government at local level is done
- RHSTEP is housed in GOB premises and getting benefits of referral services from the tertiary and secondary hospitals for management of complication of MR, post-abortion complications and septic abortion care. Hospital Director/Superintendent is Project Advisor and Senior Obstetrician is Technical Advisor of the project.
- Participation in National days relevant to program

Above activities prove that the government owns the program. Government has some limitations in implementing specific program that NGOs can do. The program is complementary to the government activity. Such efforts should be continued in future to strengthen program in decreasing maternal mortality. In HNPSP it is inbuilt in the component in ESP under the maternal heath.

Coordination mechanisms initiated

There are numbers of mechanism for coordination between three NGOs and Sida and MR providing organizations. Those are

1. MR Consortium (BAPSA, BWHC and RHSTEP) sit together to resolve issues emerged from program implementation and when a decision has to be taken such as development of BCC materials. There is no fixed time that meeting should be held. It is need based.

2. Meeting with Sida Sr. Program Officer (Health) for Annual Review held in January 2005. In January 2006 review of progress of the project activities, strengthening of current program and to sensitize policy makers, MR kit and pelvic model supply situation and advice for new initiatives were discussed with Sida and three NGOs.

Such type of meetings has advantages to exchange opinions among NGOs and Sida; any difficulties in implementing program could be solved. It also creates common understanding. This type of communication between Sida and NGOs could be made frequently for program implementation and emerging problems and financial aspects.

3.2 Coordination Among MR NGOs: Coordination Committee for MR Agencies in Bangladesh (CCMRA, B)

The coordination body is formed initially by four organizations in 1987. Later other large scale MR providing organizations joined the committee:

1. Mohammadpur Fertility Service and Training Center (MFSTC)
2. Reproductive Health Services Training & Education Program (RHSTEP)-former MRTSP
3. Bangladesh Women's Health Coalition
4. Bangladesh Association for Prevention of Septic Abortion
5. Marie Stopes, Bangladesh
6. Family Planning Association of Bangladesh (FPAB)
7. BRAC joined as Observer

The committee has selected President and Member Secretary. At present Dr. Halida Hanum Akhter, Director General of FPAB is President and Dr. Altaf Hossain, Director of BAPSA is Member Secretary of the committee.

The committee is supposed to sit quarterly a year. It has a Terms of References (TOR) since its inception that has not yet been updated. The main objective of the committee is

- to work for promotion and improving the quality of MR services in Bangladesh
- discuss the problems related to MR service delivery system and solve the identified problems

During HPSP the committee was not functioning but later it is revived and functioning. Its members met several times and decided to focus MR related activities in the national perspective.

Recommendations

- The committee should revisit its TOR
- Election/selection of its President should be done every two years
- The meeting should take place regularly with definite agenda
- Membership fees should be introduced
- Criteria of eligible member should be identified
- Inclusion of interested organizations eligible to have membership and that needs initiative

- Above all every meeting should be chaired by either DG Family Planning or Director MCH (Not by name but by designation) so that government ownership of MR program is honored. Moreover government could share its experience with others and good practices of the NGO could be explored for replication in government system like introduction of User fee for MR services, inclusion of other cadres of providers in government system after providing training etc
- Director Training of NIPORT could be invited in the meeting as most of the NGOs perform MR training as component of MR services and any updates at national level could be shared to the member organization
- Dialogue with DG Health Services could be made through this committee how the intern doctors could have comprehensive training on MR
- Standardization of pre-medication and after medication could be decided in the committee meeting as several groups including GOB agencies may represent in future
- Post abortion care by using double valve syringe that is not being used in the ongoing program (supported by Sida) could be discussed and explore its feasibility. Experience of others could be shared in this forum

CCMRA, B is a forum where agenda related to MR service and training issues are to be discussed and resolved. The committee must be dynamic and should play lead role in the country's MR program as well as reproductive health and gender issues.

3.3 Other Committees

A MR Steering Committee headed was formed in February 2006 where DGFP was Chairperson. But it could not meet with definite agenda anytime for unknown reason.

Another Steering Committee was formed by Planning wing of the MOH&FW in 1998. It is also not functioning.

Through an office memo in 1992, MOH&FW formed a committee on MR Supervision and Inspection Committee with Director (MCH-Service), DFP as its Chairman and representatives from MOH&FW, DGHS, DFP and MR organization as its member. Objective of the committee was to ensure safe MR services at SDPs and ensure supply of MR equipments, ensure training of manpower and hygienic environment at the SDPs

Currently for monitoring of MR activities of BAPSA, BWHC and RHSTEP, a monitoring mechanism is developed by the ESP (RH-CH unit) of the DFP. It monitors all the activities and found functional.

Recommendations

It is recommended to put sincere and concerted efforts to make the CCMRA, B dynamic and functioning and to put all the relevant issues forward. Government monitoring mechanism is in-built to its functionaries. CCMRA, B can also arrange monitoring of activities. To make full functioning of CCMRA, B it needs to have contributions from each organization. Sida can consider the issue if it is permissible within its system of contribution in its country strategy.

4. Analysis of Service Delivery from Poverty Perspectives

4.1 Provision of Service Charge, Usage and its Criteria of Exemption

In general, NGOs introduce service charge or user fee for sustainability and cost recovery of the organization. Although user fee increases the income of the NGO, this affects the accessibility of poor as they can not afford the services. A mechanism is expected from the NGOs so that they can attain sustainability along with ensure safety net for the poor with quality services.

Bangladesh Association for Prevention of Septic Abortion (BAPSA)

BAPSA introduced service charge on the basis of discussion with community, field workers, DDFP of specific area, local leaders. However, affordability survey of the community has not been done before introducing fees.

Bangladesh Association for Prevention of Septic Abortion (BAPSA) provides MR, D&C, contraceptives, and general health services in its clinics. Most of the clinics have two types of MR services: one is without pre-medication which is called MR normal and other one is MR with painless with injection. At Chowmuhuni, Noakhali clinic, only MR (normal) service is provided while at MRHC-1 clinic; three types of MR services are available. The services are: MR (normal) which is without pre-medication and bearing pain, second one is called painless with injection and third one is with anesthesia. The service charge for MR (normal) varies from Tk. 150-200 and MR (injection) is between Tk. 310-500 in different clinic set up. MR (anesthesia) costs Tk. 1500 at MRHC-1.

Except MRHC-1, all clinics do D&C (normal) and the service charge is Tk. 500-700. There are also three types of D&C services in MRHC-1: normal (no pre-medication), local anesthesia, and general anesthesia and charges are Tk. 500, Tk. 1000 and Tk. 1500 accordingly. This clinic also provides pathology and ultra sonogram services[13]. For different types of pathology test, the charges vary from Tk. 30 to Tk. 150. In some of BAPSA clinics, pathology and other prescribed tests are referred to a specific diagnostic centre and clinics get 50% waiver of charges for BAPSA referred cases. Usually, other contraceptives are free for all clients.

According to the service providers, clients of MR (normal) are mainly from lower socio-economic status and if they can not pay the amount, they are partially or fully exempted. Poor clients are also being notified by service promoter at field level. However, most of the clients who are comparatively well off avail MR with painless injection. Prescribed medicine is given at 25–35% discount from BAPSA clinic. Post-MR contraceptives are free for all MR patients, except condom which is Tk. 2 per dozen.

There was a scarcity of supply in Depo-Provera during August–December last year where both NGOs and government service centers faced shortage of this. BAPSA took initiative to buy injectables (somaject) from its own fund and the clinic manager used to take this on need base. The clinics charged a subsidized fee from the clients and it varied based on how much BAPSA had to pay from the local markets.

Bangladesh Women's Health Coalition (BWHC)

Bangladesh Women's Health Coalition (BWHC) provides MR, contraceptives, and general health services in its clinics. It has introduced service charges for its sustainability and cost recovery. According to BWHC, the service charges in the clinics are determined through discussion with community support group and local advisory committee. Local leaders, BCC group leaders of different zones, moderators are the members of community support group and local service providers of BWHC and

[13] For lower abdomen and upper abdomen ultrasonogram, the charges are Tk. 300 and Tk. 250 respectively.

government service providers are members of local advisory committee. They placed their opinion as community representatives and a fee is determined. Moreover, a study[14] (Barkat, A et al, 2003) conducted by BWHC shows that average willingness to pay (WTP) for MR (normal) and MR (painless) is Tk. 138.86 and Tk. 202.50 respectively, and the average ability to pay (ATP) for this service is Tk. 222.59 and Tk. 224.55 accordingly. However, it is found that in some BWHC clinics, service charge of MR (painless)[15] is more than both WTP and average ATP, such as upto Tk. 1000.

There are two types of MR services available at most of the BWHC clinics[16]. The categories are: MR SES1 (lower socio-economic status) which is without pre-medication but bears pain, second one is MR SES2 (upper socio-economic status) which applies medication. The charges vary accordingly which is Tk. 100-1000 in different semi-urban and urban areas. If the clients of lower socio-economic status are unable to pay the full amount, they are partially or fully exempted.

The community volunteers of three zones identify poor clients (category C) and send to the clinic for MR of free of charge. Comparatively well off clients avail MR services with painless medication. Post-MR contraceptives (oral pill, condom) are free for all MR patients, except condom which is Tk. 2 per dozen. During shortage of supply of depo provera, the clients were advised to switch over the method. Prescribed medicine is given at 25% discount from the clinic. The service charges for LCC, RTI, gynecological care, ANC, PNC are between Tk 5–18 and EPI is free of charge. The clinic also provides pathological services and the charges are between Tk. 15–20 and Tk. 150–200 in rural and urban clinic setting.

From the service accounts of BAPSA and BWHC, it is not found which proportion of poor (who are unable to pay) receives MR services of painless injection without payment or nominal pay.

Reproductive Health Services Training and Education Program (RHSTEP)

Reproductive Health Services Training and Education Program (RHSTEP) provides MR, D&C, contraceptives, general health services, regular pathological services along with pap's smear and hysto pathological test in its clinics.

During 2004–07, it has introduced different service charge in different clinics. According to RHSTEP, this was based on economic status and capability of payment of people in the respective area. The service providers of the clinics of different districts provided this information. For example, it is assumed that clients from Sylhet district could pay more than other districts and higher charges were determined accordingly. However, no specific willingness-to-pay or ability to pay survey in the community was done before introducing the service charge.

Two types of MR services are available in this clinic; a) MR (normal) which is without pre-medication and bearing pain, b) MR (special/less pain) where pre-medication is applied. The MR service charge varies from Tk. 100-250 for normal, Tk. 250-300 for less pain and Tk 280-500 for special. The clinics also provide D&C (normal) at the cost of Tk. 300-600 and D&C (special) upto Tk. 1000. Post-MR prescribed medicine can be bought from the clinic at 25–30% discount of MRP. Although since last November 2006, Bogra clinic has stopped selling drugs as clients do not want to buy those from the clinic.

The clinics provide other health services as well such as ANC, PNC, MCH, adolescent health services, general health follow-up at Tk. 20–40 each. In some clinics, immunization (TT) is free while at others,

[14] Study on Health Seeking Behaviour and Demand for Health Services in Areas served by BWHC. June 2002.
[15] Currently, BWHC terms the services as SES 1 and SES 2 in replace of normal (without pre-medication) and painless.
[16] Two clinics do not have SES category, they follow same charge for all.

the charge is Tk. 10. Charges of other pathology services[17] vary from Tk. 10 to Tk. 80[18]. All the clinics do Paps' smear test (some do hysto pathology at Tk. 300) at Tk. 250.

Usually, post-MR contraceptives are free for all MR patients and non-MR clients. As RHSTEP did not receive the government letter of renewal of NGO enlistment since July 2005, it failed to get government supplied contraceptives from this period. All clinics only advise contraceptives to the clients when their stock is finished. RHSTEP clinic did local purchase of Blue Star (A brand name of injectable of Social Marketing Company) during October–January when there was a scarcity of depo provera. The clinic used to give one-cycle of oral pill for couple of months till December 2006 followed by advice to buy from outside during January and December. Currently the clinic provides 3-cycle of oral pills to the clients.

According to the service providers of different NGOs clinics, clients of lower socio-economic status can not afford the price of MR with pre-medication, so they go for MR without pre-medication. However, if anyone is unable to pay for latter, then they are partially or fully exempted. On the other hand, well off clients prefer MR with less pain.

4.2 Strategies and Extent of Resources to Reach Poor, Vulnerable and Excluded

According to the NGOs, poor is who are unable to pay for a specific service. For identification of poor, the NGOs are predominantly dependent on 'best judgment' of the service provider. To them, women, female adolescents are vulnerable as in several occasions; they become the victims of unwanted pregnancy, rape, sexual harassment or other violence. Wife of a husband living abroad in some districts are also considered as vulnerable. Some of NGO representatives consider commercial sex worker, river gypsy women, risk groups for HIV/AIDS i.e. injecting drug users (IDUs) as excluded group while others consider them vulnerable group. According to them, these are highly marginalized and difficult to reach.

Bangladesh Association for Prevention of Septic Abortion (BAPSA)

According to BAPSA, 25% poor are targeted to get free services. When a client comes to a clinic for MR service, she is asked to report 'occupation' along with other medical and contraceptive practices. If the occupation is farm and non-farm labor or unemployed and the client says that she is unable to pay then both clinic manager and counselor verify the case. Then they take the responsibility to sign for exemption of full or partial payment. Moreover, if a field worker finds one who needs MR but can not pay then she refers the client with the card to the clinic for full or partial exemption. However, NGO does not have any specific exemption strategy for the poor.

During July 2004–June 2005, BAPSA has done MR for 6742 clients, among them, 22% were free of charge, 50% paid partially, and the rest was fully paid. One-fourth of all MR patients were fully exempted, 60% were partially exempted, and nearly 20% was paid in July 2005–June 2006. During About 50% clients paid upto Tk. 200 and 30% clients paid Tk 201 to Tk. 1500. During January 2006 to February 2007, all clinics have performed 4678 MR cases, among them, 22% has received free service and the rest either partially or fully paid. Overall, during this period, BAPSA provides 23% free services of all MR clients.

[17] The services are: blood grouping, TC/DC/ESR, blood sugar, HB, pregnancy identification test, urine sugar, urine albumin, and urine routine examination.

[18] The charges for different pathology tests in Sylhet vary between Tk. 30 and Tk. 80, which is double compared to other clinics of RHSTEP.

Bangladesh Women's Health Coalition (BWHC)

In all centers of BWHC, households in the community are categorized into three socio-economic groups, where A is non-poor, B is poor, and C is hard core poor. This group has been calculated on the basis of district mapping of Poverty Monitoring Survey 2002[19] and BWHC centre office has identified the criteria applicable for specific centre. During their households visit, the community health visitors of different zones identify monthly household expenditure, then they categorize in which group the specific household will fall. For example, if one household's monthly expenditure at Polash is Tk. 550, then that household will be identified as C category, i.e. hard core poor. Any member of this household gets any services free from the clinic. However, the information about number of people in these categories received different services in the clinics is not fed back to and incorporated into central MIS.

Any non-community MR client who is unable to pay is also fully or partially exempted depending on the consent from both centre manager and counselor of the clinic.

Table 4.1 Socio-economic status of people by centers

Centre	A (non-poor)	B (poor)	C (hard core poor)
Tangail	>Tk. 633	Tk. 573- Tk. 633	<Tk. 573
Polash	>Tk. 704	Tk. 647- Tk. 704	<Tk. 647
Lohagara	>Tk. 571	Tk. 502- Tk. 571	<Tk. 502
Choddogram	> Tk. 616	Tk. 548- Tk. 616	<Tk. 548
Shaghata	> Tk. 477	Tk. 410- Tk. 477	<Tk. 410
Zakiganj	> Tk. 607	Tk. 530- Tk. 607	<Tk. 530

During July 2004–February 2007, 13652 MR have been done in seven[20] BWHC clinics. More than half of those (53.3%) are fully paid, 46.3% are partially paid, a negligible portion (0.4%) is fully exempted (Figure 4.1).

Reproductive Health Services Training and Education Program (RHSTEP)

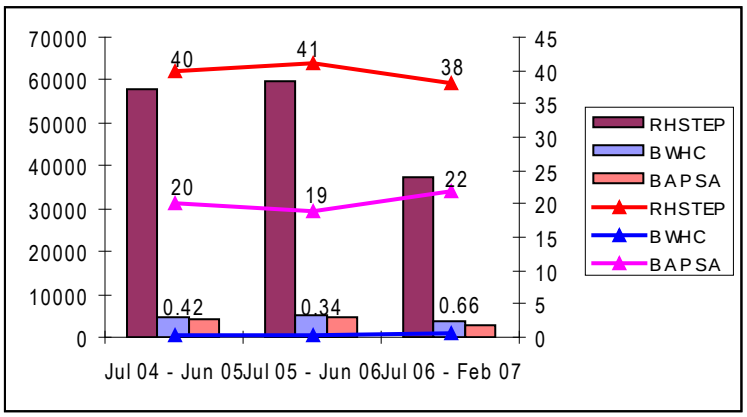
In any RHSTEP clinic, when a client comes for MR, she is taken to the counselor to a clinic for MR service. Over there, she is asked to report her assets, occupation, sources of water and sanitation, income, expenditure, along with other medical and contraceptive practices. If the client says that she is unable to pay then counselor verifies her appeal with the information and then the case is forwarded to clinic manager. Clinic manager with the consent from Technical Advisor approves the case where counselor, clinic manager and technical advisor sign. However, NGO does not have any specific exemption strategy for the poor.

Socio-economic analysis shows proportion of MR clients served by RHSTEP belongs to comparatively higher income group (Annual report, 2006). During July 2005–06, more than half of the MR clients of belong to yearly income of Tk. 40,000 and above. During July 2004–Feb 2007, RHSTEP provided 40% free services to MR clients (Figure4.1). Although several clinics[21] have not given any free service while several clinics such as,

DMCH, SSMCH, FMCH provided more than 60% free services during this period. It is to be noted that service charge for MR is fully exempted for clients of without pre-medication, no client is found to be exempted among 'with pre-medication choices in the NGOs during this period.

[19] The survey was conducted by CIRDAP and BBS.
[20] Chowddogram, Lohagara, Palash, Narayanganj, Shaghata, Tangail, and Zakiganj
[21] Such as, Bogra, Sylhet, Maternity clinic in Dhaka

Figure 4.1 Number of MR services and percentage of free patients



For all NGOs, the money income accrued from service charge was deposited into a separate account of specific NGOs. This account is used for paying salaries of the staff during fund crisis, expenditure needed to deliver other services (such as paps' smear test, etc), extended pathological test, ultra sonogram, etc.

Three NGOs have exemption rules, and the basic rule is that any one in need of help will not be denied services because of inability to pay the stipulated fee. They provide a range of clinical and non-clinical services through its branch clinics to both urban and rural people. The field health volunteers of BAPSA and BWHC identify, refer and in some cases bring poor patients who need clinical services to the clinic.

As mentioned earlier that the poverty status or socio-economic background of a client is gathered through information about income, expenditure, household member composition, asset, appearance, and area of residence. The counselor or assistant counselor of the clinic is primarily responsible to identify this while she registers the clients and provides the basis for decisions that are made to categorize the clients. Ultimate provision of free service depends on 'best judgement' of herself, clinic manager, medical doctor, and for RHSTEP clinics, the Technical Advisor as well. However, the number of poor people treated in the clinics are not incorporated in the current reporting system of the MIS of NGOs. So, it is difficult for NGOs to provide precise information about the number, proportion of and subsidized service for poor clients they reach.

Exit interviews with MR clients show that they chose clinic[22] because of combination of different reasons; a) the clinic provides cheaper services and medicines than many private alternatives even those are located in close proximity; b) a high level of client satisfaction with services and heard from those clients; c) the clinic maintains confidentiality, in other places, they ask so many questions about unmarried pregnancies or pregnancy during absence of husband[23]. Geographical location of the clinic, place of clinic set up (ensuring confidentiality[24]), length of time it takes to reach the clinic, transport cost, waiting time to get a service, behavior and attitude of the service providers is also important determinants of choice of these clinics. However, group discussion with community people show that the full fee exemption practice in the clinics is not known to them and thus, they never seek the exemption while they go for services. Accordingly, they do not know that neither do they have to pay always nor discover other advantages, such as, ensured availability of drugs, etc.

[22] Applicable to all NGOs
[23] Interviews of MR clients.
[24] Some of MR clients at RHSTEP shared that they told their home that they are going to Sadar hospital so that no one suspect her.

The NGOs also want to expand their services such as HIV/AIDS, although they did not seem to be institutionally capable to reach these groups and establishing network with other organizations specifically working with these groups.

Recommendations

It is not recommended that the NGOs should abolish the fees or to make the exemption practice publicly known. We believe delivery of MR services should not be differentiated on the basis of price and pain. The clients should be treated (for example, uniform medication for pain control) equally regardless of their ability to pay. The NGOs should take a strategy to provide 'with pre-medication' services to all clients if there exists a practice of providing pre-medication for MR. Moreover, the NGOs can think of providing better information to the field workers so that they ensure the community regarding important issues, such as, practice of exempting people who can not afford the fees, referral system, etc.

The NGOs can create an emergency account for crisis management, such as, ensuring uninterrupted contraceptive supply during shortages.

The service charges of NGOs, specifically in the urban setting need to be revisited in line with similar services given by different NGOs and/or funded by other agencies.

It is known that the NGOs serve poor people and a proportion of vulnerable group making a considerable impact on their lives. We recommend that there should be an in-built mechanism within the NGOs to serve poor (ultra and hard core) through both disseminating information (BCC) and safety net for clinical services in the community. The NGOs should adopt a specific strategy for cross subsidization from better off users to poor which is not yet designed in their program. In a nutshell, the NGOs should aim at focused and concerted program efforts to meet the needs of this group. We recommend that in the next planning process, NGOs would establish a specific strategy or mechanism to serve a fixed proportion of poor. The NGOs should develop a mechanism to collect information related to poverty status of the clients and the services, and this data should be fed into regular MIS system.

5. Analysis of Basic Performance Indicators with Unit Costs

During 2004–07, disbursement of Sida funds to three NGOs were performance, i.e. service output based. A senior technical advisor, assigned by Sida analyzed and negotiated the budgets submitted by three NGOs. The unit cost of different program categories in the budget was negotiated on the basis of the rates for services in the previous year's budget (June 2003–04), agreed rates between NGOs and the government during the HPSP, the rates of other organizations/projects who are providing similar services and the market price of drugs and others. Except start-up cost of two medical college hospitals and replacement of one supervisory vehicle of RHSTEP, no major large-scale capital investment is envisaged.

After a number of deliberations with the concerned NGOs, the unit cost was redefined as 'Iso-Resource Groups' (IRG)[25] which represents one or a cluster of health services for a particular treatment episode that have similar consumption for the provider. Thus funding becomes results or performance based. Two sets of IRG emerged. The first set consists of 'core MR services'. These include the provision of (1) MR training; (2) clinical MR interventions; (3) post MR contraception; and 4) community-based BCC activities. The second set consists of 'non-core MR activities' and termed as IRG 5, 6, and 7. According to MOU, Sida's decision to support non-core IRG activities is time-limited under the shared assumption that NGOs would need space and time to develop alternative funding channels for these non-core IRG services. Sida has given the NGOs a signal that any potential future funding might be limited to core MR services. This section of the report will explore the status of funding mechanism as well as analysis performance of the indicators with respect to unit costs. This chapter of the report is based on the financial and performance reporting of the NGOs to Sida during June 2004 to December 2007.

5.1 Service Delivery

5.1.1 Mr Training

Training on MR includes 15 days standard comprehensive training of doctors (1b), 21 days standard comprehensive training of paramedic and/or FWVs (1c), 7 days standard refresher training of FWV and/or paramedic (1a). The unit cost of three components is Tk. 8018, Tk. 11225, and Tk. 3742 per training respectively. In the IRG category 1, MR training follow up component is not included.

IRG category	July 2004–June 2005			July 2005–June 2006			July 2006–Dec 2006		
	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep
1a. Refresher MR Training to FWV/Paramedics/Nurse/MA	38	129	241	49	66	201	9	18	40
1b. Govt. Deputed FWV/V/ Paramedics/doctors, etc	–	–	36	–	–	28	–	–	0
1c. Comprehensive MR training to Paramedics /FWV/Nurse/Mas etc.	–	119	148	–	87	212	–	10	47
1d. MR Training Follow-up	–	–	63	–		163	–		0

BAPSA is responsible only for conducting refresher training of FWV and/or paramedic, BWHC conducts refresher training of FWV and/or paramedic and comprehensive training of paramedic and/or FWVs, and RHSTEP has the responsibility to conduct three trainings.

[25] For detail of IRG, please see MOU.

During two period of time (between July 2004–05 and July 2005–06), number of trainees from BAPSA has been increased. There is a sharp decrease of trainees in both refresher and comprehensive training of FWV/paramedics conducted by BWHC. During 2004–05, according to unit cost calculation, total amount for RHSTEP to conduct trainings is Tk. 2,851,770, however, adding expenditure of training materials for trainees, the expenditure became Tk. 2,899,300 and it submitted this amount to Sida for reimbursement. Following same procedure, total cost of all MR trainings during 2005–06 is Tk. 3,356,346 as number of trainees exceeded the target. However, RHSTEP reported Tk. 3,208,180 to Sida as per target for reimbursement. Financial records of July–December 2006 show that no training of government doctors has been taken place, while total cost of refresher training to FWV and/or paramedics and comprehensive training is Tk. 1,002, 450.

All trainees in a specific training do not always show up. Therefore, to achieve the target trainees the NGO needed to organize more training branches where an amount of cost involved (such as, honorarium of resource persons, logistics, etc).

Recommendations

For the cost-effectiveness of both comprehensive and refresher training, number of trainees per training should be fixed. The NGOs can prepare a list of interested doctors (both from other NGOs and private sector). If any government service provider fails to participate in the training, then that vacancy can be filled up from someone in the list. Non-government participants will pay the training fee. This will serve two purposes: training sessions will be cost-effective; and charging fees from private and other NGOs will increase their income.

5.1.2 MR

According to IRG service definition, MR is defined as a care of unwanted pregnancy episode, treatment of unsafe abortion complications (septic abortion) and treatment of amenorrhea/dysmenorrhea. Pre-MR counseling, MR intervention, pain control, infection control, and post MR control are included as service standard for performing a MR in a clinic. Abortion complication (D&C, post abortion complication management, referral, CT removal) is also included in this category. The unit cost of performing one MR and one abortion complication is Tk. 350 and Tk. 450 respectively.

IRG category	July 2004–June 2005			July 2005–June 2006			July 2006–Dec 2006		
	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep
2a. MR Done	6743	4796	58082	7754	5048	59783	3343	2697	27292
2b. Abortion Complication	733	–	1159	726	–	2233	345	–	977

Except BWHC, two other NGOs provide both MR and abortion management services. There is an increasing trend of MR services of three NGOs over the project period. Moreover, from 2004–05 to 2005–06, number of abortion complication managed by RHSTEP has been increased twice than first year.

According to MOU, the amount of money for the performance as per target is reimbursable. The performance exceeding the target and cost involved in this will be the responsibility of individual NGO. The cost incurred to provide exceeding target performance is spent from own income account.

Three NGOs are charging prices for MR services and service charge varies according to pain control and geographical location. Although pain control in MR and D&C is vital as an indicator of service standard as per MOU, the NGOs offer both without pre-medication (the client has to bear pain with low cost) MR services and with 'painless'/'less pain'/special services (when client has to pay more to lessen pain). The amount of money received from service charge is considered NGO's income and deposited.

Recommendations

The income of NGOs increases with increasing number of MR and abortion management cases. The NGOs can also adopt a cost-containment strategy as increasing number of outcomes decreases the cost of a service. Currently, none of them has this strategy.

5.1.3 Post MR contraception

The provision of post MR contraception is very important. In the IRG category, post MR contraception is defined as prevention of unwanted pregnancy which includes post MR family planning counseling and supply with modern contraceptives. The unit cost of this component is Tk. 60, i.e. one combined contact of post-MR counseling and delivery of contraceptives (preferably according to informed choice of the client and modern contraceptives) of an individual case with or without her partner is considered one unit.

IRG Category	July 2004–June 2005			July 2005–June 2006			July –Dec 2006		
	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep
3a. Post MR Contraception	6396	4597	68002	7216	4854	57523	3051	2593	26026

Note: During 2004–05, RHSTEP includes both post-MR and MR contraceptives under this category.

The NGO clinics in different area receive contraceptives (oral pill, condom, injectables, IUD, ECP) from respective upazila family planning offices with free of charge or nominal charge. From that stock, the clinics provide contraceptives to the post MR clients free of cost[26] followed by the counseling and this is maintained in NGO service and performance accounts although in government MIS form-3, there is separate section for post MR contraceptives (all are added in one category: contraceptives).

The project's internal quality assurance target is that 95% of clients are provided with contraceptives at the time of discharge. Data shows that all NGOs provide service to more than 95% of the clients. According to MOU, they are getting an amount of Tk. 60 for each service (combined with counseling) which is considered as their income as contraceptives are free from government. In some of the clinics, ECP as a modern contraceptive is not being given. Moreover because shortage of contraceptive supply in RHSTEP clinics during few months of last year compelled service provider to advise the clients to choose contraceptives instead of providing. During 2–3 months (varies across clinics) of July–December 2006, 'advice for contraceptives' has been reported as unit.

Recommendations

It is assumed from IRG category that one unit of post MR contraception service is measured as combined service of counseling and contraceptives. However, a NGO may not provide either contraceptive (because of shortage of supply) or counseling (because of vacancy of counselor in the clinic), then according to current practice any of the two is being reported as one unit. In this regard, both the NGOs and funding agency should be clear how and which unit should be reported for measuring performance.

5.1.4 BCC

According to IRG category, three types of BCC are involved in IRG 4. Those are: a) MR BCC; b) Adolescent SRH&R BCC; c) MR newsletter. MR BCC is considered as promotion of safe MR. Although in the MOU, indicators for adolescent SRH&R BCC are not defined, from the discussion with the NGOs, it is assumed that they included SRH services and education to adolescents in the community, schools and clinics. Number of both Bangla and English version of a newsletter is considered as

[26] Except condom (Tk. 2 per dozen) and ECP (Tk. 8 per packet)

separate unit item in MR newsletter category. The unit cost of MR BCC, Adolescent SRH&R BCC and MR newsletter is Tk. 10, Tk. 35 and Tk. 9 respectively. It is also assumed that cost of producing BCC materials is not included in the unit cost rather this cost reflects administering the activities.

IRG category	July 2004–June 2005			July 2005–June 2006			July 2006–Dec 2006		
	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep
4a. MR BCC	91632	147854	51000	127900	198629	79809	81159	104234	213997
4b. Adolescent SRH & BCC	18801	13112	52472	24727	18075	46398	15723	6558	45026
4c. MR Newsletter	–	–	–	52400	–	–	26000	–	–

Increasing trend of performance of both MR BCC and adolescent SRH&BCC shows that demand side knowledge of women and adolescents on SRHR including access to safe MR has been enhanced through targeted BCC. However, observations and financial document show that unit of reporting is not uniform across NGOs. Regarding MR BCC calculation, BAPSA considers number of women educated/listed in the community and in the clinic[27]. BWHC with its community based programs and clinic set up, conducted MR BCC. It adds household visits (for example, four times visit of 35000 households in a year) in the calculation. RHSTEP considers persons in calculating unit of MR BCC, which includes BCC in the community as well as in the clinic when MR clients, attendants and other patients wait for a service.

Regarding calculation of units for adolescent SRH&BCC, BAPSA and RHSTEP consider persons and contacts along with health services to the adolescents as a unit. On the other hand, inter-personal communication, group session, training man days, number of adolescents (both community and schools) in pre-test and post-test of BCC session, health services all together are considered as adolescent SRH&BCC in BWHC.

Among three NGOs, BAPSA has the responsibility to produce and distribute MR newsletter, both in Bangla and English. As indicators are not mentioned in the MOU, it is assumed that combined amount of production and distribution of the newsletter is considered as a unit. No newsletter was published in 2004–05 while BAPSA produced and distributed 52,400 (Tk. 471,600) and 26,000 (Tk. 234,000) during 2005–06 and July–December 2006.

Recommendations

Three implementing NGOs along with funding agency should specify the indicators and process of calculation of MR BCC and adolescent SRH & BCC to avoid double counting as well as to ensure appropriateness and uniformity in the reporting by unit cost.

Adolescent health service should be separate from BCC as two are completely different type of services. Moreover, unit cost should be defined according to mode of BCC delivered. For example, interpersonal communication involves time cost of a service provider while in a community BCC or a school BCC consists of honorarium of resource person, logistics support, etc. Again, cost will also vary according to number of persons in a BCC session. So, these issues should be taken into consideration before introducing unit cost per performance.

[27] Detail in Chapter II.

5.2 Non-core IRG

5.2.1 RTI/STD, cervical cancer screening

In IRG category 5, treatment of RTI/STD (other than HIV/AIDS) and cervical cancer screening are included. According to MOU, unit cost of other RTI/gyn interventions is Tk. 200 and that of cervical cancer screening is Tk. 550.

IRG Category	July 2004–June 2005			July 2005–June 2006			July 2006–Dec 2006		
	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep
5a. Other RTI/ Gyn interventions	12656	11617	1416	13324	16337	3250	9109	9835	2474
5b. Cervical cancer screening	–	–	9394	–	–	11393	–	–	4617

Three NGOs are involved in providing services to RTI/gynae complication. BAPSA and BWHC treat and refer patients to other health facilities if needed. The medical doctors of RHSTEP treat the patients and refer them to Technical Advisor of the Project. However, it is not found either from performance or financial reporting how many are referred and treated cases.

Under cervical screening sub-category, RHSTEP has been screening and doing diagnosis uterine disease by pap's smear test in its 17 clinics. RHSTEP has achieved more than two and a half times of its target during last year, of which it has only received the reimbursement according to the target mentioned in the proposal. Rest of the cost has been incurred from the service charge.

Recommendations

Unit cost of RTI/gynae interventions needs to be revisited as treatment and referral do not incur equal cost. RHSTEP has been scaled up the paps' smear test in its 17 clinics from nearly two years. It is recommended to evaluate the service according to socio-economic-demographic factor, accessibility of poor women, quality of care, clinical intervention and so on.

5.2.2 Safe pregnancy

According to IRG category, safe delivery, ANC, PNC, and FP (non-MR clients) are included in safe pregnancy. Overall, safe pregnancy is termed as care of a wanted pregnancy episode which includes 3 ANC visits including TT, uncomplicated delivery attended by skilled staff and 2 PNC visits. Unit cost of safe delivery is Tk. 500 while ANC, PNC and FP (contraceptives) is Tk. 60 each. Unit is calculated as number of contacts, i.e. if a mother comes to the clinic for PNC and then asks for any contraceptives and given so, then unit will be two as she is given two different services, PNC and FP.

IRG category	July 2004–June 2005			July 2005–June 2006			July 2006–Dec 2006		
	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep	Bapsa	Bwhc	Rhstep
6a. Safe delivery	–	3969	2	–	4286	12	–	2406	15
6b. ANC,PNC, FP (contraception)	14894	34643	5856	19905	45395	5674	9040	23330	10343

BAPSA does not provide safe delivery service. Safe delivery, according to BWHC, is the summation of number of community and non-community delivery by BWHC trained TBA and number of ensured institutional delivery by TTBA. The BWHC does not have this facility in its clinics. During July 2004 to February 2007, number of safe deliveries at BWHC clinics are 10661 (Tk. 5,330,500). One RHSTEP clinic has the provision of delivery. In total, 29 (Tk. 14,500) deliveries have taken place here over three

years. As this service was not included in the line item of original budget of RHSTEP, the spent money has not been reimbursed from Sida.

During July 2004 to February 2007, BAPSA, BWHC and RHSTEP served 43839 (Tk. 2630340), 103368 (Tk. 6,202,080) and 21,873 (Tk. 1,312,380) contacts for ANC, PNC and FP (non-MR clients).

Recommendations

Unit cost of safe delivery needs to be revisited. Currently unit cost for facility-based service delivery is same as that of only referral services.

Safe pregnancy should be termed as safe motherhood package which includes 3 ANC visits including TT, normal delivery with skilled staff, 2 PNC visits. Unit cost of this combined service can be determined accordingly[28].

5.2.3 Child health/maternal health

According to IRG, child health and/or maternal health is the seventh category. Preventive care, limited curative care, EPI, micronutrient supplementation are included in this group. Unit cost of reported each episode is Tk. 75.

	July 2004-June 2005			July 2005-June 2006			July 2006-Feb 2007		
IRG category	**Bapsa**	**Bwhc**	**Rhstep**	**Bapsa**	**Bwhc**	**Rhstep**	**Bapsa**	**Bwhc**	**Rhstep**
7a. Child Health/ Maternal health	23359	40413	5780	38708	49087	13189	16216	25944	9753

From July 2004 to February 2007, BAPSA, BWHC and RHSTEP served 78283 (Tk. 5,871,225), 115444 (Tk. 8,658,300). This is difficult for two reasons. One is: as two different services are combined together, it is not possible from financial account proportion of child health service or maternal health services among total services. Moreover, there is a possibility of adding a woman seeking for ANC into either safe delivery or ANC or maternal health category. This creates triple counting of one service.

Recommendations

Child health and maternal health need to be considered as individual service, thus unit cost will be revisited accordingly.

5.3 Overhead Cost

Proportion and type of overheads vary across NGOs. BAPSA has 30% administrative overhead cost which includes a) maintaining training liaison and selection of MR trainees; b) monitoring of the distribution of MR equipments; c)quality checking of MR services at providers' level; d) orientation workshop of FP worker on prevention of unwanted pregnancy.

BWHC has same proportion of overhead cost. The expenses incurred in the overheads are: salary and allowances of the staff, supply and stationery, printing, office, vehicle and computer maintenance, rent and utilities, telephone, fax, internet and email services, audit fee and bank charge.

RHSTEP gets only 0.78% as its overhead. The items included in the overheads are: centers Opening Bogra, Video camera, partial payment of ultra sonogram machine of RHSTEP DMCH, medicine, printing of IEC materials, TA/DA, preparatory meeting of centers establishment, development of financial manual, cell phone for drivers, dialogue program of Safe MR organized by RHSTEP, BWHC & BAPSA, feasibility study of Chittagong Hill Tracts program.

[28] UPHCP and Demand-side voucher scheme has determined the cost of delivering this type of package.

5.4 Financial Management

The spent money of three NGOs has been reimbursed during last three years if the service was mentioned as line item in the original budget. However, money spent for outcomes exceeded targets were not reimbursed and NGO has the responsibility to spend from own resources. As per MOU, each NGO was supposed to submit a narrative and analytical report including a presentation of difficulties and shortcomings, together with a discussion of possible remedies. In reality, both six-monthly and yearly reports contain financial statement only without such presentation.

Recommendations

It is recommended that NGOs should report the difficulties in financial mechanism in their half yearly and annual financial report to Sida. Moreover, three NGOs should discuss within themselves to ensure uniform and appropriate reporting as well as to exercise possible remedies of the difficulties they faced.

All NGOs need to have a clear conception regarding the reimbursement mechanism (for example, if the performance exceeds the target), possible areas of utilization from income/own/service account, etc. Sida should provide a guideline in this regard to ensure transparency and accountability.

The strength of unit cost is that performance of a service can be measured as how much is spent to provide one unit of specific service. However, it does not consider the inflation rate incurred over the years. For this reason, implementing agency has to provide service with a fixed amount of money (even the price of equipment rises, or salary increases, etc) where quality of service, sometimes, may be sacrificed.

6. Conclusions

The overall goal of Sida's support to MR program during 2004–07 is to 'improve the health and social status of women and adolescents and contribute to capacity development of service providers and thus help reduce the maternal mortality and morbidity in Bangladesh.' In support of this overall goal, three NGOs, BAPSA, BWHC, and RHSTEP received Sida's funds to provide services according to their agreement.

The evaluation found several strengths and weaknesses of individual NGOs and their performance varies accordingly. Each NGO has its own uniqueness in their service delivery model.

BAPSA performs exclusively, several tasks for the program, such as, training liaison, publishing and disseminating newsletter, and supervision of MR kit distribution. Moreover, it also monitors quality of care of MR services at government facilities and orientation of frontline government FP workers on MR. The nature of this task is more than service delivery. BAPSA can seek more logistic support to ensure, expand and strengthen these activities. It should put effort to make the MR newsletter more target-oriented, informative and attractive. One unique performance of BAPSA is that it has published a take home pictorial as a post MR BCC which is being distributed through its clinics. Other NGOs can use this for same purpose.

It is found that BWHC has an organized and established BCC activities at the community and school level. The adolescent health program organizes training for peer educators, cultural program, and community and group sessions. BWHC has systematic supervision of the field level BCC activities from the central level. Other two NGOs can explore feasibility of BWHC's program strategy to strengthen their BCC activities at the community level. During operational planning of next phase, BWHC should think of upgrading clinic infrastructure and services, such as, post abortion care, clinic furniture, etc.

RHSTEP is housed in public health facilities and therefore referral, diagnosis and treatment of complicated cases are guaranteed here. Among the sister organizations, RHSTEP's 18 clinics could be their referral centers. Keeping in mind the strength of being in the government hospitals, RHSTEP should give more focus on its current and future clinical services. The organization should assess its institutional capacity before expanding and introducing new services. As UPHCP has undertaken most of the urban areas, RHSTEP can redesign its community based BCC program.

During next planning phase, three NGOs should consider following issues: a) assess individual strengths and weaknesses regarding the program and take necessary steps to move forward; b) emphasize on quality of care; c) standardize training program; d) ensure uniformity of record keeping for common services under IRG and consistency in financial and performance reporting; e) establish a specific strategy or mechanism to serve a fixed proportion of poor; f) revisit service charges, for example, uniform service for pain control of MR.

The Executive Committee of all NGOs should play an active role in several issues, such as, a) updating medicine list for uniformity in all clinics; b) ensuring rational use of drugs; c) fixing uniform service for pain control of MR; d) strengthening monitoring and supervision of the program and other relevant issues.

Sida supported MR program which is a parallel support to HNPSP in Bangladesh enables BAPSA, BWHC and RH STEP to continue to deliver and promote SRHR services and capacity building with a focus on MR. Sida can play an important role to strengthen the support as well as performance of the program during next phase. These are: a) to ensure poor-focused services; b) to emphasis on quality of care of services and MR training; c) to revisit unit cost of several categories and explore other funding options; and d) to ensure uniform financial and performance reporting system of NGOs.

Appendix 1

Terms of Reference (ToR) for Evaluation of the Swedish Support to Menstrual Regulation Program of Bangladesh, July 2004–June 2007

1. Background

Sida is supporting the Menstrual Regulation Programme being implemented by NGOs as part of its parallel support to the Health Nutrition and Population Sector Programme (HNPSP) in Bangladesh. This Swedish support should enable three NGOs, Bangladesh Association for Prevention of Septic Abortion (BAPSA), Reproductive Health Services, Training and Education Program (RH STEP) and Bangladesh Women's Health Coalition (BWHC) to continue to deliver and promote Sexual and Reproductive Health and Rights (SRHR) services and capacity building with a focus on Menstrual Regulation (MR).

The Swedish financial support was explicitly linked through unit costing to results and performance based targets. An MOU to that extent was signed between the Sida and the NGOs apart from the financing agreements. The Sida supported projects will end on 30 June 2007. According the financial agreements, now, Sida intends to make a joint evaluation of the projects. The ongoing lack of clarity regarding Ministry of Health and Family Welfare (MOHFW) – NGO partnership and contract modalities affects the MR Programme in the country. The Embassy is now actively considering to extend the financial support until end of the HNPSP, June 2010. The results of the evaluation would help the Embassy to decide about any future support to the above-mentioned NGOs. It is also expected to contribute to the improvement of SRHR Programme by BWHC, BAPSA and RH STEP in the next phase.

2. Objectives of study

Following are the major objectives of the evaluation:

2.1 Analysis of target achievement according to the project documents;

The consultants shall analyse factors both within and outside of the project condition that contribute to the achievement against the targets stipulated in the proposals. (includes but is not limited to NGO provider capacity, NGO institutional setup, NGO relationship with MOHFW and other agencies).

2.2 Status of coordination mechanism of the MR program;

To ensure ownership and thus sustainability of the MR program both within the public and private health system, a number of coordination mechanisms have been designed/initiated. The analysis shall reflect on the appropriateness, technical feasibility and institutional effectiveness and of these coordination mechanisms.

2.3 Analysis of basic performance elements as defined in the MOU and the unit costs:

i. Service delivery

   MR Training (IRG 1)

   MR (IRG 2-3)

   MR BCC (IRG 4)

   Non MR (IRG –5-7)

ii. MR Training Liaison

iii. MR kit distribution supervision

iv. MR newsletter production and distribution

The analysis shall provide a separate section/discussion on each of the above performance elements as they might apply. Should there be significant performance differences in between the three NGOs; the report shall present relevant findings in a desegregated form.

A unit cost based financing was introduced to the NGOs by Sida in 2003. An analysis shall be provided on its strengths and weaknesses comparing with the line item/ component based financing. Amongst other things, the focus should be on its value addition, relevance and justifications and cost-effectiveness.

2.4 Analysis of the service delivery from the poverty perspectives:

The consultants shall examine the extent to which resources (human, financial, drugs) are reaching the poor, vulnerable and excluded groups.

The strategies to reaching the poor, vulnerable and excluded groups shall be reviewed and discussed with the poor people. The provision of service charge, its usage and the criteria of exemption should be reviewed. Moreover, the level of knowledge of poor people about availability of services needs to be assessed. Progress with strategies to strengthen demand by the poor and other vulnerable and excluded groups including BCC shall be covered as well.

3. Methodology

The consultants shall review all relevant documentation and data. Following are some key documentation as reference:

Government of Bangladesh:

1. HNP Strategic Implementation Plan (SIP)

2. Maternal Health Strategy

NGOs

1. MOU between Sida and BWHC, RH STEP and BAPSA

2. Agreements with BWHC, RH STEP and BAPSA

3. Project Documents of BWHC, RH STEP and BAPSA

4. Progress reports

Sida

1. Country Assistance Strategy, January 2002–December 2005

2. A Situation Analysis of the Bangladesh National Menstrual Regulation Program, March 2003

3. Assessment Memo on Swedish Support to the Menstrual Regulation Program of Bangladesh

4. Evaluation Report of National MR Program, June 2003 – June 2004

The consultants should carry out interviews/ discussion with relevant GOB personnel, NGOs, DPs and other stakeholders. The service users, particularly the poor should also be interviewed. Besides, any other activities relevant to the evaluation can be carried out.

4. Timeframe, evaluation team & budget

This consultancy shall be for 21 working days during March 2007, including report writing. Sida will recruit two consultants for the assignment. The consultants shall jointly propose a plan including the timeline for conducting the evaluation, reporting and dissemination in line with the methodology to be applied, and a budget based on the ToR for review and approval by Sida. The budget shall include fees, reimbursable costs, and contingency.

5. Funding of consultancy

The consultants shall be contracted and funded by Sida following Sida's guidelines/regulations for consultancy services.

6. Reporting:

i. Periodic meetings shall take place between the consultants and the Sida and relevant NGO representatives to share information on the progress of the evaluation.

ii. The report should be 25 –30 pages maximum excluding annexes. There will be an Executive Summary of the report not exceeding three pages.

iii. 10 copies of the draft Evaluation Report shall be submitted to Sida in accordance with the agreed time schedule (electronic copy and hard copies). Sida will distribute this to NGOs, GOB, and any other relevant stakeholder for comments.

iv. 10 Copies of the Final Evaluation Report shall be submitted to Sida within one week of receiving comments (electronic copy and hard copies). If, delays occur in submission of the Final Evaluation Report, no additional fund will be provided by Sida to cover the costs.

7. Dissemination of the findings:

The consultants may contact the ICDDR, B Dhaka to organize a meeting to disseminate the findings and the recommendations of the evaluation. The Ministry of Health and Family Welfare (MOHFW), Directorate General of Family Planning (DGFP), NGOs, development partners, academics and other stakeholders should be invited to join the meeting.

Appendix 2

List of Documents Reviewed

Government of Bangladesh

1. HNP Strategic Implementation Plan (SIP)
2. Bangladesh National Strategy for Maternal Health, October 2001

NGOs

3. MOU between Sida and BWHC, RH STEP and BAPSA
4. Agreements with BWHC, RH STEP and BAPSA
3. Project Documents of BWHC, RH STEP and BAPSA
4. Annual reports, Progress reports

Sida

5. Country Assistance Strategy, January 2002–December 2005
6. A Situation Analysis of the Bangladesh National Menstrual Regulation Program, March 2003
7. Assessment Memo on Swedish Support to the Menstrual Regulation Program of Bangladesh
8. Evaluation Report of National MR Program, June 2003–June 2004

Appendix 3

Name	Designation and Organization
Md. Altaf Hossain	Director, BAPSA
Md. Hedayet Ullah Bhuiyan	Training Coordinator, BAPSA
Mr Anwarul Azim	Executive Director, BWHC
Dr Julia Ahmed	Deputy Executive Director, BWHC
Ms Shiuly Hoque	Director, Admin & Finance, BWHC
Md. Masudul Haque	Director, Community Based Program, BWHC
Ms Hasina Chaklader	Director MIS, Research and M&E, BWHC
Dr. Zillur Rahman	Program Manager (RSH-Clinical Services), BWHC
Mr Ajoy Karmaker	Manager-Finance & Accounts, BWHC
Ms. Monica Bagchi	Center Manager, BWHC – Palash
Dr Abul Kalam Azad	Medical Officer, BWHC – Palash
Mr. Ahammad Kader Jaman	Center Manager, BWHC – Zakiganj
Ms Quazi Suraiya Sultana	Executive Director, RHSTEP
Ms Zakia Sultana	Director, RHSTEP
Dr. Morzina Khatun	Trainer, RHSTEP, Sylhet MAG Osmany Medical College Hospital
Dr. Mahasweta Deb	Trainer, RHSTEP, Sylhet MAG Osmany Medical College Hospital
Mr. Nihar Ranjan Das,	Acct. & Admin. Officer, RHSTEP, Sylhet MAG Osmany Medical College Hospital
Dr. Mosmt. Dilruba Parvin,	Trainer, RHSTEP, Khulna Medical College Hospital
Dr. NasreentParvin	Trainer, RHSTEP, Khulna Medical College Hospital
Mr. Nikhil Kumar Biswas,	Acct. & Admin. Officer, RHSTEP, Khulna Medical College Hospital
Dr. Monnu Jan Begum	Trainer, RHSTEP, Bogra Mohammad Ali Hospital
Mr. Md. Ibrahim Bhuiyan	Acct. & Admin. Officer, RHSTEP, Bogra Mohammad Ali Hospital
Dr Halida Hanum Akhter	Director General, FPAB
Dr Jahir Uddin Ahmed	Additional Director General, FPAB
Dr Faruque Ahmed	Director, Health Program, BRAC
Dr. Reena Yasmin	Director Services, Marie Stopes Bangladesh
Dr. Hashrat Ara Begum	General Manager Services, Marie Stopes Bangladesh
Dr Frank Paulin	Medical Officer-Public Health Administrator, WHO
Dr Sabera Rahman	President, RHSTEP
Dr A. Bayes Bhuiya	Ex-President, OGSB
Dr Mahnur Rahman	Vice President, BAPSA
Dr Syed AKM Hasan Alam	Director, MFSTC
Dr. Md. Akhtar Hossain Miaji	Director (Training), NIPORT
Dr. Md. Shirajul Islam Khan	General Physician & Surgeon, Upazilla Health Complex, Zakiganj, Sylhet
Brig Gen (Dr.) Md. Shah-E-Alam	Director, Sylhet MAG Osmani Medical College Hospital
Ms Anne Bruzelius	Minister – Deputy Head of Mission, Sida/Embassy of Sweden
Syed Khaled Ahsan	Senior Program Officer, Sida
Dr. Md. Ashraf Ali	Program Manager (CA-SS) MC&RH Service Delivery Unit, Directorate of Family Planning, Government of Bangladesh
Dr Jafar Ahmed Hakim	Director–MCH (in Charge), Line Director (MC-RH), MC&RH Service Delivery Unit, Directorate of Family Planning, Government of Bangladesh

Appendix 4

Analgesics being used by the NGOs before MR procedure (differently)

1. Injection Tramadol hydrochloride-100mg. IM
2. Injection Diclofenac Sodium-75mg
3. Diclofenac sodium suppository-adult
4. Injection Diazepam-10mg amp
5. Tablet Hyoscine butylbromide 10mg
6. Tablet Paracetamol
7. Injection Pethidine (for D&C)

Medicines being prescribed after MR in different combinations

1. Tablet Ciprofloxacin
2. Capsule Doxycycline
3. Tablet Cefixime
4. Capsule Amoxycillin
5. Tablet Metronidazole
6. Tablet Ranitidine (some places it is being used routinely after MR)
7. Vitamin B complex
8. Tablet/Capsule Iron and Folic Acid
9. Multivitamin tablets
10. Tablet Paracetamol

Emergency medicines & equipments being used by three NGOs (Need-based)

1. Injection Dexamethasone
2. Injection Hydrocortisone
3. Injection Methyl-Ergometrine
4. Infusion Normal Saline
5. Infusion 5% Dextrose in Saline
6. Injection Aminophylline
7. Injection Atropine
8. Injection Oxytocin
9. Injection Diazepam
10. Syringes
11. Oxygen cylinder with accessories

Appendix 5

List of Printed BCC Materials Developed and Being Used by Three NGOs

1. Merits and demerits of using modern family planning methods-Developed by BAPSA supported by Sida
2. Adolescents Health- Developed by BAPSA supported by Sida
3. Instructions for clients received MR services: Pictorial folded- by BAPSA supported by Sida
4. Causes and Prevention of Reproductive Tract Infection, Sexually Transmitted Infection and HIV/AIDS-developed by BAPSA supported by Sida
5. Adolescent Health Education- Developed by BAPSA supported by Sida
6. Prevention of Septic abortion: Things to remember – Developed by BAPSA supported by Sida
7. Awareness program on Prevention of Septic Abortion for Frontline Workers of the GOB: Population & Reproductive Health Information- Developed by BAPSA supported by Sida
8. Seven Messages on Menstrual Regulation: Developed by BAPSA & RHSTEP supported by Sida
9. Flipchart: Behavior Change Communication information on Menstrual Regulation-developed by BWHC
10. Awareness on HIV/AIDS BCC material-developed by RHSTEP
11. Cervical Cancer screening & Pap's smear: BCC material-developed by RHSTEP
12. Adolescent: Health, education and services- BCC material-developed by RHSTEP
13. RHSTEP fliers for different clinics on availability of services at clinics –for marketing of RHSTEP clinics
14. Wall Posters on MR (for internal use only)-when and where to do MR: Jointly developed by BAPSA, BWHC and RHSTEP supported by Sida
15. Calculation of duration of amenorrhea from the last menstrual period: A one-month title example chart-developed by BAPSA (Its rather a job-aid)

Appendix 6

Awareness Program on Prevention of Septic Abortion
One-day Orientation of Frontline Workers of the GOB (MOHFW)

Schedule

10:00 am–4:00 pm	Session	Discussants
10:00–11:00	**Inaugural**	**Local level GOB officials and BAPSA officials**
	Objectives of the program	
	Speech of Upazila Family Planning Officer	
	Speech of Medical Officer-MCH	
	Speech of Special Guests	
	Speech of Chief Guest	
	Speech of Chairperson	
11:00-11:15	**Break**	
11:00-2:30	**Working Session**	
	Pre-test	
	Brief description on activities of BAPSA	
	Discussion on Family Planning program and progress	
	Causes of Maternal Mortality in Bangladesh and steps for prevention	
	Causes, dangers and complications of Abortion and maternal mortality	
	Complications of abortion and its preventive measures	
	MR program in Bangladesh, causes of rejection for MR and steps to prevent rejections	
	Discussion Session	
	Post-test	
2:30	**Wrapping**	

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