Enhancing the Impact of Child Health Activities through the USAID-supported NGO Service Delivery Program (NSDP) in Bangladesh

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ACRONYMS

ADB	Asian Development Bank
ANC	Antenatal care
ARI	Acute Respiratory Infection
BCC	Behavioral change communication
BCCP	Bangladesh Center for Communication Programs
BCG	Bacillus of Calmette and Guerin
BINP	Bangladesh Integrated Nutrition Program
BRAC	Bangladesh Rural Advancement Committee
DGHS	Directorate General of Health Services
CARE	Cooperation for Assistance and Relief Everywhere
CDD	Control of diarrheal diseases
CH	Child Health
CIDA	Canadian International Development Agency
C-IMCI	Community Integrated Management of Childhood Illnesses
DFID	Department for International Development (UK)
DPT	Diphtheria, pertussis and tetanus
DTTEM	Deloitte Touche Emerging Markets
ENC	Essential Newborn Care
EOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunization
FP	Family planning
ESP	Essential Services Package
FY	Fiscal year
GoB	Government of Bangladesh
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HNPSP	Health, Nutrition Population Sector Program
HPSP	Health Population Sector Program
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
IMCI	Integrated Management of Childhood Illnesses
Intrah	Innovative Technologies for Health Care Delivery
IOCH	Immunization and Other Child Health
IUD	Intrauterine device
LAMB	Dinajpur-based Hospital
LT	Long-term
MCH-FP	Maternal and Child Health-Family Planning
M&E	Monitoring and Evaluation
MEASURE	Measure Evaluation Project
MEDS	Monitoring, Evaluation, Design and Support Project
MIS	Management Information System
MOCAT	Modified Organizational Capacity Assessment Tool
MOH&FW	Ministry of Health and Family Welfare
MSH	Management Sciences for Health
NIPHP	National Integrated Population and Health Program
NIDS	National Immunization Days
NNP	National Nutrition Program
NGO	Nongovernmental Organization
NIRAHPAD/ MA	New Initiatives for Reproductive Awareness and Healthy Pregnancies and Delivery through Multiple Approach

NSDP	NGO Service Delivery Program
NSP	Nutritional Surveillance Project
OR	Operations research
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary health care
PHN	Population health and nutrition
PMP	Performance Monitoring Plan
PNC	Postnatal Care
PNA	Performance needs assessment
PRIME	Primary Providers' Training and Education in Reproductive Health
QA	Quality assurance
QI	Quality improvement
RADDA	Radda MCH-FP Centre
RFA	Request for Application
RH	Reproductive health
RSDP	Rural Service Delivery Partnership
RTI	Reproductive tract infection
RTI	Research Triangle Institute
RTO	Regional technical officers
SCF/US	Save the Children Federation/United States
SNL	Saving Newborn Lives
SO	Strategic Objective
SOW	Scope of Work
STI	Sexually transmitted infection
SWAP	Sector-wide approach
TA	Technical assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOT	Training of trainers
UHC	Upazila Health Complex
UNICEF	United Nations Children’s Fund
UFHP	Urban Family Health Partnership
UPHCP	Urban Primary Health Care Project
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

This report assesses the child health activities and planned interventions being carried out in Bangladesh by the NGO Service Delivery Project (NSDP), the largest assistance activity of The United States Agency for International Development (USAID)/Bangladesh's Population, Health and Nutrition (PHN) Office. On the basis of this assessment, the report recommends strategies for improving the coverage and impact of child health activities planned for implementation with the project's nongovernmental organization (NGO) partners and includes a plan of action to guide these proposed changes. This work on which this report is based was carried out by a three-person team in Bangladesh between February 24 and March 14, 2003.

A $60 million multi partner cooperative agreement that began in May, 2002, the NSDP is led by Pathfinder International. The NSDP, which builds on the activities of two previous NGO projects, includes 41 local NGOs that operate static and satellite clinics and a network of 7,000 community based rural depot holders. Child health receives approximately one-third of the project's total budget.

The major findings of the assessment suggest that some changes in staffing and resource allocation will be necessary to make child health a part of the NSDP that has real impact. All of these changes are judged, however, to be within reach without major strategic changes in the NSDP's basic family planning mandate.

FINDINGS

Project-Level Strategic Findings and Program Directions

The assessment team identified two project-level findings that impede child health programming. First, like its predecessors, the NSDP has not focused on expanding coverage or priority interventions that have the most impact on child health. Although NSDP clinics provide care to large numbers of patients, acute respiratory infections (ARI) and diarrheal disease remain major causes of child morbidity and mortality. Second, much of NSDP programming is driven by unofficial policies about sustainability, services to the poor, and the importance of market share. These views encourage NGOs to judge their success largely by cost recovery and emphasize the primacy of static and satellite[1] clinics over community-based services. This approach is

[1] This report discusses the satellite clinic system as part of the NSDP's community-based network. These clinics were interpreted as such because they are currently the only consistent curative presence that the project has at the community level. The Team strongly agrees with a point that has been raised by USAID/Dhaka, however, that satellites are actually extensions of the static clinic system. We also agree that due to their intermittent nature, they are not adequate for the delivery of effective child health services. Certainly the project's static clinics are not the answer either, but given available resources and the NSDP's larger reproductive health mandate, the Team was reluctant to recommend a new delivery system for child health services.
The body of this report offers many suggestions how the NSDP can strengthen the response capability of existing systems. These include expansion of the number and frequency of satellites, increasing the number and responsibilities of depot holders, reworking the strategy for Community Integrated Management of Childhood Illness (C-IMCI), and improving collaboration with other programs and NGOs to create a community-based service network within

not conducive to the provision of many critical child health services. Unless these two issues are resolved, the NSDP is likely to spend a great deal of money but have little impact on child health in NGO service areas.

Other secondary program findings are as follows:

- The NSDP lacks clarity on the objectives and benefits of planned child health initiatives, especially those which introduce new strategies (e.g. integrated management of childhood illness [IMCI], community integrated management of childhood illness [C-IMCI], and essential newborn care [ENC]).

- The primacy of static clinics over satellites and other community-based services is encouraged as informal policy by some parts of the NSDP. This greatly reduces the probability that NSDP can have a positive affect on child health in extremely low-resource environments.

- Training has been identified as an essential activity for achieving NSDP objectives. The reliance on training as the main strategy for introducing and sustaining child health interventions, however, is not sufficient. Other strategies (i.e., supervision, program planning and evaluation) will be needed. The current focus on developing capacity to conduct training internally is also not optimal, since many child health programs also offer these capabilities. Other approaches should be explored.

- CARE (Cooperation for Assistance and Relief Everywhere) and SCF/US (Save the Children Federation/United States) are the NSDP's primary child health partners, but have very small roles in the project and their expertise is underused. Child health specialists from these organizations are low in the management structure and usually have poor support from senior managers.

- Project NGOs are usually not included in decision-making, and processes that affect them are not transparent.

NSDP Management

Major findings about NSDP management related to child health include the following:

- The NSDP organization is strongly vertical, creating barriers to integrated efforts, especially in child health. The Clinical Services Unit, where most activities are located, does not have a community health approach or management perspective to support child health efforts.

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designated catchment areas. The Team feels that it doesn't matter what strategy the NSDP uses to place child health services in the community as long as they hear the message clearly that child health programming that makes a difference will demand a community based component that can deliver emergency curative care for the big child killers in Bangladesh, ARI and CDD.

- The NSDP has no senior-level technical expert in child health. This is a significant impediment to developing an effective child health agenda.

- There is no specific plan to help NGOs operationalize activities over the long term. Such a plan is especially necessary for child health interventions, which are being introduced through small pilot activities that are intended to be scaled up rapidly.

- The management information system (MIS) and monitoring and evaluation (M&E) systems of the project need to be reviewed and adjusted to better support child health needs. Universally accepted key indicators for child health should be incorporated into the existing system.

- Institutional development is excessively linked to financial concerns. In order to build NGO capacity, other technical and programmatic elements need to be addressed in addition to ensuring adequate financial viability.

- Current logistics plans may be unrealistic, given the NSDP's current staffing and capacity. The rapid expansion of IMCI will exert new heavy demands on these systems, but there are no concrete plans to meet those demands.

Child Health Technical Components

The NSDP's technical approach to child health features a series of separate interventions introduced through training. The project has no systematic plan for how new strategies will be integrated, and it has not analyzed the costs and benefits of such integration to individual NGOs. There is a common perception that some technical initiatives "belong" to specific NSDP partners. Those who have a bigger share of management and resources are able to push forward initiatives that they perceive as important. Others initiatives, championed by staff with less influence, have not gained much traction.

The Essential Service Package (ESP)

The ESP[2] appears to have worked well for NGOs; however, it has limited capacity to meet child health needs at the periphery. It cannot respond well to child health emergencies, such as the provision of antibiotics for ARIs and treatment for severe diarrheal disease. This strongly limits the NGOs' ability to make an impact on child health.

The NSDP has differing views about how this limited emergency capability should be overcome. Many see improved static clinics and community education as the answer, while others believe that only improved treatment options in the community will

[2] The Essential Services Package is a full range of basic health interventions defined by the GoB's Health and Population Sector Program and introduced into all services under the Mission's two previous NGO projects in rural and urban areas.

adequately address the problem. These differing views struggle against each other and affect some ESP service delivery.

Clinical IMCI

Clinical IMCI is the main mechanism through which modern child health is being implemented in the NSDP. Under a joint program with the Government of Bangladesh (GoB), the NSDP has 15 pilot clinics in urban areas where IMCI is being initiated as a national strategy. There is much internal pressure on the NSDP to implement IMCI rapidly. The current plan calls for establishing up to 55 clinics this year, and similar scale-up is planned for the following years.

It is clear that clinical IMCI is the future for project NGOs, but before this can happen, a number of issues need to be discussed and resolved:

- There is no clear understanding of the advantages of IMCI in NGO clinics beyond making them more programmatically up-to-date. Current expectations about the benefits of IMCI may not be realistic.

- NGOs may not be aware that an IMCI clinic system is complicated and expensive to maintain. It is also not clear whether the NGOs will be able to assume these costs when the NSDP ends.

- Clinical IMCI is currently considered largely a training issue. There has not been adequate thinking and planning about recurring costs, logistics, and other support systems.

Community IMCI

The C-IMCI strategy is closely aligned with that of the GoB and, if plans go forward as described in March 2003, the NSDP will initiate activities in 9 pilot areas in 2003. Over the next three years the NSDP hopes to roll out this program to approximately two-thirds of its 278 clinics and 7,000 depot holders.

Although C-IMCI is potentially the most important child health intervention proposed by the NSDP, it is not supported by a clear mandate, a strategic framework, or a detailed implementation plan. Despite hard-working, talented staff, the initiative has not had strong senior management support nor has it been widely discussed and embraced by the NSDP as a pivotal intervention. A careful examination of the far-ranging implications for community-based programming and services is overdue. Decisions about whether and how to move forward will require serious technical and programmatic review and much broader institutional support than C-IMCI currently enjoys.

Neonatal Health and Linkages with Maternal Health and Malnutrition

NSDP activities do not have a neonatal component and the current service delivery system is not well positioned to deliver essential newborn care (ENC). There are no plans to intervene with neonates at the community level, although C-IMCI may provide more focus on newborns in the home. The project proposes to adapt successful strategies from the Saving Newborn Lives (SNL) initiative, but this passive approach places meaningful neonatal activities at least two to three years away.

Improvements in neonatal care are closely linked with better maternal health, but the NSDP has not yet addressed these program strategies. With the exception of a plan to improve the referral process, there are no strategies to move forward in this area. Likewise, nutrition is underrepresented. Counseling mothers is the only nutritional intervention being contemplated, and there are no links with the recently expanded activities of the GoB's National Nutrition Program (NNP).

Behavior Change Communications

Behavior change communication (BCC) activities are not well aligned with child health needs. Current plans focus mainly on expanded community awareness of NGO services, household prevention and community mobilization to support C-IMCI. The Bangladesh Center for Communications Programs (BCCP) is a good resource, but it will have to support this program area to a greater extent than currently anticipated. Necessary adjustments include a better technical background in child health interventions, less use of mass media, and more emphasis on adapting and reproducing materials from other sources. Effective BCC support to child health will involve some new thinking and, probably, some reallocation of priorities and resources within Objective 2 of the NSDP's four major objectives.

Coordination

The principal findings in Coordination are:

- Internal coordination has been a lengthy and difficult process, but it is improving. In the past, partner NGOs have not been systematically included.

- The project's relationship with other USAID-funded programs in child health is presently weak. The NSDP has not contacted many organizations and does not have an explicit strategy for exchanging information and coordinating with other groups that have related interests.

- Coordination with the GoB is both formal and informal, but it is influenced by USAID's current limited collaboration with government programs. There are many opportunities to increase collaboration that the NSDP, with USAID support, could explore.

- NSDP currently collaborates with some urban health services in municipalities and city corporations, but greater participation of NGOs would be welcome.

- NSDP collaboration with other donors and programs has not been systematically explored. Many NSDP staff has experience working and coordinating with Bangladesh-based international and national organizations, but their expertise is not used.

- Project links with other NGOs are often more informal than formal. Better collaboration could help to expand the NSDP's capacity in child health. Productive exchange with the Bangladesh Rural Advancement Committee (BRAC) is also needed.

- The NSDP has limited collaboration with private-sector facilities, private doctors, traditional practitioners and traditional birth attendants (TBAs) in the community. These represent missed opportunities for more effective referral in child health, especially for neonates.

RECOMMENDATIONS

Project Level Recommendations and Program Directions

- The NSDP and USAID should clarify the ground rules regarding the expectations for the amount of coverage and impact that the child health interventions should achieve.

- Views about sustainability, services to the poor and market share need to be reviewed and defined. All partners must collaborate in this effort.

- The project needs to develop a cohesive child health strategy as soon as possible

- The NSDP must clarify its position regarding static clinics and community-based services. Effective child health requires that some emergency curative services be consistently available at the community level.

- The NSDP needs to review its training strategy in child health. The creation of sustainable, cost-effective collaboration with organizations and institutions that already have good child health expertise should be explored.

- The project needs better ways to make NGOs part of the decision-making processes that affect them. There must be greater transparency, and the NGOs must receive the information and guidelines they feel they need in a more timely fashion.

Management Recommendations

- NSDP should add a senior-level child health position or positions at or above the current senior management levels to provide comprehensive technical leadership in child health.

- The NSDP should significantly reorient the management structure and functions at the central and regional levels to develop and support implementation of child health activities.

- Using the child health strategy and its indicators, NSDP should work with the various technical support units (e.g., training, MIS, M&E, and sustainability) to improve support to these activities.

- The MIS/M&E system needs review and adjustment to (1) summarize and analyze child health data based on universally accepted indicators; and (2) simplify, clarify, and distribute data to NSDP program staff and NGOs.

- The Quality Improvement (QI) Unit must modify some of its approaches to better respond to child health and community-based services.

- NSDP and USAID management should continue their discussions about realistic sustainability objectives. The Institutional Development Unit can then develop a work plan and timetable to respond to these objectives.

- NSDP management should work with the Logistics Unit to assess and improve its capacity to meet the needs of an expanded child health program.

Technical Components

- The Essential Services Package. The ESP should be viewed as a platform for consolidation of NSDP child health services and as a lead-up into clinical IMCI and C-IMCI. The project also needs to plan for the introduction of new strategies into ESP services.

- Clinical IMCI. The plans for rapid scale-up of clinical IMCI at project clinics should be reexamined and possibly slowed down. Although NSDP NGOs are anxious to offer IMCI at their clinics, the implications of this expansion (e.g., its cost, feasibility, and timing) have not been sufficiently considered. The current fast-track strategy is likely to create more problems than it solves, as neither the project nor NGOs seem fully prepared to assume the increased management and financial burdens that will be needed to support an adequately functioning IMCI system.

- Community IMCI. C-IMCI is likely to be the most important child health measure proposed by the NSDP. At this point, however, it is far from this potential, despite

best efforts of project staff. The project will have to make a number of adjustments in its approach and provide much better support for this important intervention.

- Neonatal Mortality and Linkages with Maternal Health and Malnutrition. NSDP should significantly increase its focus on neonatal health, and neonatal mortality should be an aggressively pursued target of C-IMCI. The project should also strengthen its linkages with maternal health activities and consider incorporating nutrition in child health interventions. The NSDP should try to avoid "going it alone" in these areas. There are many organizations and activities working on these issues with which the project could partner.

- BCC Activities. The BCCP should be brought into the overall planning process for child health activities as early as possible, and the NSDP should take steps to ensure it has access and resources to learn about the technical aspects of interventions in this area. The BCCP should also refocus some strategies and methods to make them more appropriate for child health in low-resource settings.

Coordination

- NSDP should continue to focus on strengthening internal coordination among partners. Particular attention needs to be given to improving coordination with the local offices of CARE and SCF/US.

- USAID should work with the project to clarify its relationship with the GoB, and the NSDP should develop a strategy for formal and informal interaction, coordination, and collaboration. Special efforts are needed to enhance coordination between NSDP's regional offices and the GoB, and between NSDP NGOs with local and municipal governments.

- The NSDP should continue, build upon, and strengthen current coordination with municipalities which have limited resources and therefore a greater need for coordination with NGOs. It should continue to coordinate with city corporations and the Urban Primary Health Care Project (UPHCP).

- The project should develop a strategy for interacting with relevant international and national organizations and begin implementing this plan as soon as possible. This plan should include collaboration with BRAC.

- NSDP should identify other networks of NGOs and programs working in child health and explore mechanisms for collaborating and sharing of information and experiences. A direct exchange of technical assistance (TA) and joint training with these groups should be considered.

- The project should become more familiar with child health programs of other donors and seek ways to collaborate with them in child health programming, including the exchange of technical expertise and training in child health.

- NSDP should improve coordination with private health sector facilities and physicians and with local practitioners and TBAs.

I. BACKGROUND

Historically, USAID/Bangladesh has funded strong programs in support of better access to quality family planning and reproductive health care. This focus, which emphasizes smaller families and fewer, healthier children, is seen as the most critical component of the overall commitment to child survival set forth in the USAID/Bangladesh Mission strategy.[3] To support this strategy, the mission also funds research, infectious disease programming, and child health activities in NGO projects within the Population, Health and Nutrition (PHN) portfolio.

Bangladesh has made progress in reducing infant and child mortality rates over the last decade, but significant problems still exist, particularly with respect to children under the age of five. In 1995-1999, the infant mortality rate was estimated at 66 per 1,000 live births, and neonatal mortality was 42 per 1,000 live births. Less than 60 percent of children are fully immunized by their first birthday, 38 percent of infants are given supplementary feeding during the first three months of life, and 48 percent of children between 6 and 59 months of age have moderate-to-severe anemia. In recent years these rates have changed for the worse as the country has discontinued outreach services in favor of static clinics.

This poor outlook is compounded by an exceedingly grim picture of neonatal mortality. More than 90 percent of mothers deliver their babies at home. The majority of neonatal health problems occur in the community, where families have no support from trained health care professionals. Sixty-four percent of all infant deaths occur during the neonatal period (birth to 28 days), primarily as a result of premature birth, birth asphyxia, pneumonia, and septicemia. There are at least 100,000 stillbirths annually, bringing the total perinatal (i.e., stillbirths and deaths in the early neonatal period) and neonatal deaths to 250,000 annually.[4]

Most deaths in infancy are from readily preventable or treatable conditions such as pneumonia, diarrhea, measles, and neonatal tetanus. Protein-energy malnutrition is also a strong cause of death from infectious diseases: 66 percent of childhood deaths in Bangladesh are currently attributable to malnutrition, even though the immediate cause of death may have been due to some other cause. This is approximately 250,000 deaths among children under five years of age annually (more than 600 per day).

[3] USAID/Bangladesh's Mission Goal is poverty alleviation. The Mission is organized into six Strategic Objectives. The Population, Health and Nutrition (PHN) Team's Strategic Objective is *fertility reduced and family health improved*. (See USAID's web page www.usaid.gov/bd for more information.)

[4] State of the World's Newborn, Bangladesh. UNICEF, 2001.

II. SCOPE OF WORK AND METHODOLOGY

The purpose of this assignment was to assist USAID/Bangladesh's PHN Office and its largest assistance activity, the NGO Service Delivery Project (NSDP), to assess current child health activities and planned interventions carried out by the project and its NGO partners. The team was also asked to make recommendations and to develop a plan of action to help the NSDP and NGOs to implement the recommendations.

The review was carried out by a three-person team identified and fielded by the Monitoring, Evaluation, Design and Support (MEDS) Project (Contract no.HRN-I-00-99-00002-00). The team carried out its work in Bangladesh between February 24 and March 14, 2003. The team leader was Melody A. Trott, Ph.D.; the other team members were Judith Justice, Ph.D., M.P.H., and Rose Schneider, R.N., M.P.H. The scope of work (SOW) for this assignment is included as Annex A. The Plan of Action developed for this Assessment is included in Annex B.

ASSESSMENT METHODOLOGY

The team carried out the following activities as part of this assignment:

- Review of documents provided by USAID/Washington, USAID/Bangladesh, the NSDP, and other donors and programs working in child health in Bangladesh. A list of documents reviewed is included as Annex C.

- Participation in a two-day team planning meeting at the MEDS Project offices in Washington, D.C., on February 20 and 21, 2003. The agenda of this meeting and the initial technical assignments of the MEDS team are included in Annex D.

- Attendance at briefings by USAID/Washington personnel, PHN staff at USAID/Bangladesh, and the technical and management staff of the NSDP. The team also met with the leaders and staff of many programs and institutions in Bangladesh and with the Ministry of Health and Family Welfare (MOH&FW). A list of contacts is included as Annex E.

- Participation in meetings in Bangladesh with NSDP staff and other relevant organizations. Team members and NSDP staff made field visits to program operations in Sylet, Dinajpur and Khulna. These included both rural and urban sites and service facilities at all levels, including private and Government of Bangladesh institutions that the program uses or plans to use for referral. (See Annex F for a list of meetings and itineraries.)

- Development and presentation of Summary Recommendations to the NSDP. This Summary, which was distributed to the NSDP staff and USAID/Bangladesh, is included in Annex G.

While in Bangladesh, team members usually operated independently of each other to maximize their work and meeting coverage. NSDP technical staff accompanied the team to almost all meetings and gave freely of their time and energy to maximize the value of this assessment. The enthusiasm that they brought to this exercise was the major factor in making this assignment both successful and pleasurable.

III. USAID/BANGLADESH PROGRAM

USAID's Population, Health and Nutrition (PHN) Office provides assistance to Bangladesh through the National Integrated Health and Population Program (NIPHP), which was launched in 1997. All mission PHN activities are subsumed under the NIPHP, which is implemented under an agreement with the Government of the People's Republic of Bangladesh Ministry of Health and Family Welfare (MOH&FW). The NIPHP supports activities in family planning and reproductive health, child health, social marketing, HIV/AIDS prevention, logistics and commodities procurement, and technical assistance to the GoB, among others. USAID also provides for TA to these through field support agreements with many USAID/Washington centrally-funded and managed projects.

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The NSDP, a $60 million, four-and-a-half year cooperative agreement, is the mission's largest PHN activity. The Pathfinder Fund is the lead grantee.[5] The NSDP began work in May of 2002, building on activities of two previous NGO projects, the Urban Family Health Partnership (UFHP), and the Rural Service Delivery Partnership (RSDP), and other partners, including the Quality Improvement Project, Primary Providers' training and Education in Reproductive Health (PRIME), and Quality Assurance II.

At present, the NSDP works with 41 local NGOs, 278 static clinics, approximately 70 upgraded satellite clinics, 13,817 satellite clinics sessions a month and some 7000 community based rural depot holders[6] serving over 1.5 million clients a month throughout Bangladesh. The project supports these NGOs to deliver an essential services package (ESP) that was defined in the GoB's Health and Population Sector Programme (HPSP) 1998-2003.[7] "Essential services" include child health, maternal health care, reproductive health care, clinical and non-clinical family planning, communicable disease control, tuberculosis, safe delivery (including first aid emergency obstetric care and post abortion care), and limited curative care. NGOs working with the NSDP offer all services within the capabilities of their points of service and will upgrade static facilities to improve clinical capabilities.

[5] In addition to The Pathfinder Fund, the Consortium partners include the Bangladesh Center for Communications Program (BCCP), CARE, Deloitte Touche Emerging Markets, Intrah/University of North Carolina Medical School, the Research Triangle Institute (RTI), Save the Children Federation (SCF/US), and the University Research Corporation (URC).

[6] Depot holders are minimally compensated rural community based health workers. The NSDP system currently has about 7000 in NGO catchment areas. Depot holders have had some training in ESP and provide family planning counseling and some commodities (condoms and orals), as well as oral rehydration salts (ORS) for treatment of childhood diarrhea. They are supervised by paramedics and refer clients to the NSDP static and satellite clinic system and to GoB facilities if they are available.

[7] The HPSP (1998-2002) is a multiple donor-supported GoB health sector-wide approach program (SWAP) which is scheduled to end in June, 2003. At present, there is no agreement for a follow-on program, although the GoB is working on a new design.

Major objectives of the NSDP project are as follows:

- Objective 1. Expanding the range and improving the quality of ESP provided by NGOs at the clinic and community levels;

- Objective 2. Increasing the use of ESP services, especially by the poor;

- Objective 3. Increasing the capacity of NGOs to sustain clinic- and community-based services, both institutionally and financially; and

- Objective 4. Influencing the GOB, in coordination with other donors, to expand the role of NGOs as providers of ESP services within the national health system.

Approximately two-thirds of current NSDP funding is from population-related accounts. The remaining one-third supports programming in other areas; approximately 30 percent for activities in support of child health.

IV. FINDINGS

The NSDP is a complex project with many ambitious plans for improving the services and sustainability of its partner NGOs and the communities they serve. Many functions and activities are still in the planning stages, making this an opportune time for this collaborative assessment of NSDP child health activities. The major findings are summarized below.

In reviewing these findings, it is important to begin by noting that the NSDP inherited a system that had barriers to more effective targeting and expansion of child health services. Plans for addressing some of these barriers are already being discussed. Equally important, many of the issues discussed below could, with careful review and some modifications, be resolved within existing project strategies and plans. Finally, the NSDP already has in place a cadre of skilled technical personnel who, with some additional support, are capable of implementing many of the changes necessary to improve its child health programming.

The findings below imply that some changes in staffing and resource allocation will be necessary to make child health a part of the NSDP that has real impact. All of these, however, are within reach without major strategic changes in the NSDP's basic family planning mandate, provided that the project has the motivation and will to make them happen.

PROJECT-LEVEL STRATEGIC FINDINGS

The two issues that seem to pose the greatest impediments to the development of a more comprehensive and effective child health program are (1) limited coverage and an inadequate focus on child health priority interventions; and (2) varied interpretations of NGO sustainability, the mandate for providing services to the poor, and the importance of market share in defining these services. These two issues are discussed below with specific reference to child health. Some aspects influence broader areas of the project and may merit a general review by NSDP management in the future.

Coverage and Focus on Priority Child Health Interventions

Under the RSDP and UFHP, NGOs provided families in their catchment areas with access to most of the major child health interventions defined in the ESP.[8] These included services in the extended program for immunizations (EPI), control of diarrheal diseases (CDD), and acute respiratory infection (ARI). Evaluations of these projects, conducted by

[8] The Essential Service Package (ESP) is a full range of basic health interventions defined by the HSPS and introduced into all services under the RSDP and the UHSP. These services vary some by sites, but are theoretically available throughout the NGO service delivery system, based on the capability of providers at the point of service (depot holders, for example, currently offer no child health interventions other than CDD counseling and oral rehydration solutions.).

Measure Evaluation Project (MEASURE)[9] in 1998 and 2001, found only limited progress in expanding coverage; in fact, interventions in some priority child health activities actually were declining. Annex H, Table 1 summarizes the survey findings for both rural and urban areas. The disappointing results in child health detailed in this table occurred despite previous projects' considerable number of clinics, customer contacts, staff and resources.

Although the NSDP is not responsible for the results of the RSDP or the UFHP, its current strategy, activities and allocations of resources appear to follow the same pattern. As a result, the team was concerned that without changes, it was likely that this new effort would also not achieve improvements in coverage or, worse still, that coverage would continue to decline.

To explore this possibility, the team conducted and analysis of data primarily on EPI from the project's management information system (MIS) for its first six months. EPI is the area in which the NSDP is most active and has the most information, but it was assumed that it could also be used as a proxy for trends in other child health services being delivered. The original NSDP Performance Report for July-December, 2002 is reproduced in Annex H, Table 2.[10] Annex H, Table 3 (Contacts for Services) and Table 4 (Coverage) reorganizes and summarizes this same information. The specific results of this analysis follow Tables 3 and 4 in Annex H.

This analysis suggests two important points regarding NSDP service delivery in child health:

Contacts for Services.[11] As Table 3 indicates, the NSDP NGOs had a very high number of EPI contacts (almost 3 per infant over the six month period) but the percentages of individual vaccinations actually delivered are low. This suggests that these high contact numbers do not translate into a significant number of fully immunized children in the project's NGO catchment areas. A number of factors contribute to this,[12] but the fact remains that there seem to be many missed opportunities to deliver this important child health measure during the project contacts with children. Assuming that EPI is a legitimate proxy for trends in other child health interventions (e.g., there is no monitoring of ARIs in the under 1 year olds, but nationally, ARI is responsible for about 20 percent

[9] 2001 Rural Service Delivery Partnership Evaluation Survey. MEASURE Evaluation. Associates for Community and Population Research, Dhaka, Bangladesh. December, 2002. 2001 Urban Family Health Partnership Evaluation Survey. MEASURE Evaluation, Mitra and Associates, Dhaka, Bangladesh, December 2002.

[10] The NSDP Performance Table presents its data using general categories that do not allow the analysis of information on universally accepted categories of services for child health intervention priorities; for example, the number of ARI contacts under one year of age, when a child is most vulnerable is not shown.

[11] The NSDP's use of "contacts" as a performance indicator is problematic, as there is presently no way to assess what it means in any given context. In some cases, the delivery of a specific service is counted as one contact, in which case, several "contacts" may be recorded for the same client in the same visit if they received more than one service (i.e. if a child was seen, immunized, and given Vitamin A, three contacts might be counted). In other cases, "contact" can be equated to a "visit" during which a child may have received several services or even none. Regardless of services delivered, it is counted as a single "contact." This also makes assessing the coverage of services particularly difficult.

[12] Problems with vaccine availability from the GoB may play a role here, as could the option that parents have to take children to other services for some vaccinations. USAID/Bangladesh also feels that the NSDP may actually have somewhat higher rates, but does a poor job of reporting and taking credit for its EPI successes.

of mortality of children under 5 years of age[13]), these data suggest that the NSDP is not yet sufficiently focused on the delivery of priority child health interventions that can have a real impact on child survival and well being.

Coverage. Table 4 estimates coverage[14] for the major health services in the target populations of children and mothers for this same six month project period. It suggests that the NSDP has serious coverage issues, as EPI activities currently leave about 35-45 percent of children not fully vaccinated and that current coverage is lower than it was in the MEASURE project's 2001 Survey. The table also indicates that there are many cases of diarrhea and ARI, including severe cases, which are not seen in the NSDP clinic system. While this is not surprising, given that this service delivery system has poor emergency response capability, these data highlight the project's current low coverage in these interventions and suggest that there is a huge unmet need for child services in these critical areas.

The project's current service delivery strategies also make it difficult to target priority child health interventions effectively. Static and intermittent satellite clinics[15] with fixed daytime hours cannot respond well to child health emergencies, especially those that occur in neonates and young children with pneumonia or severe diarrheas. Child health services need to be open during the evening and throughout the night. These data suggest that there are large numbers of missed opportunities to address these major child killers in the NGO catchment areas. The NSDP's child health programming is not focused on the critical interventions that could change key indicators for the most vulnerable groups. [16]

Sustainability, Service to the Poor, and Market Share

In the NSDP there are divergent and strongly held views about sustainability, services to the poor and market share versus coverage, but no coordinated project-wide policies that define these concepts and guide their application. Rather, larger partners who control all or most of a major objective tend to establish "strategies" for their activities based on

[13] See information provided by USAID/Bangladesh regarding ARI incidence in Bangladesh, Annex H.

[14] Coverage estimates the proportion of individuals in a target population that receives, or conversely doesn't receive, services.

[15] Static clinics are not within easy reach of much of the population; satellite outreach clinics, with a wider clientele, operate in a locality only once a week or once a month.

[16] This report discusses the satellite clinic system as part of the NSDP's community based network. These clinics were interpreted as such because they are currently the only consistent curative presence that the project has at the community level. The team strongly agrees with USAID/Bangladesh, in that the satellites are actually extensions of the static clinic system and that they are not adequate, due to their intermittent nature, for the delivery of effective child health services. Certainly the project's static clinics are not the entire answer but, given available resources and the NSDP's broader reproductive health mandate, the team was reluctant to recommend a new delivery system for delivery of child health services.

The body of this report offers many suggestions how the NSDP can strengthen the response capability of current systems. These include expansion of the number and frequency of satellites, increase in the number and responsibilities of depot holders, rework of the strategy for C-IMCI, and improvement in collaboration with other programs and NGOs to create a community-based service network within designated catchment areas. The team feels that it doesn't matter what strategy the NSDP uses to place child health services in the community as long as they hear the message clearly that child health programming that makes a difference will demand a community-based component that can deliver emergency curative care for the big child killers such ARI and CDD.

institutional expertise and interest. These are often seen by staff as representing the official project position. Nevertheless, such strategies generally reflect fairly narrow institutional biases, rather than comprehensive views that could apply across all areas and activities.

These informally derived strategies are beginning to drive NSDP programming. At present, child health is not seriously affected, as most of these initiatives are still in the early stages of development and implementation. This is likely to change over the next few months as programming begins in earnest. These inconsistent operational definitions will encourage some activities and restrain others. If unchecked, the effect of these current "working definitions" will be to restrict child health to a relatively minor role, if not a minor expense, within the NSDP's main agenda.

Sustainability

NGO sustainability is an important component of USAID/Bangladesh's original Request for Applications (RFA)[17] and the Pathfinder Consortium's program description.[18] However, the NSDP has not developed a unified view of what "sustainability" means for all project activities. There is likewise no clear agreement between NSDP and USAID about this issue. As a result, the current definition of sustainability has evolved primarily through activities carried out in Objective 3, and focuses on financial sustainability, cost recovery, and institutional development that will make NGOs more competitive as vendors of health services.

This definition affects not only program decisions (e.g., how services are made available) but also technical decisions (e.g., what kinds of services are offered). To move toward sustainability goals that project staff promote as part of Objective 3, NGOs are seeking increasingly to add more complex services (e.g., long-term family planning methods, deliveries) that will enable them to increase fees. Their community-based services to the poor are increasingly seen as a detriment to their bottom-line profitability and ability to be sustainable. Child health services do not do well in this environment.

The longer term effects are not apparent now, because NGOs are heavily subsidized through NSDP grants. They can continue to make choices "in the middle" that allow efforts to improve their financial sustainability and their responsiveness to the NSDP's mandate to provide for the poor and underserved. When the project ends and NGOs must make choices about their future, however, sustainability as now defined will likely have a substantial negative impact on those who must rely on subsidized prices, i.e., the poor.

[17] Request for Applications (Solicitation Number: 388-02-001. Bangladesh Non-Governmental Organization (NGO) Service Delivery Program (NSDP) in Bangladesh.) USAID, December 13, 2001.
[18] Program Description, NSDP. Pathfinder Consortium. May, 2002

Serving the Poor

The NSDP is struggling to find a balance between making NGOs less subject to the vagaries of future funding and the health service needs of vulnerable populations. Ongoing and planned technical activities and a series of workshops with NGO partners are looking at these issues and seeking strategies to better serve the poor. These have included developing a "poor-friendly" price structure for services, reorganizing cost-sharing and fund-raising strategies, allowing poor women to use their microcredit program passbooks for emergency services, and designing supervision and monitoring procedures for greater coverage.

As important and laudable as these efforts are, however, they are not occurring within the context of a macro-level project decisions about the absolute role of services to the poor and what NGOs should do to continue providing them, both during the project and afterwards. Consequently, they beg the larger question of the appropriate balance between sustainability (regardless of how it may be eventually defined) and the delivery of child health (and, to a large extent, perinatal) programs that will have some impact on health status.

Coverage versus Market Share

The need for NGOs to gain market share in the geographic areas where they work is a frequent and disturbing theme in NSDP staff discussions. The ability of NGOs to provide improved services, to become more competitive, and to attract clients with greater ability to pay is essential to sustainability and a desired goal. There seems to be little recognition that market-share strategies do almost nothing to extend overall coverage, but instead drain off the most financially advantaged clients and leave the poorest with even less access to care. When these negative implications are pointed out, most staff members express confusion. They say that this is not the specific intention of activities that stress competition in local health care markets. They often add, however, that this is perhaps an inevitable by-product of sustainability.

The emphasis on market share seems to have come about in the absence of decisions about strategy and balance. It is complicated because the project has senior staff and a competent BCC partner with long experience in family planning, where market share, cost recovery, and coverage are not always incompatible goals. In child health, finding a balance is more difficult, because effective programming depends on increased coverage and access to emergency care. By definition, these will include a substantial population with limited ability to pay for services.

PROGRAM DIRECTIONS

There are a number of secondary findings that affect the NSDP's ability to plan and implement child health activities. Although not as far-reaching as the issues above, they must be considered before the project goes much further.

Clarity on Child Health Objectives

In the projects that preceded the NSDP, child health services, while universally available, served as something of a "loss leader" to attract family planning and reproductive health clients. This pattern has continued into the early months of the NSDP and is probably related to the need for service continuity. The current project, however, clearly does not view child health this way and has proposed the transfer of new strategies that it believes will upgrade and modernize services currently. These include the integrated management of childhood illness (IMCI), community IMCI (C-IMCI) and essential newborn care (ENC).

Despite these new initiatives, the NSDP does not yet have a clear view of its objectives in child health. Plans for new interventions are not coordinated to address the major causes of child morbidity and mortality, and there is no agreement on how best to deliver these new services through existing NGO systems. There are many diverse views, and they do not work in concert. While the NSDP has a large reservoir of staff experience in child health, these individuals have not yet coalesced into a team with a shared vision and mandate. As a result, there is no clear focus on what the NSDP should accomplish for child health over the longer term.

Community versus Static Clinic Service Delivery

NSDP planning documents contain no explicit policy that, over the life of the project, the delivery of curative services will be shifted from community-level providers (i.e., satellite clinics and depot holders) to NGO static clinics. There seems to be no management or technical consensus about the primacy of clinical services over community-based programming, even though this does seem to be the de facto project approach. Training plans, strategies and working group documents all point to a diminished role for community-level services in NGO service areas over the next four years, although education and mobilization efforts would actually increase. This seems related to working assumptions in some units that clinic-based services are more cost-effective and offer better strategies for sustainability. There is no strong voice in NSDP senior management for community services, although less-senior staff, especially those working in child health, support them.

These differing views and the lack of a definitive policy present a serious dilemma for the NSDP. Sustainability, as now defined, may contribute to the financial health of some NGOs, although project managers estimate that only about one-fourth of the NGOs will fully benefit from this assistance and become marginally independent. At the same time, the continued move away from community-based care has huge implications for NGO service populations. Project NGOs often work in some of the poorest and most difficult regions of Bangladesh[19] and are frequently the only viable service providers. A focus on clinic-based services will mean no services at all for large numbers of people.

[19] NGO catchment areas are actually decided by the MOH&FW and are concentrated in areas where the GoB has no services or the populations are hard to reach. The NSDP feels that their NGOs are disadvantaged by the districts assigned to them because they are dispersed and in difficult areas.

The NSDP has not yet confronted a basic truth of NGO services in extremely low-resource environments such as Bangladesh, namely, that subsidized community-based curative care is the only way to make a difference in the health indicators of the poorest and most vulnerable. This is especially true for child health. To date, the NSDP has avoided unpalatable discussions and choices about what health services will be offered to whom and where. Before investing one-third of its total resources in child health, it must take a clear position. Without a strong community component that offers curative services, the planned investments in child health will have limited returns.

Training

Training is identified as an essential activity for achieving the NSDP's four primary strategic objectives and its overall goal. Several of the project's senior managers view training as their primary responsibility. The NSDP's Quarterly Progress Reports for 2002 and interviews with staff indicate that training was *the* major activity during the first year, and this emphasis is expected to continue.

The team felt that the primacy of training as the main strategy for introducing child health interventions was important, but not sufficient, for the nature of the job. IMCI, C-IMCI and ENC, like many other of the project's new strategies, are extremely complex and will require more TA, follow-up, and on-site supervision than is currently contemplated by either the Training or the Operations Unit.

The team also felt that the current focus on developing capacity to conduct training internally, rather than jointly or in collaboration with other programs and institutions, was not optimal. Some limited training (e.g. training for NGO physicians in IMCI) is being done in collaboration with GoB and other organizations. Over the longer term, however, the NSDP's intention is to train and place master trainers in their own identified training institutions and to install a permanent capability in the major child health technical interventions.

Bangladesh has many players in the child health arena, but at the time of this assessment there were no plans to explore collaborative efforts or to exchange training with organizations that seem to have good capabilities in this area (i.e., the SNL Initiative or Lamb Hospital's maternal and neonatal health training). Instead, the NSDP strategy seems oriented to developing training capability through institutions such as the Radda MCH Clinic and Training Centre, with which they plan to continue training in reproductive health. This strategy could benefit from further review, as child health could be enhanced by increased collaboration with other institutions, especially those that have experience and training capability in the main technical interventions.

Child Health Partners in NSDP Program Decisions

The NSDP partners with the greatest expertise in child health are CARE and SCF/US. These are also the newest members of the consortium, and they have the smallest proportion of the NSDP's budget allocation. CARE and SCF/US staff often occupy positions that are low in the NSDP management structure, making it difficult for them to influence the project's child health agenda. These staff members report to senior managers who often do not understand or support their work on child health activities. At present, neither CARE nor SCF/US is able to exert much influence over the child health agenda, although they have the most experience in this area and are responsible for implementing large parts of it.

The relationship between the local offices of these organizations and the NSDP is potentially important but at present seems very limited. NSDP regional offices are co-located with CARE, but there is no technical interaction between their staffs. Both CARE and SCF/US report that they would value a closer relationship with the project, in part because it offers a national network for operations research, dissemination of program results, and expansion of safe motherhood and child health strategies. They feel that the current organizational structure of NSDP prevents them from having a significant input into decision-making.

The team felt that the small role child health partners currently have in the project and the lack of meaningful technical interaction with the local offices of these organizations serve as important missed opportunities. CARE and SCF/US could play an important part in setting and carrying out a meaningful agenda.

Transparency and Inclusion of NGOs in Decision-Making

Forty-one NGOs are part of the NSDP partnership. Interviews indicated that these NGOs did not view themselves as a proactive force in the project. Their self-described role was one of waiting for guidelines and regulations to be passed down from the central level. For example, when discussing ways in which NGOs could collaborate with local and municipal government, managers said they had established relationships under the former UFHP and RSDP, but that the new regulations for NSDP would prohibit providing staff to assist with government EPI programs. Another example arose during discussions of the use of resources generated from clinic fees to support development of new child health services. NGO staff said that they were not permitted to use these resources and had to wait until they received guidelines.

NGO flexibility will be needed in order to respond effectively to government requests for collaboration and to find innovative mechanisms for developing outreach and community-based services to respond to child health needs. NGOs did not appear to have many opportunities to participate in the decision-making process, except for the yearly meeting for all NGOs.

PROJECT MANAGEMENT STRUCTURE AND CHILD HEALTH

Management Structure and Support to Child Health

The management structure of the NSDP is organized into six pillars that support family planning and child health activities at the central and regional levels (see Annex I, NSDP Organizational Diagram). This management structure is led by senior-level staff with significant skills and experience in clinical services, MIS/M&E, health management and finance, BCC, and administration. A senior staff person for the Program Operations pillar has been identified and is expected to join the staff soon.

The NSDP organization is strongly vertical and based largely on consortium partner control of individual objectives. For example, Innovative Technologies for Health Care Delivery (Intrah) is the main partner for Objective 1, and Deloitte Touche and Research Triangle Institute are primarily responsible for Objective 3. This structure creates some barriers for adequate support of integrated efforts that require communication across the separate management pillars. Some cross-pillar committees and work groups exist (e.g., a work group on services to the poor), but the team did not see much evidence that they have become an effective force for moving integrated initiatives forward.[20]

Child health is particularly affected by the project's vertical structure. Subunits that have some responsibility to support these activities are scattered in various pillars. For example, the community response team is placed under the Health Management and Finance Unit. Teams for training, IMCI, and emergency obstetrics care are under the Clinical Services Unit, a group that does not have experience with the community health approach needed to support these teams and their efforts. While the Operations Unit has both central and regional staff, it does not have obvious links to the community response team, IMCI, EOC, or other child health units. Project staff working in them understand the problem, but generally feel they do not have the senior management support within their respective pillars to initiate and sustain integrated activities.

Senior Management Technical Leadership in Child Health Programming

The senior staff of NSDP provides strong technical and management leadership in reproductive health, but their support for child health is much more limited. There is no senior-level technical expert in child health with the field expertise and designated authority to develop and guide programming. This lack of leadership has been a significant impediment to developing the new child health agenda. Absent senior-level support, the ability of project staff at lower levels (e.g., community response, IMCI, EOC) to move forward planned interventions is severely constrained. It also compromises the project's ability to develop and implement an integrated and coherent response to child health is compromised (see Technical Components of Child Health for further discussion).

[20] NSDP leaders are working hard to weld the project's disparate elements into an integrated team. It is a big job because of the number of partners in the consortium. Much progress has been made and more is expected as the NSDP nears the end of its first year.

Capacity to Strengthen NGO Management and Operationalize Programs

Currently, the NSDP focuses much of its efforts on training, but in child health (and probably other areas) this is not yet matched with concrete plans to support NGOs in the implementation of new interventions. This is partly due to the current lack of an operations officer. The team felt that even when such a person is in place, the NSDP needed to provide more support to NGOs for operationalizing activities than is currently contemplated. This is particularly true for child health, which is being introduced through small pilot activities that will be scaled up rapidly.

Regional technical officers (RTOs) in the eight regions could be key to better operational child health support. Although eager and apparently qualified, the RTOs visited during the field trips did not seem to have clearly defined roles and appeared to be somewhat underemployed. Their job descriptions were not matched with the necessary formal linkages with NGOs, the MH&FW, city corporations, or other institutions that would allow them to support management and implementation. RTOs were not fully included in project communications and do not appear to receive program information, data and other resources. Some of this will change when an operations officer is in place. Nevertheless, the team felt that current plans, even when fully implemented, might not make optimal use of RTOs.

Another significant barrier to increasing operational support in child health is the NSDP's current approach of working vertically with an NGO to develop its systems and services. This approach raises several issues: it is not cost-effective, it does not capitalize on geographic or technical synergies, and it does not effectively use the RTOs to monitor and support technical programs. It also works against the needs of introducing and sustaining new interventions like clinical IMCI that could benefit from collaborative, multi-NGO efforts at the regional and local levels. Although both vertical NGO and regional and multi-NGO support can be provided at the same time within the project, it is a complex undertaking that should be considered as soon as an operations officer is in place. This issue should be addressed in the context of the current institutional development approach, which works more closely with individual NGOs.

Consistency in Six Management Pillars to Support Child Health

Although the NSDP does not have a formal child health strategy, senior staff that head the six pillars say that they try to provide consistent support to child health. These activities, however, tend to focus on discrete elements (i.e., training NGO staff in child health, M&E, or QI) in child health. Each pillar structures its assistance on the basis of its own understanding of child health within the NSDP. For example, clinical services supports IMCI training but expresses limited interest in responding to other child health training needs, while QI focuses on improving static clinic operations but has not developed quality indicators for community-based child health activities. The result is that each unit supports child health in a way that is consistent with its own limited mandate and interests and exerts much influence on how these activities are carried out. This contributes to the fragmentation of efforts and will probably have greater disruptive influence as the program matures.

Management Information Systems Support

The MIS system supports the NSDP with extensive data collected daily by NGOs. MIS staff work diligently to provide detailed data to NSDP and feedback to NGOs. The team noted, however, that a number of issues should be addressed in order to make current MIS efforts more effective in supporting child health.

- The NSDP indicators used for child health that are summarized in the quarterly report summaries are not the same as the universally accepted key indicators for child health. Annex J, Table 1 compares MOH&FW universal indicators with those used by NSDP.[21] Ironically, the NGOs collect and report most of the universally accepted indicators. Therefore it is possible for NSDP summaries to analyze and present these in the quarterly reports.

- The NSDP staff in the Clinical Services Unit and IMCI and regional operational staff stated that they do not regularly receive, review, or monitor NGO service statistics and data for management purposes. Currently, M&E staff monitor NGO data and provide feedback to the NGOs, without Program staff participation.

- The MIS collects data on service delivery contacts at NGO points of service, an approach developed during various USAID-NSDP meetings. However, to effectively support a child health strategy with community outreach activities, the MIS will need to revise its indicators and address how to measure community mobilization, health promotion, referrals to non-NSDP facilities, etc. Services provided to NSDP "customers" by the MOH&FW or other providers are not included in NSDP's MIS. As a result, the MIS might inadequately represent these services.

- MIS data collection activities require a significant investment of time and resources for the NGOs. The size and complexity of the MIS and the burden it creates for NGOs has been discussed in the October–December 2002 Quarterly report. This will need to be taken into account in any changes.

Quality Improvement Support to Child Health

The Quality Improvement Support unit is positioned under the clinical services pillar. QI staff, building on the progress made in the NIPHP project, have reviewed and revised QI materials, validated new material and developed a draft strategy for the QI activities. Staff also discussed their plans for a more focused strategy and tools for working with NGOs. These efforts, however, are largely focused on QI in NGO static clinics, based on their views that the NSDP will continue to encourage NGOs to locate most services there.

[21] For example, since the 0-28 day and 0-11 month periods are vulnerable periods for ARI/pneumonia, summarizing NSDP data on these age groups would be appropriate. NSDP summarizes "all children treated for ARI/pneumonia" without age-specific data. NSDP summary data for immunizations also record "total child immunizations provided." The "total number of CDD cases" without age breakdowns are presented in NSDP's quarterly summary.
Data collected at the NGO level is disaggregated by age. Therefore, the MIS could summarize data based on "MOH&FW/internationally accepted" indicators. This would provide program staff with more useful data for management decision-making.

The QI unit does have plans to develop tools for clinical services provided in satellite clinics in the near future. However, it does not have an approach to adequately measure and improve community mobilization or organization activities, improve BCC (separate from clinical services), or measure and improve other nonclinical activities.

A review of the QI draft observation checklists found that they do not generally include counseling, nutrition education, or health promotion. The QI staff conceded that if child health activities expand beyond static clinics to include health promotion and community organization activities, they will have to address how to measure and improve them.

Institutional Development and Sustainability Unit Support to Child Health

The Institutional Development Subunit is developing an in-depth assessment of each NGO as a base for providing technical assistance on sustainability. It has done a number of institutional assessments but has not yet developed a summary of findings of the cumulative findings of the five NGOs assessed that would allow it to establish common patterns. A discussion with staff and review of one in-depth assessment suggests several key issues that have implications for child health programs:

- The support that NGOs receive from the NSDP is often oriented toward an activity or a project. Attention to institutional structure, board development, staffing, organizational functions, or diverse funding issues that would allow the NGOs to continue to function after NSDP support ends has been much more limited.

- The institutional development process does not assist NGOs to examine their basic mission and long-term objectives. Some NGOs, if offered this opportunity, might question the advantages of project-defined sustainability when compared with disadvantages of curtailing services to their traditional constituencies.

- NGOs experience very high staff turnover, especially among physicians. Given the cost of training doctors for specialized services like clinical IMCI, this is a threat to sustainability as it is currently defined.[22] These issues need to be discussed with NGOs.

- There is a need to professionalize boards and diversify responsibility beyond a single person or project director. This is an important aspect of defining long-term "mission," and it requires more investment in institutional development activities. Professionalizing organizations probably is a much more important goal than financial sustainability or mastery of the systems that lead to and support it.

[22] Low salaries and poor benefit packages contribute to this. Anecdotal discussions suggest that many physicians would prefer GoB postings if the opportunity arises. NGO employment is often considered to be entry-level.

In short, institutional development seems excessively linked with financial concerns. These activities have an important role to play with NGOs, but they should be expanded to include others organizational development areas. These include strengthening NGOs' institutional governance and overall structures and systems; examining the long-term objectives and goals, broadening revenue bases (including support from other donors), and addressing long-term workforce recruitment and retention issues.

Logistics Unit Support to Expanded Child Health

The team performed only a limited review of logistics support for child health. However, the Logistics Unit reportedly has staffing limitations that may affect its ability to support the expansion of child health activities. Expanding the current child health efforts and starting up additional child and related maternal health interventions will strain its current capability. The expansion of the regional offices will also require additional logistics support to supply and support regional staff, who currently operate with borrowed equipment and limited supplies.

If NSDP plans to support the NGOs to develop their own logistics systems to eventually manage all supplies, pharmaceuticals, transport, and other needs, the project's logistics staff and systems will need to be expanded. In addition, the rapid expansion of IMCI will exert new demands on these logistics systems, but there are no concrete plans to address them.

TECHNICAL COMPONENTS OF CHILD HEALTH

Many NSDP staff and the NGOs are enthusiastically welcoming the new technical child health initiatives in the areas where they work. Some of the project's most talented and motivated staff head these initiatives, and their excitement is contagious. As yet, however, the NSDP as a whole has not supported the anticipated leap toward the future with a considered analysis how these new approaches can best serve the specific populations in NGO catchment areas. Moreover, there has been little discussion of how these approaches will be integrated with the ESP.

The current NSDP child health technical approach is best characterized as a series of separate interventions that will be introduced into NGO services through a progressive training effort over the life of the project. This apparent lack of systematic integration is exacerbated by the NSDP staff who try to move the process forward by focusing on individual technical pieces without formal mechanisms for discussion and collaboration. NGO partners also push this somewhat piecemeal agenda because they are anxious to incorporate new activities in their program.

There is also a common perception that some technical initiatives are appropriately assigned to or "belong" to specific consortium partners. For example, clinical IMCI is seen as a training issue and the domain of the clinical training partner, Intrah; C-IMCI is seen as the primary responsibility of Save the Children, CARE and, to a lesser extent, the BCCP. Those who are higher in the management structure, and who represent larger

consortium partners, are able to push forward initiatives that they or their home institutions perceive as important. Other pieces, championed by staff with less influence, have not gained much traction.

The Essential Service Package

The ESP appears to have worked reasonably well for NGOs in Bangladesh. Field staff seem adequately trained and comfortable with the interventions, and communities appear to value the services and use them.[23] While the child health components are primarily viewed as mechanisms for attracting family planning clients, the large number of monthly contacts suggests that parents do see these clinics as a resource for their children as well as themselves.

As currently configured, however, the strategy used to deliver ESP has very limited capacity to meet child health needs at the periphery. Satellite clinics that occur only weekly and are open only during daytime hours, and depot holders do not have appropriate training to respond to emergencies or to dispense antibiotics for major childhood illnesses such as ARI[24] and severe CDD. Parents seeking treatment must often look to other sources if there is no static clinic, or no *open* static clinic, in their community. This poor emergency response capability is a major limiting factor in the NGOs' ability to provide appropriate child health services.

The NSDP has differing views about how this limited ability for emergency response should be addressed. Many see the solution in expanding and improving static clinics, educating communities to be better health consumers and "channeling" clients more effectively to these services. Others, especially those who work on issues related to the poor or in C-IMCI, believe that only improved treatment options in the community will adequately address the problem. These differing point-of-service views struggle against

[23] Interventions included in the ESP are as summarized below.

In rural are:

- Family planning services including pills, condoms, injections and intrauterine devices (IUDs);
- Maternal health, which includes (antenatal care (ANC), postnatal care (PNC), treatment of reproductive tract infection (RTI) and sexually transmitted infections (STI), child health, including EPI, ARI, CDD, Vitamin A); and
- Limited curative care.

In urban areas:

- Family planning services including pills, condoms, injections and IUDs;
- Maternal health, which includes ANC, PNC, RTI/STI treatment, child health, including EPI, ARI, CDD, Vitamin A); and
- Limited curative care.

In addition, some NSDP NGOs offer comprehensive ESP:

- Basic ESP discussed above;
- All long-term family planning methods;
- IMCI in selected settings;
- TB treatment in selected settings; and
- Safe delivery and post abortion care in selected settings.

[24] The NSDP and the GoB are currently collaborating on research to test the efficacy of using depot holders to diagnose and treat ARIs in the community. The NSDP hopes that this study will demonstrate that, with appropriate training, low-level community workers can properly diagnose and treat serious ARIs with antibiotics.

each other and probably contribute to (or at least do not help resolve) a number of issues currently affecting ESP service delivery in the field.

Some team observations about ESP services made during field visits are summarized below. Overall, the team felt that NGOs were doing a good job; in some cases, services were outstanding. Most of the problems noted perhaps cannot be generalized across the NSDP's system; nevertheless, they may be instructive in planning how to better support ESP services in the future. Some are also germane to the point-of-service issue raised above.

- The client load in static clinics varies locally. Some clinics see many clients, but others appear underutilized.

- Most of the satellite clinics observed seemed to be working at capacity, with upwards of 30 to 35 clients per day. When combined with EPI services, the client load often exceeded what a small paramedic team could handle effectively during the limited time they were in the community. This suggests that this provider level might benefit from expansion.

- Some clinics seemed very well supplied with drugs and other supplies; others appeared to have few, and in some there were apparent stock-outs. Some clinics and several paramedic teams also seemed to have a low supply of medications appropriate for children.[25] Logistics and resupply seemed to be an issue and should be followed up.

- Supervision in many areas is extremely limited. Service personnel may need some refresher training and follow-up in service supervision, especially in child health. The team observed missed opportunities to provide services to children: providers treat a sick child when problems are brought to their attention, but usually only respond to a mother's request. Oral rehydration solution (ORS) stations often appeared unused and had few or no supplies, and paramedics do not consistently inquire about child illness or family welfare.

- Services to the poorest in some NGO service areas may be very poor indeed. It was reported that many did not use NGO services that were available in their community even though other medical resources were many miles away. The reason given was that although NGO consultations were free, there was a charge for medicines. Parents apparently felt that they were better off waiting until they were sure the child was sick enough to merit the long trip to a government facility, where they knew they could obtain medications free of charge.

[25] This is perhaps understandable, given that most of the children brought for services at observed static clinics were there for EPI. Services observed in northern Bangladesh, for example, on average see only one child in five for reasons other than EPI services. This may be, however, something of a self-fulfilling prophecy. If more drugs were available, more children would be brought for treatment.

- Static and satellite clinics have almost 1.3 million ANC contacts a year, but the project has limited ability to address emergency obstetrical care (EOC) and neonatal health. The small number of referrals to higher care levels suggests that potential problems are not identified or that counseling or referral to seek alternative care is not persuasive. NGO paramedics apparently do not actively seek information from or relationships with TBAs, and there is no strategy for NGO health workers to enter households (or see mothers) who have recently given birth.

Clinical IMCI

Clinical IMCI is generally seen as the main mechanism to put child health in the NSDP. Consequently, project staff and the NGOs are interested in extending this strategy throughout the clinic system as quickly as possible. As part of the rationalization of services, the Pathfinder consortium has proposed a plan that reflects a positive perception of IMCI. The plan includes the development of an NGO IMCI training capability through one or more of its local training partners, provision of training for large number of service providers at several levels, and upgrading of existing clinic systems to meet the complex logistics and management requirements of IMCI services.

At present, the project has 15 pilot clinics in urban areas. The clinics were developed under a joint program with the GoB. This was part of the GoB's official adoption of IMCI as a national strategy in 2000 and the implementation of a pilot program in three *upizilas* (subdistricts) in 2001. This national experience was reviewed February 25-27 and March 1, 2003, as part of the planning for a new Health, Nutrition and Population Sector Program (HNPSP), which the government anticipates will begin in the middle of 2003.[26] Some of the pressure on NSDP to move forward with IMCI in its clinic system is related to the assumption that the project must be a part of a planned national expansion of IMCI in the near future.

In the work plan for FY 2003,[27] NSDP states its intention to extend IMCI to an unspecified number of NGO clinics through the development of materials and training for up to 60 additional physicians and paramedics.[28] This expansion will augment the existing programs in 15 pilot clinics. Other documents estimate this expansion at up to 55 clinics in the 2002-2003 program year, with similar scale-up in the years to follow.

[26] The meeting on "IMCI Early Implementation Review in Bangladesh" was hosted by the country's Directorate General of Health Services on February 25-27 and March 1, 2003 in Dhaka. NSDP staff participated in the country review. Members of the MEDS Team also sat in on some of this review, which included representatives from UNICEF and WHO, which are helping to fund the current initiative, as well as ICDDR-B and the MOH&FW.

[27] NSDP Annual Workplan for FY 2003. NSDP, Dhaka, Bangladesh.

[28] Until recently, the plan to train physicians in IMCI during this program year had been stalled because of USAID policies that prohibit paying honoraria to GoB trainers. Before the team left Bangladesh it was reported that this problem had been resolved through an agreement with UNICEF. Presumably, this training will now proceed, although this arrangement is temporary.

In December, 2002, Intrah conducted a performance needs assessment (PNA) of 4 of the 15 urban pilot clinics.[29] The PNA report suggests that the quality of services has improved in these clinics: physicians feel they do a better job, and parents of sick children believe they have received good treatment. These positive points were validated by a team member visit to the pilot IMCI clinic of the Kanchan Samity (an NSDP partner NGO), in Dinjapur, Bangladesh. This clinic has a talented young physician who believes that IMCI training had made a great improvement in his clinical skills.

The interview with this doctor suggested a number of findings that were not mentioned in the PNA, but that the NSDP would find useful to improve services in other sites. The physician clearly felt isolated, although there were other "non-IMCI" doctors working in the clinic. His closest technical links, the NSDP RTO and the Kanchan Samity project director, had received only an IMCI orientation and were not able to provide strong technical support for him. He felt that his overall efficiency might be somewhat less than before his IMCI training (i.e., he was seeing fewer cases), although he believed improved service quality compensated for that. He was especially concerned about childhood malnutrition, which is a complicating factor in many childhood illnesses, and felt that simply counseling the mother was not an adequate response.

Current IMCI efforts by NSDP are generally small pilots programs. It is difficult, and perhaps unfair, to extrapolate findings from these efforts to the larger problem-solving arena. It is clear, however, that clinical IMCI is the future for project NGOs, and that training will go forward to extend the system. Therefore, a number of important issues need to be discussed and resolved before more time passes:

- There seems to be no clear picture of the advantages of extending IMCI in NGO clinics beyond making them more programmatically up-to-date and keeping them in the technical forefront of child services in Bangladesh. Some NSDP staff believes that these services will make NGOs more competitive, and that they will draw clients away from private sector providers and poorer government clinics. This is not the best motivation for extending this expensive and complicated system, and it may not even be realistic.

- Plans for providing physicians and others who receive IMCI training with appropriate managerial and clinic staff support are not well developed. There is little recognition that the maintenance of this clinic system involves consistent evaluation, upgrading, and retraining, and that it can require expensive inputs.[30] It is not clear that NGOs are aware of this constraint or have plans to manage the system when the NSDP ends.

[29] Jaskiewicz, Wanda. "Performance Needs Assessment of Providers and Facilities for IMCI." NGO Service Delivery Project/Intrah. December, 2002.

[30] The NSDP estimates that it costs about 25,000 taka (55 taka = US$1.00) to train an IMCI physician. Given that NGOs have serious staff retention problems, these training costs may not be bearable over time.

- Clinical IMCI is considered to be largely a training issue. There has not yet been adequate planning to address recurring logistics and other support-systems concerns, such as commodities (pharmaceuticals) and their resupply, supervision, general logistics, and referral systems.[31]

In summary, while IMCI has many benefits for effectively managing the treatment of the sick child, there are some serious disadvantages. The project will need to review its current plans for development, implementation, and expansion given the significant investments in training required for IMCI and the even more expansive need for management and logistics support required to implement and sustain it.

Community IMCI

A document entitled "Community IMCI Strategy,"[32] released to coincide with the publication of the national "Review of IMCI in Bangladesh" in February 2003, is currently under review. Team observations and comments about C-IMCI are based on that document and interviews with NSDP staff. The comments may not anticipate changes which have already occurred or that are now contemplated as a result of ongoing review and discussion with USAID and other stakeholders.

The project's C-IMCI strategy is closely aligned with that of the GoB. It has a full range of interventions that emphasize improving the partnership between communities and service providers, increasing care-seeking behavior, and improving family practices. If plans go forward as they were described in March 2003, the NSDP will initiate activities in nine pilot areas in 2003. Over the next three years, the NSDP plans is to roll out the program to approximately two-thirds of its 278 clinics and 7,000 depot holders.

Community IMCI is potentially the most important child health intervention proposed by the NSDP. Among its most attractive aspects are the experience and commitment of the staff who support this initiative and who will manage the implementation in NGO field programs. As in many other areas of the project, however, this initiative is not yet supported by a clear mandate, a strategic framework, or detailed plans. The approach is further complicated by two other factors. First, C-IMCI is largely the provenience of the project's child health partners, Save the Children and CARE, so staff members working on these efforts have limited senior-level championship and leverage to move the activities or to successfully market their ideas within the Project. Second, the advocates of C-IMCI do not have a senior technical leader who can help them develop and review the implementation plans and make sure they are realistic, given the project's current complex directions and often-competing mandates.

[31] The IMCI system also requires more drugs and supplies than the ESP does. These are currently being met by the project for the 15 pilot clinics, but the capacity of either the NSDP or the NGOs to meet the requirements of a rapid scale-up is unknown.

[32] "Community IMCI Strategy of NSDP." Community IMCI Working Group, NGO Service Delivery Project. February, 2003.

As a consequence, the NSDP C-IMCI Working Group has tried to move forward an initiative that has not yet had wide review and discussion within the project. Because the C-IMCI strategy defines an important piece of the child health technical agenda, it needs strong management and technical support if it is to be successful. A careful examination of the far-ranging implications for community-based programming and services is overdue. Feelings about the C-IMCI Strategy were strong, and supporters of C-IMCI have been pushed to an unhealthy adversarial position. This is understandable, given what they feel is a lack of organizational support, but it is also unfortunate. C-IMCI should be a pivotal child health intervention for NSDP, and decisions about whether and how to move forward will require a serious technical and programmatic review and broad institutional support.

It is more difficult to speak decisively about some of the technical issues with C-IMCI, because they may be subject to change and are probably location-specific. The team did, however, have a number of observations that may be useful for framing future NSDP discussions about this program:

- The proposed interventions include a broad menu of activities that need to be prioritized and focused on those efforts that would have the greatest impact on child health, particularly CDD and ARI. At present, the list includes activities over which project NGOs have little or no control (e.g., drowning).

- Links between clinical IMCI and C-IMCI are not developed; C-IMCI should be an interactive strategy with clinical activities.

- The strategy does not discuss how C-IMCI will relate to and build on the existing NSDP strategy and activities of the ESP, even though C-IMCI is proposed for universal expansion in the NSDP-supported service areas.

- The depot holder is an important piece of the NSDP service network, but the strategy does not sufficiently address the roles of these individuals or that of other community health workers in curative care[33] over the long term.

- The strategy emphasizes prevention and home-based care, which is an excellent start. However, it does not address how to ensure that there are adequate care alternatives to address community-based treatment and referrals to respond to the needs of newly educated parents. This is not currently an issue for pilot activities, but it will need to be addressed for the scale-up phase.

- There is no identified nutritional intervention, even though it could be one of the most effective growth monitoring and promotion home-based strategies that could be employed to address child morbidity and mortality.

[33] There is some assumption that if the ARI research study with depot holders is positive, dispensing antibiotics will be added to the responsibilities of some, if not all, of these individuals.

Finally, the team felt that it was useful to add a word of caution: the biggest issue facing C-IMCI at this point is political, not technical. This is a very new initiative in Bangladesh, and the parameters of the GoB program are not yet fully laid out. There are also some important differences between the Bangladesh national program strategy in C-IMCI and commonly accepted international views of what an effective C-IMCI program entails, especially in community-based care. The NSDP strategy anticipates what the GoB may do, and there is some momentum in the project to move forward rapidly. However, given the many uncertainties related to the new HNPSP and other aspects of health programming, there seems to be no advantage (and possibly some real liabilities) to being "out in front."

Neonatal Health Linkages with Maternal Health and Malnutrition

Neonatal Health

Bangladesh's high rate of neonatal mortality is perhaps the biggest child health challenge that the NSDP must address. While the consortium's program description recognizes the need for action, current activities do not include a neonatal component. The NSDP's current service delivery system is not well positioned to deliver essential newborn care. Since 90 percent of births occur at home, few newborns are seen in the first two days of life, and few neonates are seen within the first 28 days. Most children are seen at the NSDP clinics at six weeks of age - a time by which much of the mortality in this cohort has already occurred. There are no specific plans to develop an approach for intervening with neonates at the community level, although C-IMCI may provide a push for greater focus on the newborn in the home.

There are a number of initiatives in Bangladesh that are focusing intently on neonatal mortality; these include a neonatal agenda that is part of the National Maternal Health Strategy, established in October 2001. Collaborative efforts between the GoB, the Saving Newborn Lives Initiative, and SCF/US (a global initiative supported by the Bill and Melinda Gates Foundation), is moving forward on two objectives: (1) to significantly increase the number and quality of skilled health staff to assist deliveries and provide post-delivery care at the community level; and (2) to strengthen the referral system and the capacity to manage life-threatening complications in *thana* and district hospitals. To support the GoB in this effort, the Essential Newborn Care Projects through Partner NGOs established and funded three projects in early 2002 to introduce community-based newborn care, using different strategies, to achieve a cost-effective, sustainable ENC package.[34]

NSDP has not become a major partner with the MOH&FW and other NGOs in improving neonatal mortality, although it is participating to a limited degree. The project has a small

[34] UNICEF is reportedly working with the MOH&FW on a large three-year project to address neonatal mortality from a prevention approach of providing multiple micronutrients, iron, and health education on breastfeeding, food supplementation during pregnancy, and diagnosis and treatment of vaginal infections. The Healthy Newborn Partnership is also working in Bangladesh. For further information on maternal health also see the Maternal Health Strategy 2003-2008, Bureau for Global Health, USAID, Washington, D.C.

pilot effort on neonatal mortality in partnership with the Essential Newborn Care Through Partner NGOs Initiative. Six NSDP urban sites have been selected to provide emergency obstetric care. There is also a small effort supported under the Clinical Services Unit to develop appropriate training materials.

Overall, however, the NSDP has not exhibited much interest in addressing the problem at the community level. There are no immediate plans to train and support cadres of TBAs, establish referral systems, or assist communities to develop emergency transportation systems. Moreover, efforts in developing training modules may be duplicative, as training modules have reportedly already been developed and approved by the SNL Secretariat. Materials adapted for TBAs were planned for November, 2002.

In order to help reduce neonatal mortality rates, NSDP could move quickly to facilitate networking with and development of new functional relationships with other child health projects that already have tested and operationalized specific neonatal interventions in field programs. While NSDP does plan to adapt and implement successful SNL interventions, its approach is far more passive than the seriousness of the situation warrants. The team was told that meaningful neonatal activities are at least two to three years away (and maybe more).

Linkage between Neonatal Mortality and Maternal Health

Improvements in neonatal care and child health status are closely linked and dependent on improvements in maternal health. In Bangladesh, maternal health status usually is influenced negatively by the women's own low birth weight status, her long-term poor nutritional status, and chronic anemia.[35] Women's lack of access to safe delivery affects both their health and that of their children. Only one-third of pregnant women receive antenatal care. During the previous projects, only 28 percent of women in NSDP rural areas had one prenatal visit during pregnancy, compared to 59 percent in UFHP urban areas. Unskilled birth attendants conduct 84 percent of deliveries in Bangladesh.

The NSDP has not yet addressed the programmatic synergies between neonatal/child health and maternal health despite the existence of opportunities to do so.[36] The project recognizes the need for action and the technical expertise to link program activities in

[35]Iron deficiency is one of the most prevalent nutrient deficiencies in the world. Pregnant and postpartum women are commonly affected because of the high iron demands during these critical periods. Counter to the widely held perception that only severe iron deficiency anemia contributes to maternal and neonatal mortality; a recent analysis found that the vast majority of iron deficiency anemia-related maternal and neonatal deaths are due to mild and moderate anemia. Overall, about 10 percent of maternal and 20 percent of perinatal mortality in developing countries is attributable to iron deficiency anemia (World Health Report, Reducing Risks, Promoting Healthy Life, 2002, p.54). About on- third of women in developing countries also suffer from Vitamin A deficiency. A community-based trial of low-dose vitamin A and beta-carotene supplementation to women of reproductive age in Nepal reports an important new finding: supplementation resulted in a 40 percent reduction in pregnancy-related mortality. Additional studies are currently underway in Ghana and Bangladesh to validate the benefits of vitamin A for reducing maternal mortality.

[36] Community-based interventions to improve maternal health have had success in some regions of Bangladesh. Saving Newborn Lives programs have trained and are supporting TBAs who monitor women postpartum, visiting on days 1,2,3,5,8,16 and 24. The medical assistant also monitors the mother and child within the first 24 hours. These communities have organized and created saving accounts for emergency obstetric care. The SNL program has also established referral linkages with the hospital for EOC.

these two areas, but it does not yet have plans to move forward. However it has plans to seek access to the home and postnatal contact with mother and infant. While the NSDP's C-IMCI strategy may be a starting point for in-home contact, much more is needed to equip providers and community workers with skills to intervene with anything more that referral.

Malnutrition

The effects of malnutrition on child health are serious and well understood. NSDP technical staff estimate that up to 70 percent of childhood morbidity and mortality may have malnutrition as an underlying cause. The situation is almost as grave for mothers; malnutrition affects the majority of women between 15 and 49 years of age. Bangladesh, with India, has the highest percentage of low birthweight neonates in the world.

Although the NSDP recognizes the negative effects of malnutrition, nutrition is underrepresented as a potential intervention in the project's child and maternal health activities. At present, counseling mothers (through use of the Mother's Card in C-IMCI) is the only contemplated nutritional intervention for children. Frequent reference is made to child feeding activities at Radda MCH Clinic, one of the Project training centers, but there are no discernable plans to incorporate and adapt this experience in NSDP activities.[37] At present, there also seems to be no technical consideration of maternal malnutrition and its links with low birthweight and neonatal mortality. Finally, the NSDP had no formal or informal relationship with recently expanded activities of the GoB's National Nutrition Program. Given the effect that malnutrition levies on the project's main targets - women of reproductive age and children under five - these would seem to be serious program gaps that should be addressed.

Behavior Change Communication

The NSDP's proposed behavior change communication activities are not well aligned with the needs of effective child health programming, although the consortium's behavior change communication partner, the BCCP, has excellent experience in supporting family planning and reproductive health service delivery. The BCCP's strongest skills appear to be in materials development and advertising,[38] and this group sees continued support for training and the expansion of NGO market share as an important part of their mission in Bangladesh. Their current plans in child health are primarily in the areas of expanded community awareness of NGO services and community mobilization to support C-IMCI. BCCP also plans to include prevention in their activities, but these plans are still largely undefined.

[37] This is not to imply that food supplement programs are the only ways that the NSDP should address this problem. Other nutritional strategies and types of collaboration, including growth promotion, could be explored.

[38] The "Smiling Sun" campaign, which is now the universally recognized logo for NGO services supported by the NSDP, was developed by the BCCP, as were most of the training and educational materials used in the predecessor projects.

At the time of this assessment, the BCCP did not yet have a signed agreement for their participation in the project. This presumably accounts for their current low profile, despite the prominence of BCC activities in the program description, the size of the BCCP budget, and the detailed activities described in the Year One Work plan. Planning documents consistently refer to BCC as a major support strategy to other child health activities, but the team did not see evidence that the BCCP is yet an active participant in the NSDP.[39]

The Team felt that the lack of involvement of the BCCP in the project to date was a serious missed opportunity, regardless of the circumstances that caused it. BCCP is an important resource that should be an integral part of the planning and implementation of all of the technical interventions described above, but particularly community-based health promotion.

That said, the team also felt that interviews with the BCC staff members and leaders of the BCCP suggested some areas where the BCCP must make some technical adjustments to better support child health. Briefly, these include:

- A better understanding of the behavior change and interpersonal communications and information needs of child health programming. The BCCP skills in developing large informational campaigns or mass media have limited use in this area.

- More specific technical background in child health interventions. It was clear that the BCC staff knew much more about reproductive health, and that they felt that basically the same communications strategies could be applied in both areas. The behavioral demands of these interventions are different, and must be treated so.

- Greater familiarity with and emphasis on behavioral strategies that focus on individuals, families, communities, and low-resource situations. Face-to-face communications, counseling strategies and positive deviance modeling are some that have worked well in child health, but there are many others.

- Much more emphasis on adapting and reproducing materials from other sources (particularly "low-tech" manuals, training materials and information packets for parents) and considerably less on the development, testing, and production of "high end" training materials (e.g. colored, plasticized training manuals and flip charts) that were produced in the previous project. There seemed little recognition that the materials produced under the RSDP, beautiful though they are, were not a renewable resource for NGOs. There are many excellent resources for materials in child health, many already being produced in Bangladesh (e.g., SNL's and

[39] This could be partly due to the BCCP's position (and legitimate complaint) that they are usually brought into the planning cycle for activities at the end, when most of the decisions about implementation have been made. This is common, although unfortunate, in BCC programming everywhere, and may be a factor in the BCCP's apparent lack of activity.

CARE's work on maternal health and newborns). There are no foreseeable reasons why the NSDP or the BCCP should develop new materials.

Effective BCC support to child health will involve some new thinking and, probably, some reallocation of priorities and resources within Objective 2. The BCCP expressed flexibility and much willingness to engage with the project on these issues. They are an unparalleled creative resource in the country, even though they may not yet have specific experience or skills in some of the areas that are most important to child health. The NSDP needs to get them involved and active as soon as possible.

COORDINATION

Coordination within the NSDP

NSDP depends on effective coordination internally among its partners and externally with government and other organizations. In fact, coordination could be viewed as the underlying concept of NSDP since it is a partnership program. The initial program design to address the objectives described in the RFA required coordination among the consortium partners who wrote the proposal. This was followed by a team effort to develop a viable work plan and implement proposed activities. At the central level, the eight core partners must coordinate among themselves and with the network of 41 NGOs supporting static and satellite clinics and community-based depot holders.

Although the NSDP is a new program, it incorporates two earlier multipartner programs that had established effective ways of working together. The NSDP is now confronted with combining these previous partners with new partners, such as CARE and SCF/US that are not familiar with the relationships and procedures transferred from the UFHP and RSDP. In addition, NSDP must incorporate partners serving both urban and rural areas who address different population needs. The previous partners focused on family planning and reproductive health and have credible expertise in these areas. However, the partnership is now being challenged to expand and strengthen its contribution in areas of child health in which there is less internal expertise. Meeting this objective will require more extensive coordination with government and other organizations in child health.

NSDP has tried to facilitate coordination of the partnership by having weekly staff meetings and monthly meetings of the partners. (Reference was made to an annual meeting of all partners with the NGOs, but this has not taken place and no details were available.) Although these meetings are appreciated, some partners, including NGOs, did not always feel included in coordination activities and the decision-making process, including development of guidelines governing their roles and activities. At the time of this assessment, the guidelines had not yet been finalized and distributed to all partners.

In an effort to decentralize, NSDP has created regional offices to coordinate with district and *upazila*-level government and non-government health organizations. The roles of these offices are still being defined. Staff of one regional office are waiting for regulations from the central level, including guidance on how and with which

organizations they should coordinate and collaborate. Opportunities to coordinate with other NGOs working in the region were not being actively pursued. There is great opportunity for coordination especially to strengthen child health at the regional level, but this has yet to be developed.

Coordination with USAID

NSDP is a cooperative agreement mechanism that defines the relationship with USAID as the funding organization. The patterns of coordination and regular communication needed to meet the needs of both organizations appear to be in place.

The NSDP's relationship with other USAID-funded programs in child health was found to be generally weak at the time of the assessment. The NSDP was described as being "internally focused and not open to collaboration." In fact, the project confirmed that the first year was focused internally, with most efforts directed to developing work plans and mechanisms for effective coordination among the partners at all levels. The NSDP had not yet contacted many organizations working in Bangladesh and does not have an explicit strategy for exchanging information and coordinating with other groups that have related interests, particularly those with expertise in child health. A PowerPoint presentation about NDSP has been prepared and could be used for sharing information about NSDP programs and plans with other organizations and GoB. The responsibility for coordinating at the organizational level rests with project leadership, but other responsibilities and demands were described as taking precedence during the last year.

Coordination with Government

Coordination between the NSDP and the Government of Bangladesh takes place at all levels and is both formal and informal. The GoB has knowledge of NSDP, in addition to previous experience coordinating with UFHP and RFHP on family planning and reproductive health. Child health interventions for UFHP and RFHP, and currently for NSDP, are based on the GoB ESP. Training for IMCI is a current focus of collaboration with the MOH&FW and other organizations such as UNICEF and the WHO.

Government officials described a positive perspective about coordinating with NGOs and recognized the value of their current and potential future contributions. They expressed appreciation for NSDP, but noted that its contribution would be enhanced if NSDP and other NGOs would take responsibility for providing services to designated populations or coverage areas. NSDP has consulted government on the location of partner NGOs. In this respect, GoB officials noted that the NSDP NGOs prefer to work in areas where they can attract the most clients and are reluctant to move to underserved and remote areas where government services are the weakest and help is most needed.

Another area where coordination could be helpful is in the reporting of coverage statistics for child health interventions. NGOs at the local, district, and municipal levels generally report their statistics, especially immunization data. However, NSDP does usually send its data to the central GoB. Further discussions with appropriate government officials at

local and central level would facilitate coordination on reporting and provision of data that will be in agreement with government statistical systems and therefore more useful for compiling national coverage and trends.

EPI was identified as an example of a child health program that coordinates well with GoB and NSDP. For example, standard reports on immunizations are regularly submitted to local health officials. However, it was noted that since government provides the vaccines and supplies, the NSDP NGOs should provide injections free of charge. (A registration fee is charged.) NSDP believes that EPI is one of its most successful child health interventions because it attracts clients to the static and satellite clinics. Although national coverage rates have declined, NSDP does not do outreach or follow-up that would help increase EPI coverage. This is an area where enhanced coordination with government and other EPI providers would potentially make a major contribution to improved child health outcomes.

Under the next GoB five-year HNPSP, emphasis is to be given to child health for: nutrition, improved EPI coverage, the introduction of Hepatitis B prevention, and some child health treatment. There will also be a focus on some infectious diseases such as *kala-azar*, filariasis, and dengue in the areas where these conditions are prevalent and services are most needed. The MOH&FW also proposes to address problems in urban areas that are not now covered by municipalities. There are many opportunities for NSDP to more closely collaborate with the GoB for implementation of the proposed interventions.

In meetings with the MOH&FW and municipalities, it was stated that the GoB wants to continue the existing partnerships with NSDP NGOs and develop new ones. The NSDP's work plan includes several proposed mechanisms for strengthening relationships and coordination with the GoB, including development of a strategy for regular meetings, participation in policy working groups and technical task forces, participation in pilot projects and research studies, and collaboration for joint training. The challenge for NSDP is to take advantage of such opportunities. The project's recent appointment of a health management and financial advisor, who is a former senior government officer, should help facilitate closer working relationships and coordination with GoB.

Coordination with Municipalities and City Corporations

Urban areas are not under the control of the MOH&FW. Health services in these areas are the responsibility of the municipalities and city corporations. Most municipalities reported a shortage of staff, health personnel, and technical expertise (which is often limited to sanitation officers), in addition to limited budget. For these reasons, they welcomed the contribution and active participation of NGOs in service delivery. NSDP has a formal relationship with the Urban Primary Health Care Project (UPHCP) to operate clinics that have been built with the support of the Asian Development Bank (ADB) in four city corporations where activities are also coordinated with UPHCP. In other areas, the NGOs coordinate directly with municipalities. Senior municipal officials have identified child health as an area where collaboration with NGOs is especially

urgent. One NSDP NGO had coordinated closely with the municipality for EPI services and even provided support for EPI workers. However, such arrangements were described as no longer possible under NSDP because funds cannot be used for additional staff. Strengthening NSDP's coordination with government would be enhanced by flexible regulations that allow NGOs to be responsive to government needs, especially in the area of child health.

Coordination with Donors and International Organizations

NSDP has had some collaboration with the Department for International Development (DFID) through the plan to operate community clinics that were constructed by the GoB but never operationalized. NSDP NGOs will run six of these clinics, and NGOs supported by DFID will operate six others. NSDP NGOs will share the pilot implementation experience from community clinics in Brahmanpara Upazila, which were assisted by DFID funding. CIDA and Gonoshasthaya Kendra are also participating in this project. NSDP does coordinate with international organizations such as UNICEF for specific projects, and with other initiatives, such as SNL, and with UNICEF and WHO on technical committees addressing IMCI and other child health interventions. Many NSDP staff have experience working and coordinating with a wide variety of Bangladesh-based international and national organizations, groups, and donors and maintain informal links with these groups. These links should be exploited more fully.

Coordination with other NGOs

Although NSDP has links with several other NGOs, coordination is often more informal than formal. Participation in technical working groups is a more formal mechanism, while membership in common professional associations is an example of an informal coordination mechanism.

Coordination related to training with other NGOs provides opportunities for technical exchange. For example, NSDP has an arrangement for the Radda Maternal and Child Health and Family Planning Centre (Radda MCH-FP) to train paramedics working in NSDP NGOs.

Referral between NGOs, especially those with child health expertise, would help expand NDSP's capacity in this area. The only area of referral between NGOs reported to the assessment team involved Shining Sun NGOs in Sylhet, which refers clients to Marie Stopes for reproductive health services that are not provided by NSDP clinics. Impressions of competition between NGOs were described as discouraging referral and closer collaboration.

The relationship between core international NGO partners, such as CARE and SCF/US, and NSDP was of interest to the assessment team because these organizations represent a reservoir of child health expertise and resources. For example, CARE is motivated to partner with NSDP, even though it has been allocated a very limited portion of the overall project budget, because of this collaboration can give it an opportunity to test and

disseminate its strategies for safe motherhood and child health through the NSDP's national network. CARE is also working with NSDP on community response and EOC. SCF/US also viewed the collaborative relationship with NSDP as a potential national network for SNL. SCF's medical director has been available for consultation and collaboration with NSDP. However, both organizations expressed disappointment about NSDP's limited attention, delays, and in some cases barriers, to developing and implementing activities to strengthen the contributions to child health.

BRAC has extensive expertise in child health and at the community level. For this reason, BRAC absence as a formal partner in NSDP for United States Government political reasons is significant. Mechanisms for productive collaboration and exchange with BRAC should be identified.

Coordination on Research Related to Child Health

NSDP does coordinate and participate in some research projects with organizations such as the International Centre for Diarrheal Disease Research/Bangladesh (ICDDR-B) and with the GoB. Collaboration in pilot projects and studies directly related to child health efforts would serve to strengthen NSDP's capacity in this area. In addition, participation in forums for discussion and distribution of research results, and for development of mechanisms for using these results would benefit NSDP and its partner NGOs.

Coordination with Private Sector Health Facilities and Doctors

The main areas of coordination with the private sector and other health facilities are through referral services. The team found no cases in which NSDP partners established formal relationships and referral links with specialty services and private health facilities. For example, in Sylhet, some non-NSDP NGOs have agreements with the Red Crescent Maternal and Child Welfare Center for referral of maternity cases. The Department of Pediatrics of Sylhet MAG Osmani Medical College has referral arrangements with other NGOs. Priority attention was provided to children referred from these NGOs to the outpatient and inpatient facilities, but NSDP NGO patients had to go through the formal registration procedure. Referral links are especially important for child health because NGO static clinics with fixed service times are not able to respond to many child health problems, especially emergencies. This is an area of missed opportunities that would benefit from NSDP follow-up and action.

Coordination with Traditional Practitioners and TBAs

NSDP has not had any formal collaboration with traditional practitioners and TBAs in communities where NGOs are working. Although it was suggested that NSDP might benefit from identifying models of nontraditional service providers and collaboration developed by other organizations, no activity in this area was identified.

Other Missed Opportunities

Although NSDP has experience with collaborative arrangements, they need to be strengthened and expanded. Its limited expertise in child health could be augmented by more extensive coordination with organizations having specific expertise that would complement current NSDP NGO experience. Many opportunities to strengthen coordination are available at all levels and should be explored and developed.

V. RECOMMENDATIONS

STRATEGIC DIRECTIONS

- NSDP and USAID should clarify the ground rules regarding the expectations for the amount of coverage and impact that the child health interventions should achieve. The resources, manpower, and other inputs needed to attain these expected results should be identified and analyzed. With this clarification, the NSDP and USAID could decide together:

  - Whether they are going to move forward with a significant child health program;

  - What the objectives and goals of such a program should be; and

  - What project resources should be applied or reallocated to ensure that these goals and objectives are met.

- The views of sustainability, services to the poor, and market share, as currently used in the project, need to be reviewed and reconciled. At present, thy may not represent the best interests of the project as a whole or of the communities that the NSDP and its NGO partners are mandated to serve. The project and its USAID and NGO partners should work together to define the acceptable balance between these issues and the demands of an effective child health program. NGOs, especially, must be helped to examine these in view of their long-term missions and goals, since conflicts and misinterpretations could endanger services to their traditional constituents. All partners must collaborate in this effort to ensure that there is clarity and transparency in the process that defines how and to what degree these concepts will operate in the NSDP.

PROGRAM DIRECTIONS

- Child health activities in the NSDP need a strategic focus and clarity that that they do not currently have. The project needs to develop a cohesive child health strategy as soon as possible. This strategy should focus on the major causes of child mortality and morbidity and define realistic objectives for NGOs in this area. It should also specify how new services and interventions will be delivered and integrated into existing programs. Finally, the strategy should align NSDP resources, partner capabilities, and the absorptive capacity of NGOs to ensure that planning and implementation are based in realistic expectations and have the management and technical support that they need.

- The NSDP must clarify its position regarding point-of-service strategies and the role of static clinics and community-based services. Effective child health depends on the consistent availability of some kinds of curative services in the

communities where children live. Services for poor children may depend on continued subsidization in one form or another. These issues need to be discussed and resolved by all major stakeholders, and a clear policy must be developed that will guide future activities. Otherwise, the large amounts of resources that the project dedicates to child health are not likely to produce corresponding returns in improved health status.

- The NSDP needs to review its training strategy in child health and seek more sustainable, cost-effective collaboration with organizations and institutions that already have good training capabilities in the project's major intervention areas. The current plans for creating capacity in the NSDP's local training partners to provide training in complex child health interventions may not be the best use of resources.

- NGO partner confidence and good relations will be an important part of the NSDP's success. The project needs to find better ways to make NGOs part of the decision-making processes that affect them. These could include greater transparency, more rapid turn-around on information and guidelines that NGOs feel they need, and more communications about child health programming and the use of funds.

MANAGEMENT SUPPORT

- Technical leadership is critical to the success of NSDP's child health program. NSDP should add a senior-level child health position or positions in the management structure. This position, which should be within the senior management structure, would be responsible for leading NSDP activities to develop a child health strategy, guide its implementation, and oversee progress on child health indicators.

- An effective management structure and support is crucial to child health programs. If the NSDP wants its program to make a difference, it will need to reorient the NSDP management structure and functions at the central and regional levels to develop and adequately support implementation of activities. A specific management strategy to coordinate the various staff members and units with expertise and responsibility for child health would be useful. The roles and responsibilities for RTOs should be reviewed to increase their participation in NGO coordination and operationalization of activities. Increasing the responsibilities and resources of the consortium's child health partners, CARE and SCF/US, should also be considered.

- Consistency of approach across management support units is needed to adequately support child health within the NSDP. Using the child health strategy and its indicators, NSDP should work with the various technical support units (e.g., training, MIS/M&E, and sustainability) to adjust their approaches to better support these activities.

- The generation and use of MIS data is vital to the child health program. The child health advisor and child health program staff should work closely with the MIS/M&E Unit to identify, produce, and use the data needed for program decisions. The MIS/M&E system will need to be reviewed and adjusted to (1) summarize and analyze child health data based on universally accepted indicators; and (2) simplify and clarify data and distribute it to NSDP program staff and NGOs. The MIS/M&E Unit will also need to explore future needs to track community mobilization, health promotion, and other activities in order to support NSDP as it expands child health with a prevention and community-based emphasis. Finally, MIS/M&E should continue to consult with USAID, NSDP, and NGOs to reduce the burden of data collection to increase the use of essential data for program management.

- Quality improvement is important to the success of NSDP child health programs. The child health advisor and staff will need to work closely with the QI Unit to incorporate into their QI approach for the improvement of community health services, community mobilization, family health counseling, health promotion, and similar issues. The QI Unit should also review current checklists to ensure that client counseling, nutrition promotion, and prevention activities are adequately represented.

- Institutional development and long-term sustainability are key to the long-term viability of the NGOs, but these have to be balanced with the continued provision of services to the poor and most vulnerable. NSDP and USAID management should continue their discussions to outline realistic sustainability objectives. The Institutional Development Unit can then develop a work plan and timetable to help the NGOs to develop their boards, management, institutional structure, and processes to meet these objectives. Issues of NGO staff recruitment and retention will also need to be addressed. NSDP and USAID will need to define realistic cost-recovery, fund-raising, and financial diversification objectives to guide NGOs toward sustainability.

- Logistics keep the wheels turning for child health. NSDP management and the child health advisor and staff will need to work with the Logistics Unit and assess its capacity to meet the needs of an expanded child health program. Additional staff may be needed to strengthen the NSDP logistics system. The future role of NSDP's Logistics Unit in providing TA to develop the NGOs logistics system capacity will also need to be defined. This may require that the Logistics Unit have more staff.

TECHNICAL COMPONENTS

The Essential Services Package. The ESP is a good package of services and should be viewed as a platform for the consolidation of NSDP child health services and as a lead-up into clinical and community IMCI. Information about coverage and lack of focus on

priority interventions suggests that the NSDP should start here to address these issues before adding more complex interventions. The project also needs to do some serious transition planning for the introduction of new strategies into ESP services.

Other things that might be considered include:

- Additions to the ESP that would allow health workers to address maternal and childhood malnutrition, neonatal health, and some prevention counseling. Good materials for all of these already exist in C-IMCI and in new programs on maternal health. Adaptations, training, and pilot tests of effectiveness could be done locally, possibly managed by the RTO.

- A judicious expansion of the existing satellite clinic system based on operations research (OR) on feasibility, coverage, and similar considerations. This might include building the supervisory skills of the paramedic and using BCC to extend the concept of the child as "client."

- Phased expansion of the depot holder system. The project might examine the feasibility of designating some depot holders as specialists in child health interventions.

- Continuation of OR on depot holders' ability to diagnose and treat ARIs. At the same time, it would be helpful to look at the design of this study to address possible flaws. Results, which are likely to be positive, should be disseminated rapidly.

- Exploration of the feasibility of financing or supplementing the expansion of the depot holder system with some type of social marketing, especially of simple curative products that support early intervention for such conditions as ringworm, scabies and topical antibiotics to treat skin, ear and eye infections. The possibility of using local pharmacies in the supply network should be explored.

Clinical IMCI. The plans for rapid scale-up of clinical IMCI at project clinics should be reexamined and probably slowed down. Although NSDP NGOs are anxious to offer IMCI at their clinics, sufficient consideration does not seem to have been given to the cost, feasibility, and timing of this expansion. Clinical IMCI services are clearly the future for child health in Bangladesh, but a fast-track strategy is likely to create more problems than it solves, given that neither the project nor the NGOs seem fully prepared to assume the management and financial burden that accompany an adequately functioning IMCI system.

Steps that would move clinical IMCI forward in a more productive and orderly manner include:

- Do an in-depth study of the 15 pilot clinics. The PNA was a step toward this, but much more information is needed, especially on the problems that may accompany introduction of IMCI.

- Develop guidelines and priorities for phasing in IMCI services in NGO clinics. Not all are NGOs are created equal. A clear strategy concerning the phase-in of IMCI services must be developed, and this strategy should be shared with and understood by NGO partners who have expressed interest in IMCI.

- Work with NGOs to ensure they understand the implications of adding clinical IMCI to their current services. This should include a realistic review of their expectations, a cost/benefit analysis, and a frank discussion of the problems of staff retention, the increased logistics burden, and the reduced client load that may accompany the introduction of IMCI.

- Improve the current technical and management support to IMCI physicians. Use training slots that are now available to send supervisory staff to the full IMCI training course. RTOs should have priority in the selection of candidates for this training.

- Think more broadly about the support systems for IMCI. It is not just a training issue - supervision, evaluation, retraining, and logistics are all part of installing this capability in NGOs. A plan must be in place to ensure these important components of IMCI are in place.

- Improve the referral network for IMCI. Static clinics will not be the "one-stop shopping"; they will be part of a larger system. The project should help NGOs identify and formalize agreements for referral to the next levels of care.

- Reconsider the feasibility and cost of creating an IMCI "master trainer" capability at NSDP partner training institutions. Since IMCI is now an official GoB strategy, and there will be many options for training physicians. For that reason, NSDP training resources might be better used for the many secondary and support staff demanded by IMCI. This type of capability may also be more sustainable.

Community IMCI. C-IMCI is likely to be the most important child health measure proposed by the NSDP. At this point, however, it is far from reaching its potential, despite the efforts of hard-working, talented project staff. To realize the power of C-IMCI, the project will have to make a number of adjustments in its approach and support for this important intervention.

- C-IMCI activities have to be set in the context of a clear project policy about community-based services. The C-IMCI strategy can then be adjusted to reflect this reality.

- Counseling, prevention, and home care are important components of C-IMCI, but they are only half the power of this intervention. The NSDP needs to specify how C-IMCI will link families and the health network together at the community level. Curative interventions should be part of this; otherwise, C-IMCI may not be worth it.

- The linkages between C-IMCI and clinical IMCI services must go beyond "channeling" clients to static clinics for services. The NSDP must look at IMCI as a system and consider the provider chain that links clinical and community services. Sending key staff to see how a complete IMCI program works in other countries would be a good way to encourage this planning.

- C-IMCI is not a clinical or training intervention in the strict sense, and it should not be treated as such. It would not be appropriate, for example, to do as some staff suggested and meld some or all of C-IMCI with safe delivery or other clinical activities. C-IMCI needs a higher profile in the project, not a lower one.

- SCF/US and CARE should be given a broader and more dynamic role in carrying out C-IMCI activities. This will probably require some reallocation of project resources.

- The C-IMCI team needs better management support for its efforts, particularly by the senior staff. This should also include more productive engagement of the local offices of SCF/US and CARE, which seem to be a largely untapped resource.

- The depot holders and the staff of satellite clinics are a critical resource for C-IMCI, but definitive roles for them are not spelled out in the strategy. This will probably require some reallocation of project resources.

- The C-IMCI team should consider a stronger emphasis on nutrition and growth promotion. Links with the NNP should be explored. There are also a number of international examples (e.g., USAID-supported activities in Zambia, Uganda, Honduras, Nicaragua, and Bolivia) of strong C-IMCI nutrition programs that the NSDP could look at. USAID/Bangladesh could provide information about such programs.

- The NSDP must carefully weigh the political advantages and liabilities of fielding and beginning to implement a formal C-IMCI strategy before the GoB has defined the basic elements of its own program. With careful planning it should be possible to begin many activities that will become part of C-IMCI without taking positions that could run counter to the national strategy in the future.

Neonatal Mortality:

- NSDP should significantly increase its neonatal health care activities and expand their coverage. Strategic alliances with other programs, including a more dynamic

relationship with the SNL Initiative, might be the best way to begin this effort. The NSDP should try to avoid "going it alone" in this area. There are many organizations involved in maternal and neonatal health in Bangladesh with which the project could partner.

- Neonatal mortality should also be an aggressively pursued target of C-IMCI. The NSDP should also actively link with the GoB, other donor program, and private agencies to make best use of and share technical and other resources to strengthen its neonatal care program.

- The NSDP should address prevention to improve maternal and child health status. Activities might include maternal iron and vitamin supplementation, tetanus immunization, and counseling women on exclusive breastfeeding, birth preparedness, and recognition of pregnancy complications danger signs. Improved training for paramedics and other community health workers, as well as TBAs and others, has a role to play in monitoring and addressing pregnancy complications. The NSDP should also establish strong referral links to facilities to ensure emergency obstetric care.

BCC Activities. The BCCP should be brought into the overall planning process for child health activities as early as possible, and NSDP should take steps to ensure that BCCP has the access and resources to learn about the technical aspects of interventions in this area.

- The BCCP should play a major role in the development of C-IMCI activities, especially prevention. BCCP is an important partner for community-oriented activities, and its expertise should be exploited.

- In conjunction with CARE and SCF/US, the BCCP would be an excellent resource for addressing malnutrition, especially child feeding.[40]

- Child health interventions are not the best candidates for advertising and "campaigns." Proposals to carry out such activities should be reviewed and discussed carefully.

- Proposals for the BCCP to continue to develop training materials for project activities need to be reviewed and discussed. Many activities may not require new

[40] Growth Promotion and other strategies that promote child feeding are primarily based on behavior change. The BCCP could be the leader in such efforts, building from the C-IMCI Nutrition counseling card for mothers, should the project decide to address childhood malnutrition in a more proactive way. They would, however, need some external technical assistance. Technical collaboration with NNP might provide this, as could the Nutrition Division of the World Bank, which supports growth promotion programs worldwide. Other resources include the Manoff Group, Inc., which is working actively in C-IMCI as well as growth promotion, and the Academy for Educational Development. Both of these organizations are based in Washington, D.C.

manuals, charts, and materials; in the major child health intervention areas, there are many excellent existing materials that can be adapted. The BCCP should help NGOs identify these resources and do any needed adaptations themselves.

- Any new materials created by the BCCP should be consistent with the abilities of NGOs to continue their production after the project ends. Expensive, multicolored, plasticized materials are not sustainable.

COORDINATION

Coordination within NSDP and Its Partners

- NSDP should continue to focus on strengthening coordination among partners internally. Particular attention needs to be given to improving coordination with NGOs and with other organizations, including the local offices of CARE and SCF/US that have expertise in child health. NSDP leaders should take direct action to ensure that these partners have a direct role in decision-making.

- The USAID/Bangladesh Health and Population staff has much to offer the NSDP in child health and other areas. Although the terms of the cooperative agreement place some restrictions on USAID's input, the NSDP should take more advantage of USAID's technical expertise, especially in research and programming.

Coordination with Ministry of Health and Family Welfare

- Clarify NSDP policy for working with the GoB and develop a strategy for productive interaction, coordination, and collaboration, both formally and informally. Activities should include joint training and participation on policy committees and technical working groups. Building on its current collaboration with the GoB, the NSDP should look for opportunities to strengthen this relationship at both the national and local level. For example, regular sharing of data from NSDP's NGOs with government at all levels would contribute to improved coordination.

- Special efforts are needed to enhance coordination between NSDP's regional offices and the GoB, and between NSDP NGOs and local and municipal government. NSDP also needs to develop guidelines for collaboration between NGOs and the GoB and specify areas where added flexibility would enable NGOs to respond to GoB requests. Such flexibility is particularly essential for child health activities, which require innovative responses and activities not currently specified in NSDP's agreements.

- Identify opportunities to collaborate with GoB on the priorities proposed for the MOH&FW's next five-year plan (i.e., HNPSP). These include the proposed emphasis on prevention, nutrition, promotion of newborn health, and reduction of neonatal mortality; expansion of EPI coverage and introduction of Hepatitis B;

limited treatment, infectious diseases that have an impact on children (e.g., malaria, childhood TB, filariasis, and *kala-azar*); and expansion of IMCI, which is now only in pilot districts; and, reduction of maternal mortality.

Coordination with Municipalities and City Corporations

- Continue, build on, and strengthen current coordination with municipalities which have limited resources and therefore increased need for coordination with NGOs.

- Continue to coordinate with city corporations and the UPHCP.

- Coordinate with GoB to address child health problems in urban areas that are not currently covered by municipalities.

Coordination with Donors and International Organizations

- Develop a strategy for interacting with relevant international and national organizations and begin implementing it as soon as possible. These organizations include multilateral organizations and United Nations agencies, bilateral donors, USAID-supported organizations such as IOCH, and NGOs working in the health sector and at community level. Special efforts to coordinate with NGOs working in child health that have outreach and community-based approaches and services are needed to strengthen NSDP's contribution to child health.

- Explore mechanisms for constructive collaboration with BRAC, which has an extensive network extending to community-based services and particular strength in child health interventions.

Coordination with NGOs

- Identify other networks of NGOs and programs working in child health and explore mechanisms for collaborating, and information sharing. Consider the direct exchange of technical assistance with these groups, including joint training.

- Continue participation in NGO policy and coordinating committees and with technical working groups.

- Find avenues through which the NSDP and NGO partners can serve as organizers and facilitators with other NGOs working in a selected area to develop a multi-NGO strategy to meet maternal and child health needs. The NGO partner could coordinate meetings and assist with the implementation of such a strategy.

Coordination on Research Related to Child Health

- Continue collaboration and identify relevant research projects for child health and collaborate with research organizations such as ICDDR-B and with GoB.

Participate in studies and pilot projects and in forums for discussing and distributing research results, in addition to developing mechanisms for reviewing and using research results.

Coordination with Private Health Sector Facilities and Donors

- Establish relationships and formal referral links with institutions providing services for maternal and child health for NGOs. These relationships should include exchange of technical expertise and training in child health.

- Work with other organizations to ensure or increase coverage of a selected population.

Missed Opportunities

- Look for missed opportunities to coordinate and collaborate with the GoB, other organizations and programs, and NGOs.

VI. PLAN OF ACTION

The team did not find it possible to develop a detailed plan of action and implementation schedule during the limited timeframe of this assignment. As the findings suggest, some of the barriers to a more effective child health program at the NSDP are structural and will demand some project-level analysis. Consortium-level decisions will have to be made in concert with USAID and, to a lesser extent, NGO partners. Discussions should be started as soon as possible. No meaningful child health program can go forward in the NSDP until these basic steps are taken.

The NSDP staff can begin a number of activities immediately. These can facilitate some of the larger discussions about the direction and scope of the NSDP's child health activities in the future. They should also pave the way for more targeted and effective interventions.

The Plan of Action Table (see Annex B) lays out the major activities suggested by the recommendations in Section V of this report. It is offered as a guide to the process of making NSDP child health programs more effective.

The dedicated professionals that work in this area already understand most of the actions that must be taken to move their efforts forward. What they need now is the encouragement to begin, plus a strong technical spokesman who can lead their efforts. They also need greater clarity on their mandate and the resources available to respond to it, and, finally, the removal of barriers that currently constrain an integrated approach.

ANNEXES

ANNEX A

SCOPE OF WORK

SCOPE OF WORK

ENHANCING THE IMPACT OF CHILD HEALTH ACTIVITIES THROUGH THE USAID-SUPPORTED NGO SERVICE DELIVERY PROGRAM (NSDP)

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BACKGROUND

Bangladesh has made significant progress in reducing infant and child mortality rates over the last decade. But between 1995-1999, the infant mortality rate in Bangladesh was 66 per 1,000 live births, while the neonatal mortality rate was 42 per 1,000 live births. This means that 64 percent of all infant deaths took place during the neonatal period (birth to 28 days). Birth asphyxia, pneumonia, septicemia and premature births are the leading causes of neonatal death. Added to this, in late pregnancy there are at least 100,000 stillbirths, bringing the total perinatal (stillbirths and early neonatal period) and neonatal deaths to 250,000 annually (State of the World's Newborn, Bangladesh, 2001).

More than 90 percent of mothers deliver at home and unskilled birth attendants conduct 84 percent of these deliveries. Hence, most neonatal deaths take place in the community without support from trained health care professionals. Early neonatal deaths and the quality of care during and after delivery are interrelated; thus, it is critical to provide essential newborn care (ENC), including postnatal visitation, given the impact of this care on neonatal outcomes. Most Bangladeshi women (84 percent) are aware of the importance of care during pregnancy but only one-third of pregnant women receive antenatal care and only two percent receive postnatal care.

Malnutrition, compounded with infections, continue to be killers, contributing to post neonatal mortality. Most of the deaths are from readily preventable or treatable conditions: pneumonia, diarrhea, measles, and neonatal tetanus. Protein-energy malnutrition is also a strong underlying cause of death from infectious diseases: 66 percent of childhood deaths in Bangladesh are currently attributable to malnutrition, even though the immediate cause of death may have been due to pneumonia, diarrhea, or a less common infectious disease. Thus, each year 250,000 deaths among children under five years of age in Bangladesh can be attributed to malnutrition (more than 600 per day). Apart from that, less than 60 % children are fully immunized by their first birthday, 38% infants are given supplementary feeding during first three months, and 48% children of 6-59 months have moderate to severe anemia.

The evidence that a large proportion of childhood morbidity and mortality (U5MR: 94/1000 BDHS, 1999-2000) in Bangladesh is caused by just five conditions does not in itself argue for an integrated approach to the management of childhood illness. However, most sick children present with signs and symptoms related to more than one of these conditions and this overlap means that a single diagnosis may be neither possible nor appropriate. Treatment of childhood illness may also be complicated by the need to combine therapy for several conditions. An integrated approach to managing sick children is consequently indicated, as is the need for child health programmes to go beyond single diseases and address the overall health of a child.

Much has been learned from disease-specific control programmes in the past 15 years. The current challenge is to apply the lessons from these programmes to strategies that promote coordination and, where appropriate, greater integration of activities in order to improve the prevention and management of childhood illnesses.

USAID/Bangladesh's Mission Goal is poverty alleviation. The Mission is organized into six Strategic Objectives. The Population, Health and Nutrition (PHN) Team's Strategic Objective is fertility reduced and family health improved. (See USAID's web page www.usaid.gov/bd for more information.)

USAID/Bangladesh's PHN program, one of USAID's largest, is currently funded at nearly $40 million per year, or about 60 percent of the Mission's FY 2002 budget. All PHN activities are subsumed under the National Integrated Population and Health Program (NIPHP), which was launched in 1997, and is implemented under an agreement with the Government of Bangladesh (GOB). NIPHP provides bilateral and field-support funding to 16 organizations for: continuation of a large NGO health and family-planning service-delivery project; commodities and technical assistance for the world's largest social marketing program the Social Marketing Company (SMC); technical assistance to the GOB for polio-eradication, logistics and procurement management, and in-service training; operations research; HIV/AIDS prevention; and adolescent reproductive-health.

NSDP

The NGO Service Delivery Project (NSDP) is a $40 million, four and a half year Cooperative Agreement with Pathfinder International as the lead grantee. Partners include The Bangladesh Center for Communications Programs (BCCP), CARE, Deloitte Touche Emerging Markets, INTRAH of the University of North Carolina Medical School, the Research Triangle Institute (RTI), Save the Children Federation (SCF US), and the University Research Corporation (URC). NSDP began work in May of 2002, building on activities of the Urban Family Health Partnership (UFHP), Rural Service Delivery Partnership, Quality Improvement Project, PRIME and Quality Assurance II.

NSDP is the primary vehicle for USAID /Bangladesh's NGO support activities through four components: provision of the Essential Service Package (ESP) service delivery in urban and rural areas including quality assurance and training; behavior change communication and marketing (BCCM); NGO institutional development and sustainability; and policy development. NSDP works with 41 NGOs, 278 static clinics, 348 upgraded satellite clinics, 13,817 satellite clinic sessions a month and 7,000 community-based rural depot holders, serving over 1.5 million clients a month throughout Bangladesh.

Within the USAID/Bangladesh Strategic Objective 1, the NIPHP' NGO Service Delivery Program has moved from a vertical family planning program to the integrated Essential Services Package (ESP), which includes addressing child health problems. Much has been accomplished, existing gaps need to be identified and addressed. A recent MEASURE Evaluation community based-survey, and analysis of NSDP service statistics, indicate that while NSDP NGOs are doing a good job of providing family planning and ante-natal care services, the program is not very effective in providing Child Survival services or improving child health indicators. This may be attributed to the fact that the NSDP model of service delivery has developed over time from the family

planning programs. A majority of the services are provided through satellite clinic sessions, which are held weekly in urban areas and only monthly in rural areas. The rural depot holders are only trained in family planning and oral rehydration therapy in order to market family planning supplies and oral rehydration salts (although a pilot program is training depot holders to enable them diagnose and treat acute respiratory illnesses.) The problem is compounded in rural areas by a scattered patchwork of NGO "catchment areas" which were assigned in the late 1980s and early 1990s by local Ministry of Health and Family Welfare officials to cover locations where government fieldworkers were not operating.

If a satellite clinic is provided once a month, the program can only treat sick children in that community that day, and mothers have to go somewhere else for most curative services. They either go to local providers such as pharmacies or traditional healers, or may go to the Thana Health Complex, if that is closer. Only families that live close to the static clinic will consider using that facility for treatment.

OBJECTIVE

The objectives of the evaluation are to conduct a situational analysis of the current NSDP child health interventions in Bangladesh to address the problem of infant and child mortality.

STATEMENT OF WORK

The evaluation team shall be mandated to:

A. Assess the present NSDP child health interventions in Bangladesh;
B. Recommend strategies for enhancing child health in Bangladesh through the NSDP; and
C. Prepare a plan of action for phasing in interventions into NSDP.

Activities:

A. Assess current NSDP child health interventions in Bangladesh

   Conduct a situation analysis of present NSDP child health activities, training, and resources in Bangladesh focusing on:

   1) EPI
   2) Neonatal Health
   3) ARI
   4) Diarrhea
   5) Measles
   6) Ear infection
   7) Tuberculosis
   8) Nutrition including micro-nutrients and feeding counseling

9) Monitoring, reporting, and supervision of child health interventions
10) Quality of care in the home and community using community based providers
11) Referral and referral level care
12) Antenatal interventions and their effects on birth weight (Nutritional status, Iron/Vit A supplementation etc)
13) Postpartum interventions affecting the newborn (Postpartum Vitamin A, etc)
14) Treatment of sick young infant

B. Recommend strategies for enhancing child health in Bangladesh through NSDP

1) Visit & review NSDP Clinical sites (IMCI sites, rural/urban sites etc)
2) Visit and review community based child health, EOC pilots already being implemented in Bangladesh (Matlab, SNL (Dinajpur) etc.)
3) Analysis and recommended strategies for NSDP
4) Present findings to all stakeholders at a meeting

C. Prepare plan of action for phasing in enhanced child health interventions into the NSDP and other vehicles over the next 4 years

1) Review NSDP proposal
2) Visit NSDP Clinical Sites
3) Review the NSDP "catchment" areas
4) Recommend phasing in enhanced child health interventions

REPORTS/DELIVERABLES/SCHEDULE

B. The contractor shall present a detailed work plan and data collection plan to USAID at the end of the first week of activities in country.
C. The contractor shall contact the USAID/Bangladesh Cognizant Technical Officer on a weekly basis to provide progress updates. Contact can be maintained by telephone when contractor team is in the field.
D. During week four (4), at least one member of the contractor team shall travel to Dhaka to brief USAID/Bangladesh on progress of activities.
E. The contractor shall submit to the Cognizant Technical Officer the following deliverable:

Final report of situation analysis on child health interventions & recommendations for enhancement including an action plan for NSDP phasing in enhanced child health intervention.

F. The contractor shall submit two hard copies of the report in English along with one (1) diskette using Microsoft WORD format. The contractor shall also submit diskettes with electronic copies to USAID/CDIE in Adobe Acrobat format.
G. The contractor shall make a presentation of findings to USAID and NSDP before leaving Bangladesh.

The following is the proposed outline for the evaluation report. The Contractor may modify the proposed outline, in consultation with the Cognizant Technical Officer, as deemed necessary.

- Summary
- Table of Contents
- List of acronyms
- Introduction: Objective of assessment
- Overview of NSDP objectives and strategy
- NSDP's organization and management structures
- Implementation of child health activities in NSDP
- Implementation progress of child health activities and achievement of results
- Barriers to achievement of objectives (on child health indicators)
- Recommendations for enhancement of child survival interventions
- Action plan for implementation
- Conclusion
- Annexes (Evaluation SOW, team composition, methodology, key informants, sites visited, records and references, indicator performance tables, survey, etc…)

The delivery schedule of the evaluation report is as follows:

- An initial version of the draft evaluation report shall be submitted to the USAID/Bangladesh Cognizant Technical Officer and other stakeholders during week six (6) of the evaluation.
- The second draft of the report shall be submitted to the USAID/Bangladesh Cognizant Technical Officer and other stakeholders before the departure of the contractor team leader in week seven (7).
- The final version of the report shall be submitted to the USAID/Bangladesh Cognizant Technical Officer within 15 working days of the contractor team leader's return to the US.

WORKWEEK

The contractor is authorized up to a six-day workweek in the field with no premium pay.

AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services under this order is 935.

LOGISTIC SUPPORT

The Contractor shall be responsible for all logistic support. The contractor team is expected to arrange its own work/office space, equipment and materials.

REQUIRED EXPERTISE AND QUALIFICATIONS

Three expatriate consultants who shall have at least seven (7) years of experience in implementing and evaluating public sector family health programs, with at least 3 years of experience working on programs in Asia, preferably Bangladesh. They shall be fluent in written and spoken English (S/4, R/4) and have a minimum of a master's degree in public health or another relevant field. They shall have proven competence in assessing the technical components of child health. Familiarity with Quality Assurance (QA) and systems reform approaches is highly desirable.

The consultants will work with assigned staff at NSDP and USAID. The Bangladesh NSDP office will provide logistics support to the consultants.

PERFORMANCE PERIOD

This assignment is expected to approximately last 50 working days starting in January 2003 based on:

- 2 days preparatory work in the US
- 5 days total for US-Bangladesh-US travel for Team leader
- 38 days for work in country
- 4 days to finalize the report in the US
- 1 day to distribute the report

REFERENCE MATERIALS

- State of the World's Newborn: 2001
- Measure evaluation report on RSDP /UFHP 2002 (Unpublished, draft copy will be made available to the team)
- SNL pilot documents
- IMCI pilot documents
- NSDP proposal
- CARE EOC project documents

ANNEX B

PLAN OF ACTION TABLE

Major NSDP Plan of Action tasks -- Project level Group --	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
USAID, NSDP, NGO meetings for priority strategic policy discussions: 1) Coverage & impact ; 2) Sustainability	X	X	X									
ID & assign Senior Management responsibility to keep this Plan of action on target & support NSDP Management & CH Working Group.	X											
Recruit and hire LT CH Senior Technical Advisor	X	X										
Create a NSDP CH Working Group (with NGO reps) to develop Child Health Strategy & support sub groups		X	X	X								
Meet with GOB, Municipalities, donors, etc: outline their input into CH Strategy				X	X							
Conduct Initial meetings with NSDP partners & NGOs re: Mgmt, resource, other implications of CH expansion strategy					X	X						
Conduct working sessions to develop Child Health Strategy					X	X	X	X				
ID& structure working sub groups to help develop & implement Policy, Mgmt, Technical, Coordination actions		X	X									
Outline a Management Strategy with defined NSDP senior management & partner responsibilities to implement needed restructuring				X	X							
Negotiate & document with NSDP partners re: restructuring of management pillars, staff & resources to implement CH Strategy						X						
Management sub group actions												
Meet with CH Advisor to ID needed Mgmt. support to expanded CH		X	X	X								
Review partner current support function to CH: MIS/M&E, QI, institutional Development, Operationalization, Logistics, etc.			X	X								

ID needed TA from NSDP Partners (or contract needed TA) to reorient the support functions of these units			X	X								
Negotiate with Partners on changed roles & begin restructuring/reorientation of support functions of these units					X	X						
Monitor progress on systems changes: adjust as needed								X		X		
Conduct overall management review to assure consistency, cohesive approach to CH support by these units												X
Report results to NSDP management												X
Policy/Strategic Directions sub group actions												
Meet with USAID, NSDP, NGOs GOB, etc: develop & analyze options for key CH Strategic Directions policy issues	X	X	X									
Draft Options Paper on key CH policy issues: coverage, sustainability, services to poor, point of service, etc.			X									
Convene meetings to present Draft Strategic Directions Options Paper to NSDP, USAID, NGOs, GOB: support these review sessions					X	X						
Compile Strategic Directions Document to guide NSDP CH expansion						X						
Distribute, discuss and provide presentations as needed to disseminate Strategic Directions Document: within NSDP & to other agencies.							X	X				
Review progress of implementation of Strategic Directions: provide semi annual report to NSDP Mgmt												X
Technical/Programmatic sub group actions												
Meet to ID & define priority CH interventions based on need	X	X										
Meet & provide CH technical input to CH Working Group		X	X	X	X	X						

Conduct a technical review of NSDP's neonatal, CH and related maternal health interventions currently used: ID changes & additional CH interventions needed	X	X	X	X								
Document & present needed technical changes & additions to CH Working Group				X	X							
Research & present appropriate NSDP options for incorporating IMCI, C-IMCI, community programming, etc. into CH			X	X	X							
ID key NSDP & NGO staff for out of country training as needed.						X			X			X
ID, review & provide quality CH technical resource material to NSDP, NGOs: ID agencies with specific CH expertise	X	X	X	X								
Conduct working meetings with BCC, training, other units. Review & revise technical content & approach to better support CH expansion		X	X	X	X							
Coordination sub group actions												
Briefly review & document current coordin-ation with agencies: partners, GOB, NGOs, donors, municipalities, private gps, etc.		X										
ID, review & document NSDP current policies & regulations re: coordination			X	X	X							
ID & document specific benefits to coordination (with *each* agency), focused on key CH interventions. Document for use in CH expansion					X							
Conduct working sessions with agency reps Re: Coordination Strategy					X	X	X					
Draft Strategy for pro- active coordination on Child Health, focusing on CH expansion, establish referral and research links						X	X					
Convene meeting: adopt Strategy: begin implementation							X					
Develop mechanisms for feedback & to identify new needs.									X			X
Review and improve Internal Coordination with Project RTOs. and other NSDP NGOs**.**											X	
Review: document progress, achievements												X

ANNEX C

DOCUMENTS REVIEWED

DOCUMENTS REVIEWED

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- Nutrition and Health Surveillance in Urban Slums in Chittagong: Key Results for the Period: February 2001 to January 2002.
- Nutrition and Health Surveillance in Urban Slums in Khulna: Key Results for the Period: February 2001 to January 2002.
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- Nutrition and Health Surveillance in Dhaka Division: Key Results for the Period: February 2001 to January 2002.
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- Nutrition and Health Surveillance in Khulna Division: Key Results for the Period: February 2001 to January 2002.
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ANNEX D

TEAM PLANNING MEETING

TEAM PLANNING MEETING[41]

AGENDA

February 20 – 21, 20003

DAY ONE	**February 20, 2003**
0830 –0900	Continental Breakfast
0900 - 0930	Welcome and Team Member Introductions Introduction to the Program i. Team Member expectations for the TPM ii. TPM objectives and agenda Overview
0930 – 1045	Scope of Work i. Review and discuss the Scope of Work
1100 – 1130	Conference call with Jim McMahan (INTRAH)
1130 – 1300	Discuss i. Background, history, and current status of NSDP ii Rationale, expectations, expected outputs iii Understanding the client iv Outstanding issues or gaps
1300 -1400	Lunch
1400 -1530	Discussion on Individual Scope of Work and team roles and responsibilities
1530 -1545	Break
1545 -1630	Continue discussions on individual Scopes of work
1630- 1730	End Product of the assignment i. Develop report outline ii. Divide responsibilities
1730	Wrap Up

[41] These responsibilities changed somewhat in the field. Rose Schneider did the monitoring/evaluation analysis and coordinated and wrote the sections of the report on NSDP management. Judith Justice did most of the interviews and wrote the sections on NSDP Coordination, and Melody Trott coordinated and wrote the findings related to the NSDP technical components.

DAY TWO	**February 21, 2003**
0830 - 0900	Continental Breakfast
0900 - 1030	Teamwork i. Work style discussion
1030- 1045	Break
1045- 1130	Administrative Briefing
1130	Wrap Up

TEAM PLANNING MEETING OBJECTIVES:

- Review the background, history, and current status of the NSDP child health interventions in Bangladesh
- Identify issues relevant to the assignment
- Agree on the purpose of the assignment and its scope of work
- Analyze and reach a common understanding of individual scopes of work
- Define and agree on team member and team leader roles and responsibilities
- Define and outline the end product (report) and gain an understanding of MEDS' expectations
- Plan how the team will work together
- Complete relevant administrative and logistical procedures

TEAM ASSIGNMENTS

Task	Person Responsible
Management of NDSP	All
Quality care/assurance	Rose
Clinical capabilities	Melody (training) and Judith
Community response and needs – Judith & Melody	Judith and Melody
NGO capabilities and responsiveness	Rose
Child health policy/programs (GOB/donors)	Judith
USAID Programs	Melody
Budgeting/costing plans/resources	Rose
Role and capabilities of partners	All
Review data to determine why USAID chose the existing interventions and implementation partners	Rose and Melody
Existing monitoring systems	Judith
Future plans	All
Are the current systems strong enough to sustain additional interventions (child survival)	All

ANNEX E

LIST OF CONTACTS

LIST OF CONTACTS

WASHINGTON

Julie Klement, Project Director, MEDS
Muthoni Ngage, Program Assistant, MEDS
Eric Starbuck, SCF/US
Jim McMann, Intrah
Barbara Seligman, GBH/PRH, USAID

BANGLADESH

USAID/Dhaka
Jay Anderson, Head, PHN Team,
Charles Llewellyn, Deputy PHN Team
Dr. Sukumar Sarker, Project Management Specialist,
Moslehuddin Ahmed, Project Management Specialist, PHN Team
Belayet Hossain, Project Management Specialist, PHN Team
Tara O'Day, Program Coordinator/Dissemination
Jeanie Friedman, Program Coordinator
Kanta Jamil, Program Coordinator/Evaluation & Research

NGO Service Delivery Program (NSDP):**
Jestyn Portugill, Chief of Party
David Weiler, Deputy Chief of Party, Finance and Administration
Jucy Merina Adhikari, Training
M. Kamrul Ahsan, MIS Specialist
Mohammad Mahbub Alam, Community Response Manager
S. M. Younus Ali, IMCI Manager
Zaman Ara, HIV/AIDS Coordinator
Jatan Bhowmick, Regional Technical Officer
Mustafizur R. Bhuiyan, Regional Program Officer
Nikhil K. Datta – Financial Sustainability Advisor
Moinul Haque, Training Coordinator
Md. Jahangir Hossain, RH/Safe Motherhood Adviser
Arkanul Islam, Regional Technical Officer (IMCI), Dhaka
Fakhrul Islam – NGO Training Specialist Coordinator
Md. Imtiazul Islam, Community Response
Waliul Islam, Health Management & Financing Advisor
Tawfique Jahan, Senior BCC Coordinator
M.E. K. Lutfullah, Office Manager
Riad Mahmud, Regional Technical Officer (IMCI), Rangpur
Naba Krishna Muni- Institutional Development Specialist Manager
Dr. Ahmad Neaz, Director, Training

Dr. Mizanur Rahman, MID & Evaluation Advisor
Dr. Shahana Nazneen Sayeed, Community Response Manager
Dr. Shalini Shah, Clinical Services Advisor
Rupa Zaman, Urban Health Coordinator

Helen Gallagher, Consultant on Community Response, Pathfinder Fund

* *Substantial assistance was also received from the NSDP Staff members who are not listed individually in the areas of financial management, MIS/M&E and quality improvement.

Ministry of Health and Family Welfare
A. Waheed Khan, Joint Chief, Planning Unit, MOH&FW
Md. Mahbubul Hoque Patwary, Assistant Chief, MOH&FW
Najmin Nahar Khan, Assistant Chief, MOH&FW
Md. Mofizul Islam, Assistant Chief, MOH&FW

Dr. M. Mahbubur Rahman, Program Manager (Child Health & Limited Curative Care, Directorate General of Health Services)
Dr. Fazul Kibria, Deputy Program Manager, ARI, DGHS
Dr. Younus Ali, Acting Deputy Program Manager, ARI
Dr. Z. A. Motin Al helal, Deputy Program Manager, Control of Diarrhoeal Diseases and Program & Program Manager, IMCI, DGHS
Dr. Sunil Kumar Das, Asst. Director & Deputy Program Manager, EPI, DGHS
Dr. Ulfat Ara, Medical Officer EPI (Surveillance)
Dr. Rahim, Medical Offcicer (Communicatons)

Reform Coordination Team (RCT), MOH&FW:
Professor M. Nurun Nabi, Chief Advisor and Head
Md. Rafiqul Islam, Joint Secretary (RETD), Technical Officer
Dr. A Nasim, Office of Director General, MOH&FW

INTERNATIONAL ORGANIZATIONS AND PROGRAMS

Bangladesh Center for Communications Programs (BCCP)
Yasmin Khan, Deputy Director

BRAC
Faruque Ahmed, Director, Health, Nutrition and Population Program (HNPP)
Dr. Zeba Mahmud, Program Coordinator (Nutrition)
Amina Mahbub, Research Anthropologist, Research and Evaluation Division
Dr. Shakila Banu, Sr. Medical Officer, HNPP

CIDA
Dr. Akram Hossain, Senior Program Advisor for Health

DFID
Dr. Muhammod Abdus Sabur, Sector Manager, Health and Population, DFID Bangladesh
Dr. Neil Squires, First Secretary, Human Development

Radda MCH-FP Centre
Dr. Rehana Begum, Head Training and Research
Dr. S. M. Mohiuddin Kamal, Program Manager

IOCH
Dr. Pierre Claquin, Chief of Party
Dr. E. G. P. Haran, Senior Child Health Advisor

Save the Children (SCF)
Mohammad Mahbub Alam, Community Response Manager, NSDP
Dr. Uzma Syed, Program Manager, Saving Newborn Lives Initiative
Dr. Nizam Uddin Ahmed, Head of Health Section

World Bank
Birte Holm Sorensen, Sr. Public Health Specialist, HPSO

WHO
Dr. Satyawati Hanna, Medical Officer (RH)
David Sniadack, Medical Officer, EPI

UNICEF
Dr. Md. Monjur Hossain, Project Officer, Health & Nutrition Section
Kayode S. Oyegbite, Chief, Health & Nutrition Section
Dr. Rownak Khan, Project Officer, Health & Nutrition Section

ICDDR-B
Dr. Shams El Arifeen, Epidemiologist and Head Child Health Unit, Public Health Sciences Division
Dr. Abbas Bhuiya, Head, Social and Behavioural Sciences Unit

Women and Children First, Perinatal Care Project
Dr. Kamruzzaman, Project Manager

Institute of Child and Mother Health (ICMH)
Professor (Dr.) U. H. Farida Khatun, Director and Head of the Department of Pediatrics

Urban Primary Health Care Project (UPHCP)
Dr. Md. Nurul Islam, Project Director
Dr. Raimo Rintala, Management Development and Training Specialist

SYLHET

Sylhet Samaj Kalyar Songstha/Sylhet Social Welfare Organization (SSKS) (Static Clinic)
Parvez Alam, Project Director
Sayed Foysal Ahmed, Senior Service Promoter
Dr. Amena Akhter, Clinical Manager
Dr. Shahedul Islam, Project Manager (Quality)

Satellite Clinic/Mallika Ideal Social Association (MISWA) & SSKS, Gowaipara, Sylhet
Md. Abul Hasnat Nuru, President
G. M. Nazrul Islam, Secretary

BRAC Development Program (BDP), Thana Fenchuganj
Salim Ahmed, Area Coordinator
Mahubub Alam, Area Manager
Nasrin Akter, Program Organizer in BRAC Health Program

Sylhet City Corporation
Abdul Hashem, Chief Executive Officer
Dr. Sudhamay Majumdar, Health Officer, SCC

Red Crescent Maternity Hospital and Child Welfare Center
Dr. A. K. Ahmed Hassain, Acting Hospital Director
Mohizul Islam, Administrative Officer
Matiur Ralman, Field Officer

Shimantik (Static Clinic)
Ruhul Anin, NSDP Field Manager
Hosna Akter, Paramedic
Jalsda Khanon, Paramedic
Kiron Bala Sutradhar, Paramedic
Rina Akter, Paramedic
Sumita Dhar, Clinic Aide
Mohamaya Rani, Clinic Aide
Maleka Baha, Clinic Aide
Misbauddin Chowdhury, Community Mobilizer
Najrul Islam, Community Mobilizer
Md Najmul Haque, Community Mobilizer
Afunaja Kartun, Community Mobilizer

Ghousgaon Satellite Clinic
Yousuf Member (Ward Member)

Golapganj Thana Health Complex
Dr. Bijoy Khishna Banik, Upazilah Health and Family Planning Officer
Dr. Md Abdul Wadud, Resident Medical Officer

Md. Abdul Hannan, UFPO
Dr. Md. Tahsinul Anam, WHO Surveillance Medical Officer
Surojit Chowdhury, TLCA HEED Bangladesh
Ranjan Kumar Bhor, Team Leader, TLCA, Golapjanj UHC

Mary Stopes Clinic
Dr. Tabinda Anjum, Clinic Doctor
Maleka Ferdous Choudhury, Clinic Manager
Mohan Lal Das, Field Coordinator
Md. Golam Hossain, Health Educator

CARE
AKM Nural Islam, Project Development Officer, OR, M&E
Md. Shafiqul Islam, TO (M&E), N. AM Project
Shishir Kanti Debnath, PDO, F&A
Tauhidul Islam, PDO (Partnering)
Tapan Dev Mitra, PDO (Training)

Pediatric Department, Sylhet MAG Osmani Medical College
Dr. M. A. Matin, Associate Professor and Head of Department
Dr. Md Ziaur Rahmnan Chowdhury, Registrar (Pediatric Ward)
Dr. Amin Uddin Chowdhury, Asst. Professor of Child Health
Dr. Md. Mosleh Uddin Chowdhury, Associate Professor, Pediatrics
Dr. Md. Mauajjir Ali, Associate Professor, Pediatrics

KHULNA

PKS Kulna (KDA) urban static and satellite clinic
Ms. Shamima Sultana, Project Director
Dr. Tahmina Khatun, Clinic Manager

Fair Foundation
Md. Shahiduzzaman – Chairman
Dr. Shahed, Fair Foundation NSDP Project Manager, Kulna

City Corporation –Khulna
Dr. ABM Mahabubul Haque, Chief Medical Officer

Khulna Civil Surgeon (MOH&FW)
Dr. Md. Hame Jamal

MOH&FW District Hospital -Khulna
Dr. Sahana Razzaque – Medical Consultant (Gynecologist and Obstetrician)

Khulna Shishu Hospital
Dr. Kamruzamman, Consultant Paediatric
Mr. Moklasur Rahman, Administrative Officer

JTS Bagaroara static and satellite clinics
Md. Mizanul Rahman, Field Manager
Maria Jharna Rani Sarder, Paramedic
Md. Sahnawaz, Community Mobilizer

MOH&FW- Upizilla Health Complex- Jessore
Dr. Santosh Kumar Bagchi- Regional Medical Officer

Immunization and Other Child Health project (IOCH)
Dr. Md. Badrul Munir Sohel –Operations and Surveillance Officer
Md. Shahadat Hossain – Polio Eradication Facilitator

Ad-din Sharsha Unit –Saving Newborn Lives project, Jessore
Dr. Moshrud Project Manager HIV AIDS Program – Administrative Directorate, Monoara Khatun – Project Manager

TANGAIL AND DINAJPUR**

Community Based ARI Control Program at Delduar
Satellite Clinic Staff and Rural Depot Holder

Swanirvar Rural Service Delivery Project
Md. Rafiqul Islam, Project Manager

Lamb Project and Hospital: World Mission Prayer League
Dr. Mark Pietroni, Executive Director and Senior Staff

Care Bangladesh HeLP Project
Field Coordinator

Kanchan Samity Reproductive Health Care Project
Dr Farida Yesmin

**The full list of contacts from the field visit to Dinjapur was lost due to an unrecoverable computer problem. Apologies to the many individuals who made this trip a very useful part of the MEDS assessment. A schedule of sites visited is included in Annex F.

ANNEX F

BANGLADESH MEETINGS AND ITINERARIES

Tentative Schedule of MEDS Team

February 24 - March 14, 2003

Date	Activity	Persons responsible
24-02-03 (Monday)		
2:00 - 5:00 pm	NSDP Presentation including Child Health activities	David Weiler
	Planning common agenda & activity (schedule) Assignment of responsibility	
25-02-03 (Tuesday)		
09:00 a.m.	Presentation on SNL by SCF	SCF-USA
09:30 am	Review discuss on C.H. activities (Technical focus areas)	Dr. Shalini
11:00 a.m.	Attend *Concern's Child Health Stakeholders* meeting	
02:00 p.m.	Attend *IMCI Implementation Review Workshop of GOB*	- All
Afternoon	Discuss the guideline of field visit - Hotel.	
26 -02-03 (Wednesday)		
Morning	▪ Continue previous day's discussion on CH activities ▪ Observe CSI training in AITAM and Radda-MCH	
03:00 pm	Meeting with: ▪ IOCH	
27-02-03 (Thursday)		**
08:30 am	Teams will visit three urban & three rural clinics: ▪ Savar UTPS and Savar, Swanirvar ▪ Singair, JTS and Mirpur, PSKP ▪ Golapbag, PSTC and Keranigonj, Bamaneh	Group A Group B Group C
Afternoon	Consolidate findings	
01-03-03 (Saturday)		
08:30 am	One team starts to visit Tangail ARI Project	Group A
Afternoon	Rest two team starts to travel for field visit	Group B and Group C

	12:00 pm	Visit Fair Foundation (ADB Building)
	02:00 pm	Meeting with Chief Health Officer, City Corporation and IOCH Representative
	03:30 pm	Meeting with Civil Surgeon
March 3, 2003	08:00 am	Visit NSDP rural JTS Bagarpara static and satellite clinic
	12:00 pm	Visit Bagarpara Upazilla Health Complex including one sub-centre
	03:00 pm	Visit Khulna 250 beds hospital (GOB)
March 4, 2003	08:00 am	Visit NSDP Regional Office, Jessore
	10:00 am	Visit District Hospital, Jessore
	02:00 pm	Visit Adnin Hospital, Jessore and SNL program
	05:15 pm	Travel to Dhaka vehicle

Group C: (visit Sylhet)

Date	Time	Activities
01/03/2003	04:30 pm	Travel to Sylhet by air and stay at Hotel
02/03/2003	08:00 am	Visit NSDP urban SSKS Sylhet static and satellite clinic
	11:30 pm	Visit BRAC Susasthya Clinic
	02:00 pm	Meeting with Chief Health Officer, City Corporation and IOCH Resp. Dr. Nurul Islam
	03:30 pm	Visit Maternity Hospital of Red Crescent Society
03/03/2003	08:00 am	Visit NSDP rural Shimatik Golapgong static and satellite clinic
	12:00 pm	Visit Upazilla Health Complex including one sub-centre/community clinic
	02:30 pm	Visit CARE NIRAPAD-MA program
04/03/2003	08:00 am	Visit NSDP Regional Office, Sylhet
	09:30 am	Visit Sylhet Medical College Paediatrics Deptt.
	11:30 pm	Meeting with Civil Surgeon
	02:00 pm	Visit Marie Stops Clinic
	04:30 pm	Travel to Dhaka

Note: Everyday evening the team consolidates the day's activities.

ANNEX G

SUMMARY RECOMMENDATIONS FOR THE NSDP BRIEFING

SUMMARY RECOMMENDATIONS FOR THE NSDP BRIEFING

March 13, 2003
MEDS Team

Strategic Directions

- NSDP and USAID should clarify the ground rules about the current child health activities and the expectations for coverage and impact that they should achieve. With this clarification, the NSDP and USAID should then decide if they are going to move forward with a child health program that will produce significant results.

- USAID and the NSDP should work together to define the acceptable balance between sustainability/market share and delivery of child health services to the poor.

Programmatic Directions

- NSDP needs a cohesive child health strategy that focuses on the priority causes of child mortality and morbidity and that aligns the project resources, partner capabilities and the absorptive capacity of NGOs to produce significant results.

- NSDP needs a clear policy on the balance between static clinics and community-based programming. This would allow them and NGOs to address the current bias that favors concentration on static clinic services over community programming. The development of community-based services in child health is essential if the project is to improve child health status.

- NSDP should include key NGO staff in the decision-making process regarding the child health strategy. This would allow transparency of the decision-making process and allow NSDP to benefit from the NGOs experiences in implementing child health.

- The projects needs to focus on prevention as a major way to address child morbidity and mortality

- The NSDP partners with long and specific experience in child health, particularly Save the Children and CARE, need to be included more proactively in the decision-making and planning for child health programming.

Management Support

- Add a senior level child health position above the current senior management levels to provide comprehensive technical leadership.

- Significantly reorient the NSDP management structure and functions at the central and regional levels to provide adequate support to implement child health. As needed increase staff capacity of staff for child health. This could include increasing the role of partners with recognized child health expertise.

- Define responsibilities for support, coordination, and supervision from all key units. Balance NSDP resources between family planning and child health to adequately support child health goals.

- Develop long term NGO manpower plan to address recruitment and retention, the quality of staff cadres, and adequate support and recognition of community cadres.

Technical interventions

- The NSDP should review and use the Essential Basic Package with special attention to selected child health interventions as its current approach to expanding child health services. This is an important platform for moving into IMCI and its strengths should be used.

- Clinical IMCI: The NSDP should assess its current plans to rapidly move forward on expanding clinical IMCI and consider a phased approach that builds on the ESP. Although NSDP NGOs will want to offer IMCI in their clinics over the longer term, the current fast-track strategy needs to be carefully assessed. This is an expensive and complex strategy – be sure you know where you are going and why.

- Community IMCI: The C-IMCI program development has enthusiastic support and there are many great ideas, but the implementation still needs some thinking and planning. C-IMCI should be approached slowly and methodically. A strong prevention strategy may be a good way to approach this. Again, build this program on what the ESP has in place.

- Build a strong neonatal intervention with a firm strategic partnership with the Saving Newborn Lives program (SNL) as that program rolls out.

- There are several important pieces that need to be more strongly incorporated into the NSDP child health thinking:

    - Links between maternal and child health
    - Maternal and childhood malnutrition
    - Greater emphasis on known winners like exclusive breastfeeding.

Coordination

- Clarify NSDP policy for working with GoB and develop strategy for productive interaction, coordination and collaboration.

- Coordinate with City Corporation: build upon and strengthen current coordination. Discuss MOH&FW proposal to provide service to municipalities in areas City Corporation unable to serve.

- Identify and explore networks of NGOs and programs and explore mechanisms for collaborating, sharing of information and experiences, etc. Consider the direct exchange of technical assistance with these groups.

- Continue participation in NGO policy and coordinating committees and with technical working groups.

- Continue collaboration and identify additional relevant research projects for child health and collaborate with research organizations (e.g. ICDDR-B)

- Coordinate with and establish formal referral links with service provider institutions.

- Develop a strategy for interacting with organizations such as United Nations; bi-lateral donors; other USAID funded organizations, such as IOCH; other NGOs in health.

ANNEX H

SELECTED CHILD AND MATERNAL HEALTH DATA

Table 1
Selected Child and Maternal Health Survey Data [42]

1998 and 2002 (percent of cited population)				
Key Indicators	**Rural**		**Urban**	
	1998	**2001**	**1998**	**2001**
Children 12-23 months receiving all EPI	**58.9**	**45.8**	**67.9**	**62.4**
BCG	89.3	89.0	92.1	95.4
DPT3	67.6	55.2	78.3	75.1
Polio3	72.1	78.6	83.4	83.7
Measles	68.9	62.9	76.3	74.8
Children 6-59 months receiving vitamin A every 6 months	**62.5**	**66.4**	**65.2**	**70.6**
Child diarrheal episodes treated using:				
ORS	53.1	66.6	71.3	80.4
Haban gur	12.6	24.4	17.7	17.1
ORT	62.9	75.4	77.0	82.5
Child ARI cases treated at:				
Health facility	32.4	23.7	53.7	30.5
Other				
EPI Drop-out rates:				
DPT3/DPT1	NA	35.8	NA	19.3
Polio3/Polio1	NA	12.8	NA	10.0
Infant and child mortality	**NA**	**103.4**	**NA**	**72.3**
Infant (under 1 year)	NA	77.0	NA	53.0
Child (1 to under 5 years)	NA	28.6	NA	20.4
Any ANC for women with live births in last year	**39.3**	**46.8**	**65.2**	**79.2**
Pregnant women taking iron supplement	**NA**	**41.3**	**NA**	**58.9**
Women exclusively breastfeeding for:				
4 – 5 months	NA	28.4	NA	11.7
6 – 7 months	NA	11.6	NA	1.9
Women delivered by trained provider	**NA**	**NA**	**NA**	**NA**

[42] Source: 1998 Rural and Urban Baseline Surveys and 2001 Rural and Urban Surveys

Table 2
NSDP Performance

NSDP PERFORMANCE
July - December 2002

PART 1: ESP SERVICES		NSDP Total						
A. CHILD HEALTH		July 2002	Aug 2002	Sept 2002	Oct 2002	Nov 2002	Dec 2002	Total
A1: EPI (children under 1 year of ago)								
Immunization	BCG	25925	25770	26060	27922	28753	26480	162910
	DPT1	26465	26001	26408	27824	28568	31051	166317
	DPT2	26384	25479	25247	25631	25325	25981	154047
	DPT3	25523	25020	24799	24816	23598	23004	146760
	Polio 1	26260	26829	26591	27934	28654	28684	164952
	Polio 2	26031	25488	26588	25524	25199	25883	154713
	Polio 3	25250	25115	24766	24865	23507	23013	146516
	Polio 4	26735	29114	30566	29168	26934	25072	167589
	Measles	27295	28438	29077	29288	27465	25238	166801
	Total of A.1	235868	237254	240102	242972	238003	236406	1430605
	Daily Average per clinic	34	34	33	34	33	33	33
A.2: Other Child Health								
CDD	No dehydration	113375	122369	125085	121455	116930	114256	713470
	Some dehydration	19134	19806	18390	18699	18036	17525	111590
	Severe dehydration	1233	676	567	494	438	602	4010
	Dysentery	8925	9183	8463	8626	8434	8152	51783
Vitamin A	< 1 year	18273	19570	19732	20160	18882	17036	113653
	1-5 years	4297	7099	3914	3674	3686	3255	25925
ARI	Cough (no pneumonia)	94021	98424	97982	101271	97177	95152	584027
	Pneumonia	11998	12798	12661	11447	10784	10468	70156
	Severe pneumonia	438	528	455	389	357	375	2542
	Total of A.2	271694	290453	287249	286215	274724	266821	1677156
	Daily Average per clinic	39	41	40	40	38	37	39
B. MATERNAL HEALTH								
ANC	1	38393	38872	38858	36397	32538	29625	214683
	2	29748	30493	31425	29393	26865	24335	172259
	3	25803	26735	27618	27490	24076	22518	154240
	>3	16650	17704	18160	17491	16306	15332	101643
PNC	1st visit	19047	19965	21066	22034	22081	20966	125159
	Revisit	4839	4710	4878	4832	5057	4589	28905
	Vit-A supplementation	16089	17716	19604	20072	20827	19462	113770
TT	Pregnant women	57437	59157	59252	57325	50015	49413	332599
	Non-Pregnant women	94543	91367	99119	97092	77010	76591	535722
Deliveries performed		79	104	120	119	120	127	669
Post-abortion care		110	85	79	132	77	85	568
Total of B		302738	306908	320179	312377	274972	263043	1780217
Daily Average average per clinic		43	44	44	43	38	36	41
C. FAMILY PLANNING								
Service	Pill	377152	390867	400197	401284	403695	407791	2380986
	Condom	127078	126488	139907	136870	132886	131546	794775
	Injectable	135019	132153	136235	139528	130723	132900	806558
	IUD	1491	1783	1814	1610	1267	1495	9460
	Norplant	1417	1461	1545	1449	756	887	7515
	Vasectomy	854	1241	1217	953	336	291	4892
	Tubectomy	68	114	130	130	19	54	515
	Total of C	643079	654107	681045	681824	669682	674964	4004701
	Daily Average per clinic	92	93	95	94	93	93	93

Table 3
Selected Child and Maternal Health Contacts Reported for the NSDP Project
July – December 2002

	Contacts		
Target Group and Service	**Number**	**Percent**	**Percent**
Child and maternal contacts	4,887,978	-	100
Children under 1 year:			
All EPI contacts	**1,430,605**	**100**	**29.3**
DPT contacts, All	**467,124**	**36.7**	
DPT1	166,317	11.6	
DPT2	154,047	10.8	
DPT3	146,760	10.3	
BCG	**162,910**	**11.4**	
Polio contacts, All	**633,770**	**44.3**	
Polio1	164,952	11.5	
Polio2	154,713	10.8	
Polio3	140,516	10.2	
Polio4	167,589	11.7	
Measles	**166,801**	**11.7**	
Children under 5 years:			
Other child health contacts, All	**1,677,156**	**100.0**	**34.3**
Vitamin A	**139,578**	**8.3**	
Under 1 year	113,653	6.7	
1 – 5 years	25,925	1.5	
CDD, All	**880,853**	**52.5**	
No dehydration	713,470	42.5	
Some dehydration	11,590	6.7	
Severe dehydration	4,010	0.2	
Dysentery	51,783	3.1	
ARI, All	**656,725**	**39.2**	
Cough, no Pn	584,127	34.8	
Pneumonia	70,156	4.2	
Severe Pneumonia	2,542	0.2	
Women:			
Maternal health contacts[43]	**1,780,217**	**100.0**	**36.4**
ANC, All	**642,825**	**36.2**	
ANC 1	214,683	12.1	
ANC 2	172,259	9.7	
ANC 3	154,240	8.7	
ANC 3+	101,643	5.7	
PNC, All	**154,064**	**8.6**	
1st visit	125,159	7.0	
Re-visit	28,905	1.6	
Vitamin A	**113,770**	**6.4**	
TT, All	**808,321**	**48.8**	
Pregnant women	332,559	18.7	
Non-pregnant women	535,722	30.1	

[43] Excludes family planning, STIs, reproductive tract infections (RTIs), communicable diseases, and limited curative care for other problems.

Discussion of Table 3. Table 3 shows that during the first six months there were approximately 1.4 million EPI contacts with children under 1 year of age. Based on a target population of 529,146 infants, this results in an average 2.7 contacts per infant over the six-month period. There were another 1.7 million contacts for Other Health Services among children 0-5 years of age, and 1.8 million maternal health contacts. Although these figures are impressively large, it is quite likely that the number of infant visits was substantially less, since multiple vaccinations were routinely administered at the same time.

Most of the 1.677 million contacts for Other Children's Health Services were for diarrheal problems (53 percent), and respiratory problems (39 percent); only eight percent were for vitamin A. One in five of the diarrheal contacts and one in ten of the ARI contacts were reported to have received treatment, which could only occur at static or satellite clinics that had trained medical staff. The reported number of contacts is high because contacts with depot holders are included in the Tables, but they do not involve treatment. A recent 3-month study indicated that 37 percent of the ARI contacts were with depot holders, who function only in rural areas (see Annex H, ARI Information provided by USAID/Bangladesh).

Despite much activity as measured by contacts, there is little focus on priority services, a conclusion reinforced by the fact that there is no monitoring of ARI in the under 1 year age group where it is a major killer. Nationally, ARI is responsible for about 20 percent of all mortality of children under 5 years of age.

Table 4
Selected Child and Maternal Health Coverage in the New NSDP Projects
July – December 2002

Target Group and Service	Population	Contacts	2002 Coverage	
			July–December	Annual Rate*
Children under 1 year:	**529,146**			
All EPI Contacts		**1,430,605**	**270.4**	**540.7**
DPT 1		166,317	31.4	62.9
DPT 2		154,047	29.1	58.2
DPT 3		146,760	27.3	54.6
BCG		**162,910**	**30.8**	**61.6**
Polio 3		146,512	27.7	55.4
Measles		**166,801**	**31.5**	**63.0**
Vitamin A		**113,653**	**21.5**	**43.0**
Children 1 -5 years:	**1,998,995**			
Vitamin A		**25,925**	**1.3**	**2.6**
Children under 5 years:	**2,528,141**			
CDD, All		**880,853**	**34.8**	**69.6**
Dehydration		115,600	4.6	9.1
Dysentery		51,783	2.0	4.1
ARI, All		**656,725**	**26.0**	**52.0**
Pneumonia		72,698	2.9	5.8
Pregnant women:	**591,859**			
ANC 3		154,240	26.1	52.1
ANC 3+		101,643	17.2	34.3
TT		332,599	56.2	112.4
Postpartum women:	**591,859**			
1st visit		125,159	21.1	42.3

*Monthly average times 12.

Discussion of Table 4: Table 4 presents coverage estimates based on the 6 month NSDP contact report and independent estimates of target populations. It is most reliable for EPI vaccination contacts, since each of the 9 doses (three DPT vaccinations, one BCG, and four polio and measles) is given only once to each infant. Coverage is estimated by dividing reported contacts by the target population size.

Coverage for vaccinations is estimated for each from the NSDP contact data. For BCG and Measles, and for the critical 3rd shot for DPT and Polio, the coverage is in the range of 55 and 65 percent, which means that between 35 and 45 percent of infants were not covered. The critical DPT3 vaccination coverage, 54.6 percent, was the lowest of all the vaccinations. Equally significant for each of these vaccinations, coverage is lower than that reported from the 2001 survey.

The estimated rates have a different meaning for diarrhea and ARI contacts, since the same child may appear and be counted for both diseases on a single visit, and again for subsequent visits. Therefore the resulting numbers for these problems are not the

proportions of the target population served, but are a measure of the patient load as a proportion of the target population. The proportion of the target population making contact for these problems must be lower than the figures in the table because of multiple visits by the same patient. CDD experts report that during a year period multiple episodes of diarrheal problems for the same child are common for children under 5 years of age.

The annual rate for CDD is 70 percent but only 9 percent were identified as dehydrated and 4 percent with dysentery, and, therefore, presumably medicated. The other 57 percent reported "No dehydration" and may or may not have been given ORS packets, but this is not reported. For ARI, the rate was 52 percent, and only 6 percent were medicated, and the other 48 percent presumably not medicated. This indicates that there were many cases of diarrhea and ARI, including severe cases, not seen in the static or satellite clinic system. As these clinics respond poorly to emergency situations, this is not surprising. These data suggest, however, that there is a huge need for services to cope with these problems and for a better way to track unmet needs. While not all children with diarrhea and respiratory problems presented to health workers require medication, the low levels of reported medication for these dangerous childhood illnesses shows the need for increased emphasis on priority childhood interventions to lower the unmet need and gaps in coverage.[44]

[44] Experts indicate that three or more ARI episodes per year can be expected in the 0-5 year age group. Acute lower respiratory infections per year among children 0-5 years of age are reported at 0.45 in the Global Burden of Disease Report.

USAID/Bangladesh Information on ARI

NSDP did an additional analysis of ARI contacts for October - December 2002. Results revealed that depot holders provided 37 percent of all reported ARI contacts (45 percent of the total "no pneumonia" cases). Paramedics and physicians provided the rest. Only the urban static clinics have physicians NGOs in the urban areas do not have depot holders.

1. "Contacts for ARI" are cases seen by a paramedic or physician or a depot holder. These contacts include cases of "no pneumonia," "pneumonia," and "severe Pneumonia." Antibiotic use should coincide with the numbers of "pneumonia" and "severe pneumonia" cases.
2. Except in the pilot ARI project areas, depot holders were not trained by NSDP to assess, classify, and treat ARI. However, some NGOs have "oriented" depot holders to deal with ARI as they encounter it very frequently. Depot holders give some home management and referral advice on ARI cases. This information is reported in NGOs' reports.
3. The mortality data shown below are from the report on evaluation survey of RSDP and UFHP (2001). The data are for the five years preceding the survey. Explanations for lower numbers in the non-RSDP and non-UFHP areas may be seen in the reports.

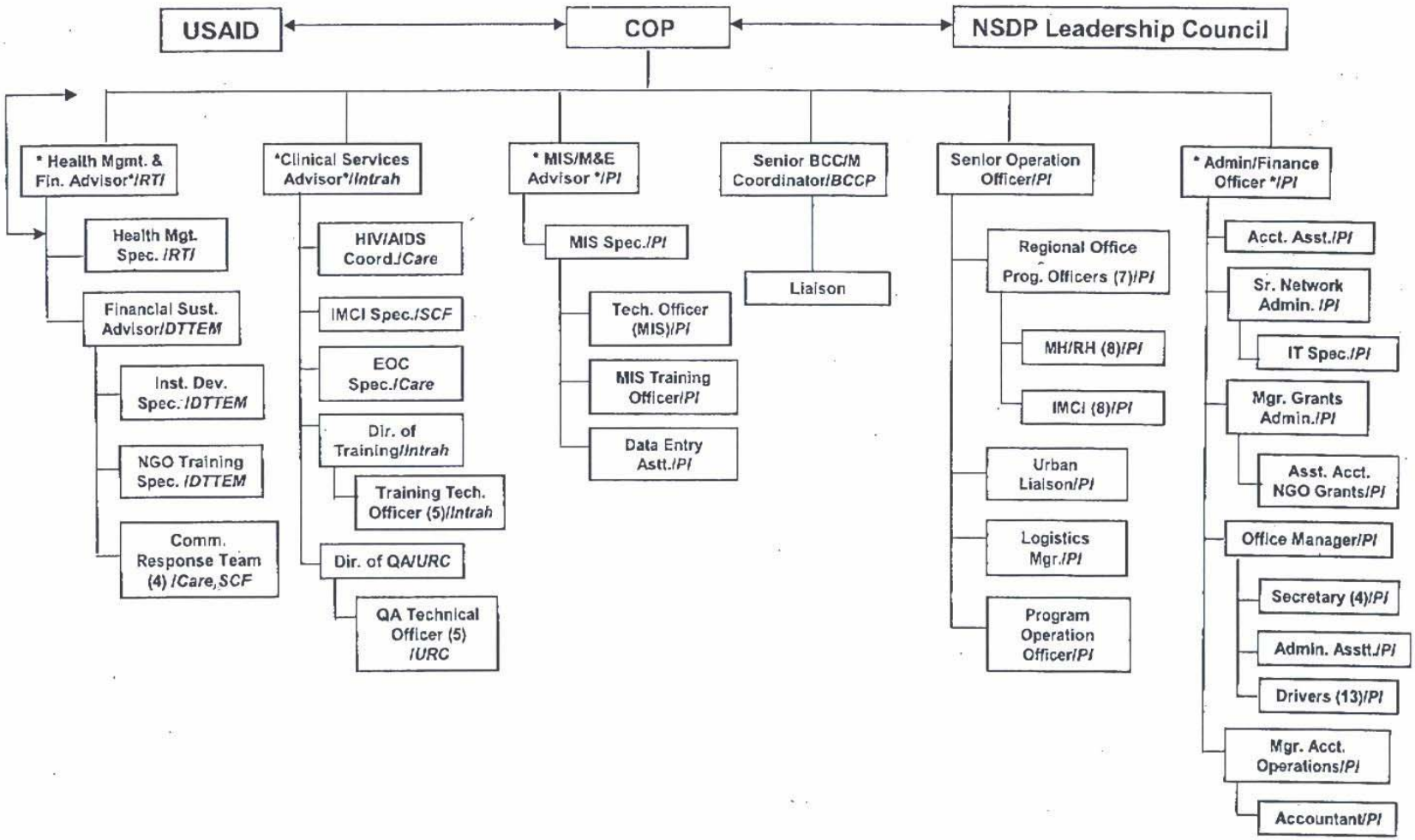
Indicators	**Rural Areas**		**Urban Areas**	
	RSDP	**Non-RSDP**	**UFHP**	**Non-UFHP**
Infant Mortality	77.0	70.5	53.0	65.8
Child Mortality	28.6	24.1	20.4	14.3
Mortality under five years of age	103.4	92.9	72.3	79.2

Please note that ARI accounts for about 20 percent of deaths in children under the age of five years in Bangladesh. This information is national and not specific to NSDP areas.

ANNEX I

NSDP ORGANIZATIONAL DIAGRAM

NSDP Organogram



ANNEX J

TABLE OF KEY INDICATORS

TABLE OF KEY INDICATORS

Key Indicators Used by the Ministry of Health and International Organizations and in NSDP Quarterly Reports			
MOH Indicator		**NSDP Indicator**	
Cases of ARI		**Cases of ARI**	
No pneumonia		No pneumonia	
0-11 months		Not analyzed	
1-4 years		0-5 Years	
Pneumonia		Pneumonia	
0-11 months		Not analyzed	
1-4 years		0-5 years	
Severe pneumonia		**Severe pneumonia (diagnosed, initially treated, and referred)**	
0-11 months		Not analyzed	
1-4 years		0-5 years	
Very severe disease		**Very severe disease (diagnosed, initially treated, and referred**	
0-11 months		Not analyzed	
1-4 years		0-5 years	
Total ARI cases		Total ARI cases	
Total ARI deaths		Not collected	
Number			
Vitamin A		Vitamin A	
1 dose with measles vaccine (children under 1 year)		1 dose (children under one year of age)	
2 doses (children 1 to 5 years of age)		Number of children receiving Vitamin A	
Neonatal mortality		**Neonatal mortality**	
Child 0-28 days		Not collected	
Diarrheal disease cases (0–11 months, with dehydration)		**Diarrheal disease cases (0–5 years, with dehydration)**	