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USAID/BANGLADESH: SMILING SUN FRANCHISE PROGRAM (SSFP)
MID-TERM ASSESSMENT

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ACRONYMS

ANC	Antenatal care
ARI	Acute respiratory infection
BATB	British American Tobacco (Bangladesh)
BCC	Behavior change communication
BCCP	Bangladesh Center for Communication Programs
CA	Cooperating agency
CADM	Comprehensive approach of diarrhea management
CDD	Control of diarrheal diseases
CBSG	Capacity Building Services Group
CSP	Community service providers
CWFD	Concerned Women for Family Development
DOTS	Directly Observed Treatment, Short-course
DPT	Diphtheria, pertussis, tetanus
EPI	Expanded Programme for Immunizations
ESD	Essential service delivery
FDF	Franchise development fund
FGD	Focus group discussion
FMO	Franchise manager organization
FP/RH	Family planning/reproductive health
GH Tech	Global Health Technical Assistance Project
GOB	Government of Bangladesh
ICDDR, B	International Centre for Diarrhoeal Disease Research, Bangladesh
IMCI	Integrated management of childhood illness
LAPM	Long-acting and permanent methods
MIS	Management information systems
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NGOs	Nongovernmental Organizations
NSDP	NGO Service Delivery Program
PI	Program income
PMP	Performance monitoring plan
PNC	Prenatal care
RSDP	Rural Health Services Delivery Program

SSFP	The Smiling Sun Franchise Program
TB	Tuberculosis
TOT	Training of trainers
TPM	Team planning meeting
UFHP	Urban Family Health Partnership
USAID	The United States Agency for International Development
USG	United States Government

EXECUTIVE SUMMARY

The Smiling Sun Franchise Program (SSFP) is the United States Agency for International Development (USAID)/Bangladesh's largest health initiative; it is the latest in a series of programs going back to at least 1998 that have sought to improve the ability of local non-governmental organizations (NGOs) to provide basic health services to the poor. Implemented under a contract between USAID and Chemonics International, SSFP works with 28 NGOs that operate 320 clinics and 8,500 satellite (outreach) sites in urban and rural areas nationwide in Bangladesh. Designed in 2007 when the mission was told that its funding for health care would decline drastically, SSFP was intended to prepare these NGOs for the withdrawal of USAID support. Although SSFP and its predecessors have both emphasized quality of care and program management, only the former made financial sustainability its principal priority.

Sustainability is pursued through user fees and development of a franchise under which NGO clinics are to be licensed to use the Smiling Sun brand—developed under a previous program—to promote themselves as sources of quality care for which clients will pay. Smiling Sun clinics stress the courteous provision of standardized services in attractive settings, with supervision and assistance from a franchise management organization (FMO). By the end of the program, revenue from paying clients and/or third-party payers is expected to finance service provision by NGOs, including free or discounted services for the poor as well as long-term operation of the FMO. Service provision is expected to increase while USAID's costs decline. These objectives are embodied in three desired outcomes in USAID's contract with Chemonics: establishment of a franchise, declining USAID cost, and increasing service provision, including a greater number of services to the poor. This assessment reports on progress in attaining these outcomes as of April 2010.

ESTABLISHING THE FRANCHISE

Progress in establishing an effective, sustainable franchise was assessed in terms of 10 criteria derived by one of the assessment team's five members. In addition, the literature on social franchising for health was reviewed, as was SSFP's progress in cost recovery, to estimate the likelihood that the program's financial sustainability objective could be attained. The team concluded that there has been only limited progress in establishing a franchise. Problems have included recruitment and retention of qualified staff; insufficiently targeted and at times poorly executed training; a nonfunctional franchise board of directors; insufficient attention to marketing and communication; and inadequate buy-in to the franchise concept by NGOs, which see it as imposed by USAID and do not perceive benefits from membership equal to the eventual cost thereof. Although SSFP has a reputation for quality services and its management information system (MIS) is superior in terms of data provision, quality-assurance and supervision activities often are largely pro forma, and problems persist in the use of data. International experience suggests that establishing a viable franchise is a long-term task, and it was perhaps unreasonable to expect Chemonics to accomplish it completely in the four years allotted for SSFP. But time aside, both international experience and SSFP's record in cost recovery to date indicate that, franchise or no franchise, it is not feasible to recover through user fees the costs of (i) a FMO, (an eventual substitute for technical assistance provided by USAID) and (ii) a service-delivery program focused on the poor (financed by USAID). The assessment team believes that the design of SSFP, prompted primarily by USAID budget imperatives, was fundamentally flawed in this respect.

DECLINING USAID COSTS

USAID's costs for service-delivery have not declined during the first two years of the program. Rather, they have increased and seem likely to rise further by the end of the program. USAID is planning a detailed audit to determine reasons for the increase, but Chemonics stated that it was caused by inflation, the need to raise salaries to retain qualified staff, and insufficient revenues to cover these costs. SSFP has secured (or retained from previous programs) non-USAID funding from three private companies and a local philanthropy, but these monies largely support services for new clients and have little effect on USAID's costs.

INCREASED SERVICE PROVISION

The program has increased the volume of services provided, especially recently. Service contacts are up overall, with the use of family planning and postpartum visits increasing substantially. However, it is unclear whether the increased volume of services provided by SSFP translates into a greater market share for the program.

However, there are significant missed opportunities for service provision, including some major causes of preventable mortality: childhood pneumonia, unsafe deliveries, and poor newborn care. In addition, the lack of postabortion care in Bangladesh is unaddressed by SSFP. Although collaboration has been discussed with Engender Health's Mayer Hashi program to increase the use of long-acting and permanent methods (LAPM) for family planning, and training has been provided for service providers, LAPM use remains chronically low in SSFP and elsewhere in Bangladesh. Ministry of Health (MOH) policy that SSFP-diagnosed cases of tuberculosis (TB) be treated in government facilities may result in cases lost to treatment. Furthermore, the indicators used to measure progress in service delivery are modest, and clinic catchment areas, inherited from previous programs rather than planned by SSFP, are small and often overlap with government health facilities. Despite the program's national presence, the above factors probably place significant limits on its national public health impact.

SSFP reports that about 26% of its service contacts are with poor people — a percentage that seems to be increasing and compares positively with other social franchising programs. However, this finding results from actions of previous programs rather than a specific SSFP strategy for reaching the poor, and it does not indicate that SSFP serves 26% of the poor population in its catchment areas. It is doubtful that SSFP can cover a substantial portion of this population while also attaining its objective of 70% cost recovery (a figure still 30% shy of actual self sufficiency).

Although overlap with government facilities may result in a larger percentage of the poor population served than can be served by SSFP alone, it is unlikely the program can cover a substantial percentage of the poor while attaining the 70% cost recovery.

In addition to increasing "client volume" (the number of clients) the Chemonics contract calls for a rise in the "range of services." The meaning of this phrase is not specified, but, according to USAID, it refers to the number of SSFP clinics. The program has added three clinics and 87 satellite sites since its inception. The assessment team believes that the emphasis on outreach sites as opposed to fixed facilities is appropriate, given the views of staff and stakeholders that people are more likely to use services available near their homes. The team believes SSFP's outreach should be extended to encompass non-medical providers such as "village doctors," drug sellers, and traditional birth attendants. As no plan for using revenues (program income [PI]) has been approved, USAID to date has neither agreed to add 10 clinics nor accepted a proposal to expand safe delivery or emergency obstetric care, aside from upgrading a few clinics to enable provision of these services.

Although marketing efforts seem central to increasing service utilization and revenue, communication activities have been limited under SSFP—in terms of promotion of Smiling Sun clinics generally and for specific services (e.g., LAPM, child pneumonia, safe deliveries, and newborn care). The program has emphasized inexpensive local clinic-promotion campaigns largely designed, implemented, and funded by the NGOs. It does not have experienced communication staff or a coherent communication strategy and has made haphazard use of a capable local communication agency (developed with substantial prior USAID investment). While the team does not believe that SSFP's communication activities have been particularly effective, there are no data on the influence of these efforts on service utilization.

The assessment team identified best practices and lessons learned and made 11 recommendations to USAID for improving the program in its final 17 months. The latter are summarized as follows.

SUMMARY RECOMMENDATIONS

1. Cease further efforts to establish the Smiling Sun franchise.
2. Instead, create an NGO Consortium governed by the NGOs, which would own the Smiling Sun brand, establish their own priorities, and cost-recovery targets based on these priorities, and liaise with donors and government to secure additional funds and technical assistance.
3. Continue to work with NGOs on cost recovery and business planning, but without the 70% cost-recovery target and with increased emphasis on nonfinancial aspects of program sustainability.
4. Increase emphasis on conditions responsible for sizeable portions of preventable mortality (childhood pneumonia, safe deliveries, and newborn care) and on long-term family planning.
5. Secure professional expertise to strengthen communication activities in line with a new MOH communication strategy and with renewed emphasis on family planning (especially long-acting methods), childhood pneumonia, safe deliveries, and newborn care.
6. Provide NGO staff with the commodities they currently use informally in home deliveries, and track these deliveries and their outcomes in the program's MIS.
7. Assess the technical and management-development needs of individual staff and provide needs-based training as indicated.
8. Maximize NGOs' outreach capacity to the poor by (i) re-directing support for cost-ineffective clinics in rural areas so that they operate more as hubs for increasing the number of satellite sites and (ii) linking these sites with "village doctors," drug sellers and traditional birth attendants.
9. Explore potential NGO management of MOH community clinics in areas where the MOH is having difficulty opening these facilities.
10. Use SSFP's MIS and GIS capability with the MOH to eliminate service-delivery redundancies and gaps in areas where SSFP clinics are located.
11. Revise program structure and job descriptions to implement the above recommendations.

I. INTRODUCTION

SSFP provides family planning, maternal, newborn, and child-health services in urban and rural areas in 61 of Bangladesh's 64 administrative districts. It is funded under a contract between USAID/Bangladesh and Chemonics International, which provides technical assistance and sub-grants to 28 local NGOs. These NGOs operate 320 static clinics (286 "vital" clinics offering a basic service package and 34 "ultra" clinics that add emergency obstetric care) and approximately 8,500 satellite clinics held one or more days/week by rotating staff. The NGOs deploy approximately 7,000 paid staff plus about 6,200 volunteer community service providers (CSPs), or community mobilizers/health educators and providers of family planning and a few other basic commodities. The program began October 1, 2007 and is scheduled to end September 30, 2011.

At USAID/Bangladesh's request, four consultants recruited by the GH Tech Project of USAID's Global Health Bureau and a representative of that bureau's Maternal and Child Health Division visited Bangladesh from April 3 to April 26, 2010[1] to (i) assess progress in accomplishing the three main objectives specified in the contract and (ii) make recommendations to improve SSFP and inform future USAID-funded service-delivery programming. This work was performed in accordance with a scope of work provided by USAID/Bangladesh (see Annex 1).

Prior to arriving in Bangladesh, the consultants reviewed background documents provided by USAID/Bangladesh (see Annex 2). In country, the team spoke with more than 91 people, including Chemonics staff, NGO management and clinical staff, officials of the Ministry of Health and Family Welfare (MOHFW), USAID cooperating agencies (CAs), and USAID staff (see Annex 3). These consultations took place largely through meetings scheduled by USAID, with follow-up meetings scheduled by the consultants. Consultants usually split into two or more groups for these meetings and were occasionally accompanied by USAID staff. Follow-up conversations were conducted by the consultants alone. Data on cost recovery and service provision were compiled by Chemonics at the consultants' request and extensively reviewed, often with Chemonics staff. Six static clinics and three satellite clinics were visited in Dhaka and in and around Sylhet. Plans to visit clinics in Khulna division were abandoned due to last minute flight cancellations, both outbound and return. A list of discussion topics was prepared by the consultants in advance of these clinic visits. The team also attended briefings by a separate USAID Population Assessment team and reviewed its draft report.

The consultants briefed USAID/Bangladesh, the U.S. Ambassador, senior SSFP staff, and MOH officials, including the Government of Bangladesh's (GOB) Secretary for Health, on its findings and left a draft copy of this report with USAID prior to departure. USAID comments on the draft have been considered in finalizing this report.

[1] Two of these consultants left Bangladesh with prior USAID agreement April 14 due to previous commitments.

II. BACKGROUND

SSFP is the most recent iteration of a series of USAID-funded local NGO programs that began in 1998 with the Rural Health Services Delivery Program (RSDP) and the Urban Family Health Partnership (UFHP). These programs were motivated largely by a plateau in total fertility that became evident in the early 1990s, after nearly two decades of fertility decline under the GOB's vertical family planning program. That program was based largely on door-to-door delivery of temporary methods, and the GOB and its major donors, including USAID, believed that further progress in lowering fertility required a more synergistic approach to family health, including more emphasis on LAPM and facility-based services. Therefore, GOB and USAID sought to integrate their separate family planning and health activities, and UFHP and RSDP provided a package of "essential services" through fixed facilities (static clinics) and community outreach sites (satellite clinics). UFHP and RSDP were followed in 2003 by the NGO Service Delivery Program (NSDP), which made some adjustments to these earlier efforts, but mainly consolidated UFHP and RSDP under one administrative umbrella.

SSFP inherited the NGOs along with their service-delivery infrastructure (static and satellite clinics), staff (professionals and CSPs) and systems (including quality-assurance and management-information); the Smiling Sun logo/brand; and the essential-services package from its predecessor programs. (The number of static clinics has increased by about 1% under SSFP.) However, in anticipation of the likely (in 2007) termination of USAID assistance to the NSDP NGOs in 2011, USAID designed SSFP to provide substantially greater emphasis on enhancing the financial sustainability of the NGOs supported under the previous programs. This is in fact the principal thrust of SSFP and of Chemonics' contract with USAID. Sustainability is pursued through (i) user fees, and (ii) a franchising model under which clinics providing standardized, quality-controlled services are permitted to use the Smiling Sun brand and are monitored by and receive technical and marketing support from a centralized FMO. The intent is to associate Smiling Sun clinics with courteous, high-quality services and thus attract paying customers. Resultant revenue is expected to (i) ensure the sustainability of services, with higher-income clinics financing themselves and subsidizing lower-income clinics; (ii) subsidize the provision of services to the poor who remain, as under previous programs, the main target group for SSFP; and (iii) finance the operation of the FMO.

It was expected that the SSFP NGOs would become independent of USAID support by late 2011, while expanding the provision of health and family planning services, especially to the poor.

The SSFP contract specifies three performance objectives (expected outcomes):

Establishment of a Smiling Sun Franchise: "A franchise network is in place and a local FMO is competently managing the franchise operation."

Continued Service Delivery with Declining USAID Funding: "Smiling Sun NGOs and their clinics continue service delivery with a reduction in grant money while continuing to provide quality services to the target population."

Increased Clients, Especially Poor Clients, and Wider Range of Services: "NGO clinics, satellites, and community workers continue to expand the volume of clientele (especially for key ESD (essential service delivery) services), coverage of poor clients, and range of services available and quality of care."

This report assesses SSFP in terms of these three objectives.

III. OUTCOME 1: THE SMILING SUN FRANCHISE

A. ESTABLISHING THE FRANCHISE

To attain SSFP's objective of financial sustainability, the franchise will need to obtain the long-term funding from donors and/or NGOs' clients needed to keep the franchisor (the FMO) and the franchisees (the NGOs) in business. To do this, the team believes the franchise needs to be:

1. Fiscally transparent and responsible;
2. Efficient and effective in its use of resources;
3. Well-managed;
4. Able to recruit, train, and retain well-qualified staff;
5. Capable of providing quality health services based on documented best practices;
6. Competent in monitoring and supervising service delivery effectively;
7. Able to market its services successfully;
8. Innovative in providing services;
9. Respected by its clients and among its peers; and
10. Effectively engaged with the MOH in policy formulation and program coordination.

Since the NGO franchisees (the actual "franchise network" noted in the first contract objective) were already in place at the start of SSFP, the team assessed the extent of the program's success in establishing the franchise based on these criteria.

1. Fiscal Responsibility

As provided in the contract, Chemonics has proffered USAID with a complete annual accounting of all contract-related expenditures, including those associated with SSFP grants to NGOs. FMO staff assist all NGOs in preparing their budgets, reviewing their monthly financial reports, and monitoring clinic finances, which should bode well for future financial management. Reporting on cost recovery and the use of project income appears complete and current. Although all this is a good sign, to date there is no track record for FMO financial responsibility in managing an independent franchise after USAID support ends.

2. Management

For the franchise to succeed in four years, SSFP needed to create an organizational structure that vested responsibility for developing the franchise in those who would subsequently be operating the FMO. Therefore, SSFP separated responsibilities for managing the USAID contract and managing the activities and staff of the FMO, establishing a structure for an organization that will be independent of USAID and Chemonics. NGO field staff seemed to clearly understand these differences, indicating a good conceptual foundation for the eventual handover of responsibilities to the FMO. SSFP staff's ability to access information requested by the assessment team indicates that the program is reasonably well-organized and administered.

However, while SSFP intends to begin transition to an FMO in the third year of the program, a long-term business plan for the FMO has only recently been developed. The assessment team could not review the report because it was not made available to them. However, the team

believes that such a plan should have been the foundation upon which the FMO was developed and should thus have been compiled in SSFP's first year. In addition, although SSFP has developed a series of policy papers on the franchise and its implementation, these have not been shared with the NGOs. More than two years into the project, NGO staff do not understand the process or scheduling associated with the transition to a full-fledged franchise managed by an FMO.

Moreover, the FMO's board of directors seems completely nonfunctional and unfamiliar with the program and the newly registered Smiling Sun Health Services Trust (the legal embodiment of the franchise to be managed by the FMO). The team's meeting with four board members—only one of whom seemed to understand the franchise—indicates that the board has only met twice: once for a general orientation and once to elect a chair. No project business was conducted, and board members were not consulted on any decision. Following the board's first meeting April 27, 2009, it was understood that the chair was asked to sign a check and refused on the grounds that she was unaware of her responsibilities in the matter. Aside from the two board members from the Membership Council (see III. C below), all individuals were selected by Chemonics and none has visited an SSFP clinic.

Similarly, the team found the minutes from meetings of the Membership Council, created by elected NGO project directors (see Section III. C below) to be uninformative, unfocused, and not substantial. Members said that SSFP has not distributed the minutes and seemed to have limited understanding of the long-term implications of the franchise being established under SSFP.

3. Efficient and Effective Use of Resources

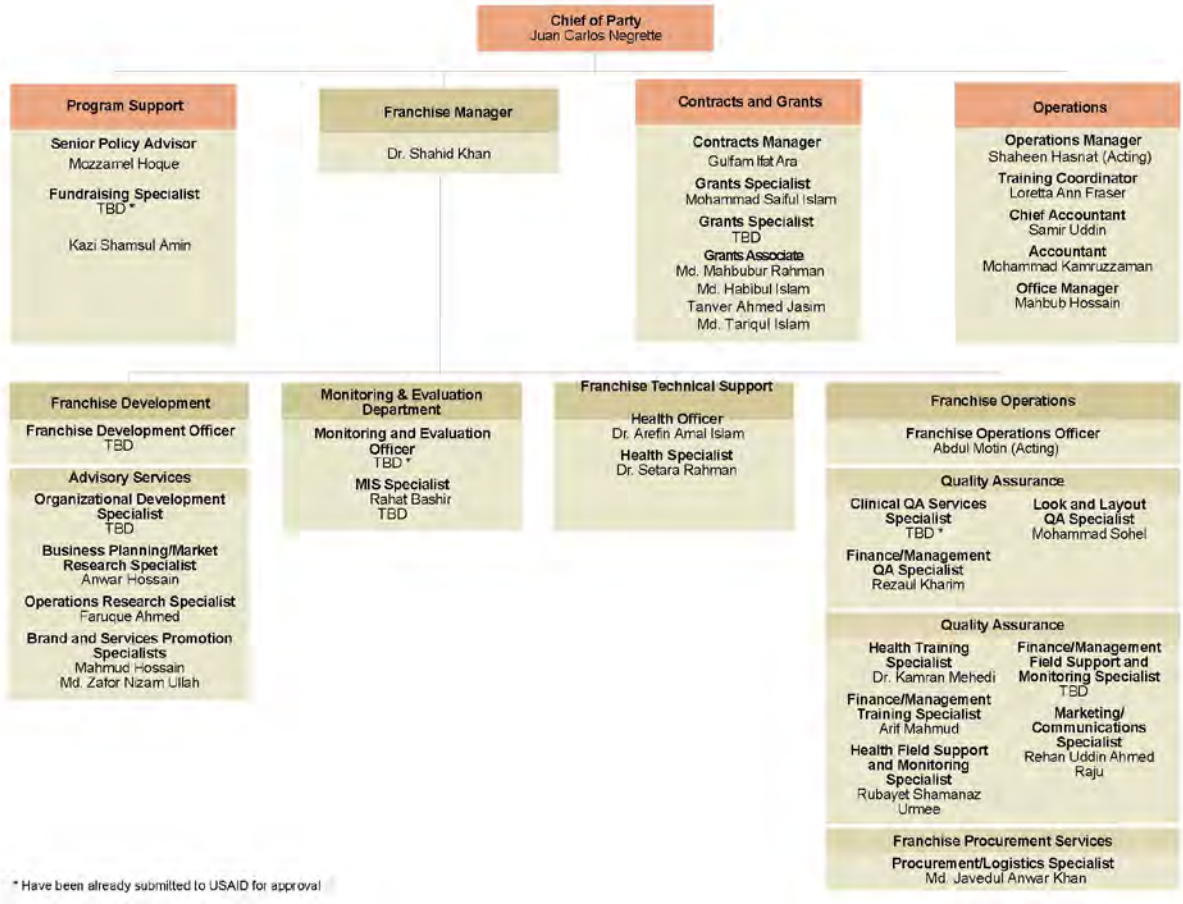
SSFP has negotiated with eight pharmaceutical firms on behalf of program NGOs to procure drugs and supplies at a 23% discount, clearly demonstrating a value of membership in the franchise. Furthermore, SSFP's emphasis on its "double-bottom line" (cost recovery and subsidized services for the poor) is at least conceptually consistent with effective resource utilization. Finally, SSFP's work with NGOs on the use of PI has continued its predecessors' encouragement of careful NGO allocation of these resources to well-defined budget items. However, except for a limited evaluation of its training program (see 5 below), the team found no data on efficiency or effectiveness of resource utilization in terms of the costs of specific results or impacts obtained by SSFP.

4. Recruitment, Training, and Retention of Staff

There has been significant turnover of SSFP staff, with resignations in 12 core positions since the start of the program. The most serious was the year 1 loss of the Franchise Manager. This person is responsible for the core of the program: developing the franchise and transitioning from a USAID program to an independent franchise managed by the FMO (see 2 above). This required Chemonics' Chief of Party to assume franchise-management responsibility in addition to his other tasks pending recruitment of a replacement who started work only during the final days of this assessment.

Although SSFP reports that 90% of its key staff are now in place and intend to remain with the franchise, its organizational chart (Figure 1) shows that core positions still are unfilled.

Figure 1. Smiling Sun Franchise Program Staffing Plan



It is difficult to establish the causes of this problem. SSFP-HQ (Chemonics' locally hired staff) salaries have generally been higher than those of other international NGOs, and some stakeholders think that SSFP-HQ simply did not hire the right people originally. It also is possible that SSFP-HQ failed to establish a working environment in which job satisfaction, motivation, supervision, and sense of value to the organization were sufficient to retain key staff.

On the other hand, NGO staff (service providers, et al.) have been paid less than the MOH. SSFP has recently raised salaries for the NGO staff, which they have welcomed and which may help solve this problem, at least in fixed and satellite clinics. Turnover of paramedics and especially physicians in NGO clinics was pronounced. Physicians in urban areas reportedly see SSFP as transitory clinical work (lasting about a year) in the course of obtaining credentials to join the MOH or assume more lucrative positions in the private sector. Rural clinics offer few incentives to retain physicians. Likewise, paramedics (predominantly nurses) work in NGO clinics pending their employment by the MOH.

It would seem that this turnover must result in incompletely trained staff in some clinics and possibly reduced client volume (see Section V. A), but it is difficult to judge the extent of this problem or its impact on patient care. While SSFP's indicator "Number of medical and paramedical practitioners trained in evidence-based clinical guidelines" shows SSFP exceeding its targets for years 1 and 2 (1,158 against target of 900 for year 2), this indicator is inadequate because it says nothing about the percentage of currently employed and trained staff. This problem also exists for similar indicators: "Number trained in maternal/newborn health" and

"Number trained in FP/RH [family planning/reproductive health]," and "Number of people trained in DOTS [Directly Observed Treatment, Short-course]"—without appropriate staff denominators, the significance and extent of training gaps is impossible to track.

In its first year, SSFP assessed the training needs of the NGOs' 320 clinics. However, the team could not determine the extent to which the training subsequently conducted was based on this assessment or how many participants were trained in the 12 sessions conducted during the first year. However, year 2 data indicate that SSFP provided eight clinical trainings and that 87 physicians participated in one or more of all 20 (12+8) trainings, as did 2,637 paramedics. Training for the latter emphasized community-level interventions. In addition, eight CSPs were trained in community-level IMCI (integrated management of childhood illness), and 78 counselors received relevant training, all provided by one of eight local institutions contracted by SSFP and used previously by predecessor programs.

SSFP has sponsored clinical training in family planning, including LAPM; clinic management; maternal health (ANC [antenatal care], PNC [prenatal care], and sexually transmitted infections/reproductive tract infections); and IMCI (CDD [control of diarrheal diseases]), ARI (acute respiratory infection), fever/malaria, malnutrition, anemia, ear infections, and child feeding). NGOs report that they are satisfied with this training, but SSFP has not evaluated it. SSFP expects to have all clinical staff trained in the above by the end of the current year, but heretofore chronic staff turnover may prevent this.

In addition, 178 trainings for NGO staff in program management were given by FMO staff during the first two years of the program. The number of staff trained was difficult to determine, but at least 80 participated in at least one training on brand and service promotion, marketing, management, logistics and operation, financial management, and monitoring and supervision.

To maximize its sustainability by NGOs, management training under SSFP was provided through the training of trainers (TOT). In February 2010, SSFP's Franchise Development Team evaluated this training in terms of knowledge gained in program and financial management. Although financial management fared somewhat better than program management and staff trained as trainers did better than those trained by their peers in the subsequent TOT "cascade," the evaluation concluded that the training was deficient in all areas and that refresher TOT was needed to produce adequately trained NGO staff. SSFP is to be commended for its candor in confronting this problem.

The program also has sponsored numerous trainings for FMO and NGO staff. Topics ranged from communications to business plan development to franchise operations and quality control. SSFP staff informed the assessment team that the curricula for these trainings were based on standardized assumptions about the development needs of a generic franchise management organization rather than on SSFP-specific training needs assessments. The team suggests increased attention be placed upon identifying and responding to the training needs of their FMO staff and their NGO members.

5. Provision of Quality Health Services

SSFP has largely continued the quality-assurance activities of its predecessor programs and expanded on some of them. The program's emphasis on quality is seen as a strength by stakeholders, the MOH, and program staff. Staff seem familiar with quality-assurance guidelines. A number of quality-assurance committees, from clinic-level circles to a national group, address quality but these focus on the limited activities captured in SSFP's MIS forms and checklists, and management meetings seem more frequent than quality-assurance meetings at the lower levels of the system. Implementation of clinic quality circles seems variable in terms of the frequency of

meetings and depth of discussion. SSFP's year 2 annual report[2] noted 47% achievement of the target for "clinics with a quality management system in place."

6. Monitoring and Supervision

Partly as a result of work under SSFP's predecessor programs, SSFP has an extensive, standardized MIS that, if fully applied across all clinics, could significantly improve the use of data for project management and quality control. Recently introduced quality improvements have increased the potential for using clinic-level data for local planning and management.

The system is based on a daily record, a summative monthly record and a monthly clinic performance form. Data are entered in these instruments at the clinics and transcribed into a computer system for reporting to NGO headquarters and SSFP. The data include routine service statistics and input for quality assurance, monthly marketing plans, and annual business plans. The system permits tracking of both individual patients and clinic visits (contacts) but aggregation limits the system's ability to separate service-delivery contacts and individual patients as data move up the system. The former measures service volume, but the latter would help SSFP to determine whether individual clients are receiving the services they need and would provide a better estimate of the percent of catchment populations "reached" by SSFP. SSFP is piloting a system that reports individual client information in four districts, but it has yet to be scaled-up, and its use for quality assurance has been limited even in those districts.

While the MIS is impressive and clinic staff and NGO project directors stated that data are regularly transmitted to the FMO, its practical use to improve service delivery has only recently begun, as noted above. The year 2 annual report noted in 5 above shows that SSFP had reached only 20% of its target for using data for decision-making, but here again the indicator is weak (use for what?) and does not necessarily measure significant progress or the lack thereof. In addition, some NGO staff believe that while performance monitoring and feedback are necessary, the behavior of some SSFP staff have been overbearing in providing it. Some NGOs see the MIS and quality assurance as burdens, and several clinic and NGO staff said they would drop the quality circles and checklists if grant funds ceased.

During year 2, SSFP developed a number of tools and procedures to enhance the FMO's ability to monitor the quality of NGO services. But discussion with NGO program directors and clinic managers indicates that SSFP supervision often has been passive and infrequent. SSFP's second annual report identified reduced SSFP supervision and monitoring as a possible cause of the decline in the number of clients treated for ARIs. SSFP's recent introduction of a well-conceived and supported quality monitoring and supervision protocol reportedly covering 100% of NGO clinics appears to be an important step in addressing quality issues identified previously.

During SSFP's second year, all 320 clinics were required to submit annual business plans to the FMO. Several SSFP technical officers were responsible for helping the clinics develop these plans and monitoring their implementation after approval. FMO review and monitoring of 320 clinic plans seems an unsustainable exercise in micromanagement that undercuts the NGOs' longstanding relationships and experience with their clinics and clients. It seems more appropriate, efficient, and sustainable for the 28 NGOs themselves to retain oversight responsibility to review the 320 clinic plans and consolidate them into 28 franchise plans, which could then be reviewed and monitored by the FMO.

[2] Pp D11–D13.

7. Marketing

Marketing support from the franchisor typically is a major membership benefit in a franchise, but SSFP's marketing efforts have been limited and rudimentary, largely involving use of the inherited Smiling Sun logo and local promotional activities implemented with limited guidance from SSFP and paid for by NGOs from their PI. The program has no clear communication strategy and limited in-house communication expertise, and its use of a professional local communication agency has been sporadic and hampered by staff turnover and subcontracting delays. Discussions with NGO field staff indicate that the brand is associated with quality services, but this may be the legacy of major marketing campaigns conducted under predecessor programs. While client contacts have reportedly increased by an impressive 33% and 21% from year 2 to year 3 at ultra and vital clinics, respectively, it is difficult to attribute this to SSFP marketing activities but rather, perhaps, cash incentives (see 8 below) because no evaluation of the effectiveness of these activities has been conducted.

8. Innovation in Service Provision

With training provided by ICDDR, B (International Centre for Diarrhoeal Disease Research, Bangladesh), SSFP has introduced most of its clinic managers to the comprehensive approach of diarrhea management (CADM). Eight trainers from SSFP's collaborating training institutions were trained in CADM, including the use of zinc for the enhanced treatment for diarrhea. Most clinic staff and more than 5,000 CSPs have been trained in those aspects of CADM appropriate to their duties.

To improve clinic management, SSFP has replaced physicians as clinic managers with trained administrators—a well-taken decision often unpopular with the physicians in question. Physicians now concentrate on service quality while clinic managers oversee clinic operations and administration.

In August 2009, SSFP introduced a six-week pilot incentive program in which clinic staff and CSPs received commissions for increasing clinic contacts. Of the 360 clinics, 224 received incentives under this innovative method for increasing service utilization.

SSFP has introduced uniform business planning tools and trained NGO staff to use them. This has enabled NGOs with initial reluctance to further develop the competitive, business-oriented attitude encouraged under previous programs. However, in commenting on these tools, NGOs expressed concern with the SSFP-introduced innovations to the point of indicating that they would drop the quality circles and checklists if grant funds ceased. It may be necessary for SSFP to simplify these procedures to make them more acceptable to the NGOs and/or enter into renewed dialogue with the NGOs to convince them of their utility.

9. Recognition by Clients and Peers

As noted above, Smiling Sun clinics seem to be associated with quality care. SSFP's use of trained paramedics at 8,545 satellite clinics and of approximately 6,200 CSPs has enhanced SSFP's recognition in the communities it serves. During the past year, SSFP has begun to work more proactively with USAID projects, including Modhumita (FHI), MaMoni (SAVE), Mayer Hashi (Engender Health), and Leaders of Influence on initiatives of mutual interest.

10. Engagement with Government

During the first year of the program, FMO staff, many of whom had limited, if any, health-sector experience, did not sufficiently engage with the MOH, potential CA collaborators, or USAID. At the urging of USAID and the MOH, SSFP began during year 2 to work with the MOH and familiarize it with SSFP activities. In August 2009, SSFP met with the MOH and USAID to review

program activities and establish an agenda for year 3. Based on feedback from SSFP staff, the MOH, and USAID, the team believes that SSFP's organizational culture has shifted toward encouraging collaboration with the MOH. However, MOH officials at the central and district levels indicated that their familiarity with SSFP is still incomplete. The MOH can track immunizations and contraceptives because GOB subsidizes these commodities to SSFP but reports limited understanding of SSFP's other activities. This indicates that additional SSFP attention to this issue may be required.

SSFP provides the MOH with its service statistics, coordinates with the MOH in providing family planning and immunizations, and is a member of the Inter-Agency Coordination Committee for the national immunization program, EPI (Expanded Program for Immunizations). It is working with the MOH to pilot a voucher system (Demand-Side Financing Program) to provide services to poor pregnant women and serves on the MOH technical committee for this initiative. Some district-level coordination of ANC, PNC, and IMCI with the MOH's EPI and FP programs occurs at a small number of sites but does not reflect regularized joint planning. SSFP has worked with the MOH to arrange no-cost LAPM training for its physicians and paramedics, but access to this training still is problematic for SSFP, constraining the program's ability to increase its provision of LAPM.

Affecting MOH policy is not mandated in Chemonics' contract with USAID, and SSFP has, therefore, not been a major player in the formulation and implementation of significant policy initiatives (e.g., the national health and population policies), despite having a full-time policy advisor on its staff. This represents a missed opportunity to influence MOH relationships with NGOs and NGOs' ability to contribute to national health strategies.

Based on the above analysis, Figure 2 summarizes SSFP/FMO's progress to date in establishing a sustainable franchise.

Figure 2. SSFP Progress toward Establishing a Sustainable Franchise (as of April 2010)

Sustainability Criteria	Minimal Progress		Satisfactory Progress		Good Progress	
Fiscally responsible						
Well-managed						
Effective, efficient resource use						
Quality human resources						
Provision of quality services						
Monitoring and supervision						

Sustainability Criteria	Minimal Progress		Satisfactory Progress		Good Progress	
Marketing						
Innovation						
Recognition by clients and peers						
Engagement with MOH						

B. APPROPRIATENESS OF THE FRANCHISE MODEL

In addition to examining SSFP's progress in establishing a sustainable franchise (Section A above), the assessment team reviewed the historical strengths and weaknesses of social franchising generally to estimate its likely effectiveness in attaining USAID's objectives. Experience in 46 franchise programs with more than 26,000 clinics[3] provides a wealth of information on the effectiveness of these programs in providing financially sustainable services for the general population and the poor.

1. Strengths

Cross-subsidization: Collecting fees from the 74% of SSFP clients classified as non-poor could, if sufficient, provide revenue to defray recurring costs including the expense of free or discounted services for the 26% of SSFP clients classified as poor. Likewise, pooling resources among profitable and not profitable clinics could, if sufficient, allow the franchise to sustain clinics that have many poor clients and therefore cannot cover their costs.

Cost savings: Acting on behalf of 28 NGOs with 320 clinics, the franchise could realize cost savings in the procurement of drugs, supplies, training, and marketing materials.

Improved quality of care and innovation: If effectively trained and supervised, NGO franchisees could form a critical mass for encouraging the adoption of improved service delivery methodologies and effective technical innovations in the Bangladesh health system generally.

Policy change: A franchise representing a large number of NGO providers could enhance the NGOs' role in formulating national policies affecting the delivery of essential services to the poor.

2. Weaknesses

Long-term FMO maintenance cost: The literature clearly indicates that developing an effective social franchise in health is a long-term proposition, and given the progress to date as noted in III A above, the team does not believe that the SSFP franchise can be institutionalized in the time remaining under the contract. Furthermore, the staff and operating costs of the FMO—which are essentially a replacement for the TA inputs of previous USAID programs—currently are supported almost entirely under the contract with USAID. In the future, these costs are to

[3] Montagu, D. and the Global Health Group. *Clinical Social Franchising 2009: Annual Description of Country Programs Worldwide*, 2009.

be paid mostly from the NGOs' PI. This will be a significant recurring cost, and there is scant evidence that the NGOs will be willing or able to assume it.

Lower priority for services that do not cover their costs: There is a widespread perception among NGOs and other stakeholders that the franchise's need to recover costs to remain in business will, once USAID support ends, produce a decline in the provision of high-impact public health services that offer little or no revenue. Family planning is a major concern in this regard.

While contraceptives are provided free to SSFP NGOs by the MOH, commodities account for only part of the cost of family planning services. If fees for service are insufficient to cover the full cost, NGOs will be forced to accord a lower priority to family planning.

Loss of rural clinics and those with larger poor populations: Despite potential cross-subsidization, worldwide experience suggests that clinics with limited revenues due to numerous poor clients or the light client loads characteristic of some rural areas are likely to be closed when USAID support ends.

Ongoing management burden of FMO operation: If the FMO is to continue to provide the NGOs with effective technical, management, and marketing support, it will need to continue to recruit, retain, and effectively manage highly qualified staff in a limited labor market. As above, this has been a problem for SSFP to date.

Limited expectations of sustainability if targeted toward the poor: An otherwise positive review of social franchising for health notes that "… it is unlikely that services targeted at the poor and/or rural populations will ever be financially sustainable through franchising or any other market-based programme." [4] While SSFP intends that cross-subsidization will solve this problem, the team found no indication that clinics with higher PI or fewer poor clients would be willing or able to sufficiently cross-subsidize other clinics. Clinics vary dramatically in the number of poor clients they serve and the strong push for cost-recovery presents a constant challenge to providing services to the poor. One NGO indicated that they would need to close several clinics with the poorest clients if USAID funding ended.

The SSFP clinics run the gamut from those that will never be financially sustainable to those that might become sustainable and those that are now. But on average, SSFP's cost recovery was only 34% at the end of year 2, and Table 1 shows that only about 21% of SSFP's urban clinics and about 12% of its rural clinics were recovering more than 50% of their costs by the sixth month of year 3. Thus far in year 3, more than half of both the 165 urban clinics (99) and 152 rural clinics (114) have failed to recover more than 40% of their costs. These rates are with only 26% of SSFP clients classified as poor and receiving free or discounted care. Thus, as it seems doubtful that the franchise as a whole will meet the target of 70% cost recovery by October 2011 while increasing service to the poor; the team believes that the SSFP franchise cannot be institutionalized in the time remaining under the contract.

[4] Harvey PD. *Let Every Child Be Wanted: How Social Marketing Is Revolutionizing Contraceptive Use Around the World.* Westport, CT: Auburn House, 2006.

TABLE 1. PERCENT OF TOTAL URBAN AND RURAL SSFP CLINICS BY PERCENT COST RECOVERY BY YEAR

Percent cost recovery	Year 1 Oct 07–May 08		Year 2 June 08–July 09		Year 3 to date Aug–Dec. 09	
	Urban	Rural	Urban	Rural	Urban	Rural
0%–20%	6.1%	19.1%	10.3%	3.9%	4.8%	12.5%
21%–30%	43.0%	55.3%	42.4%	34.9%	29.7%	22.4%
31%–40%	25.5%	17.8%	27.3%	45.4%	25.5%	40.1%
41%–50%	13.3%	5.9%	10.3%	14.5%	19.4%	13.2%
51%–60%	8.5%	0.7%	6.7%	0.7%	6.7%	6.6%
61%–70%	0.6%	1.3%	1.2%	0.7%	5.5%	2.0%
71%–99%	3.0%	0.0%	1.2%	0.0%	5.5%	1.3%
100% +	0.0%	0.0%	0.6%	0.0%	3.0%	2.0%
Total number of clinics	165	152	165	152	165	152

Question of value added: For the franchise to be viable after USAID support ends, NGOs will need to believe that the value of membership exceeds the costs of membership, i.e., they will have to feel they are buying something that is worth the PI they will have to spend on it; the team is unsure of what that something might be. Although the NGOs participate in the franchise now to secure continued USAID funding while it lasts, they seem to have little attachment to it. SSFP provides little by way of marketing support, and its technical assistance focuses largely on the same things as two previous iterations of USAID programs. It seems unlikely that NGOs would spend their own money to continue this indefinitely, and conversations with NGO staff indicate that they are unlikely to support the franchise financially after the end of SSFP.

3. Conclusion

The sustainability of NGO services is the principal focus of SSFP, as designed by USAID and implemented by Chemonics. At the onset of the program, Chemonics, with USAID/Bangladesh's agreement, determined that sustainability could be demonstrated if the NGOs could recover 70% of their costs. (Why organizations that could not cover 30% of their costs would be considered sustainable is unclear, given USAID's seemingly obvious intention at the time SSFP was designed to completely terminate support at the end of the program.) As illustrated in Table 1, attainment of this 70% target does not appear possible during the time remaining in the program, and, as noted above, the expectation of financial sustainability runs counter to the experience of any of developing country social franchise for health. Although SSFP has successfully leveraged non USAID support through agreements with a number of strategic partners (some inherited), this support is not sufficient to address sustainability concerns to any significant degree. Plus, it largely funds additional NGO operations rather than those supported by USAID.

To balance what the assessment team perceived as an unattainable definition of sustainability, SSFP's sustainability prospects have been assessed based on 10 indicators in section A above. While Figure 2 above illustrates that SSFP has achieved progress on a number of these indicators, the time remaining in the project would indicate limited likelihood of attaining all or most of them. Therefore, cost-recovery targets aside, the team concludes that the program's four-year life span is insufficient for developing a sustainable franchise.

Given the above, the team believes that the franchise model will not enable program NGOs to sustain the provision of high-impact public health services to the poor and that further investment in the franchise is not warranted.

Instead, SSFP should reorient the effort currently focused on the franchise to the establishment of an NGO Consortium. This consortium should allow program NGOs to continue their association with each other, with donors, and with the MOH to standardize effective methods of delivering good-quality essential services to the poor, potentially including work with "village doctors," drug sellers, and traditional birth attendants. However, the consortium would set its own priorities and cost-recovery and donor-financing targets to generate revenues sufficient to pursue those priorities; it also would own the Smiling Sun brand.

C. SSFP RELATIONSHIPS WITH NGOS, THE MOH, USAID, AND OTHER PARTNERS

SSFP's relations with its partner NGOs appear to be business-like. A strong initial focus on cost-recovery and business development was augmented after the program's first year by increased attention to service quality, monitoring, and marketing. Nonetheless, there is a perception among some NGOs, especially the more established ones, that SSFP has "imposed" the franchise model on them. While SSFP has tried to strengthen its NGO partnerships by forming a Membership Council to air NGO concerns, the team's discussions with council members indicate that this effort involves more form than substance.

During its first year, SSFP's relations with the MOH were distant and not collaborative. To its credit, SSFP management took steps during year 2 to remedy this (see Section A. 10 above). In discussing their relationship, respondents from both the GOB and SSFP recognized the need for continued efforts to strengthen what the assessment team concludes is a developing partnership.

SSFP also had significant difficulty developing an effective, transparent relationship with USAID during the first year. USAID has clearly felt that Chemonics has treated questions and suggestions as unwelcome intrusions to be fended off, and Chemonics' de facto restriction of direct, substantive contact with USAID to the Chief of Party has restricted the informal give and take among staffs that can facilitate problem resolution. Although relations with USAID have improved, they continue to be strained.

This may be due in part to what Chemonics regards as unreasonable USAID expectations. The intent of the contract is clear: SSFP's principal objective is to enhance the fiscal sustainability of program NGOs to the point in which, at the end of the contract, they can continue to serve the poor without any USAID assistance. This has arguably been Chemonics' overriding concern, especially in the first year of the program. But as the budgetary imperatives that originally required the focus on cost-recovery changed, USAID has seemed to become increasingly uncomfortable with this limited and probably unrealistic vision. Therefore, USAID has urged more attention to quality control, family planning, respiratory infections, communication activities, coordination with the MOH, policy reform, etc.—all things that were the focus of previous USAID programs and are important to maximize franchise effectiveness, but that Chemonics was not specifically hired to do. Although the

assessment team does not believe that USAID's original expectations for SSFP were realistic and agrees that a broader focus is desirable, Chemonics cannot reasonably be faulted for emphasizing what it was hired to perform.

SSFP has worked with ICDDR, B (improved treatment of diarrheal disease), Engender Health (Mayer Hashi, for training on LAPM), The Asia Foundation (Leaders of Influence, to obtain support from religious leaders), and FHI (Bangladesh AIDS Project) and has coordinated with the Asian Development Bank's Urban Primary Health Care Program. Expanded collaboration with EngenderHealth could be valuable in increasing SSFP's emphasis on LAPM and maternal health. Relations with these other CAs seem professional and reasonably productive.

IV. OUTCOME 2: CONTINUED SERVICE DELIVERY WITH DECLINING USAID FUNDING

A. CONTRACT BUDGET AND BURN RATE

SSFP estimates that its balance of USAID funds at the end of the project will be approximately $1,254,000—an amount entirely due to funds not expended for NGO grants. See Table 2.

TABLE 2: SMILING SUN FRANCHISE PROGRAM: BUDGET

	Total Budget	Y1 (Oct 07–Sept 08)		Y2 (Oct 08–Sept 09)	
		Y1 (Oct 07–Sept 08) Actual	Y1 Projections	Y2 Actual	Y2 Projections
Cost reimbursement (SSFP Expenses)	$13,497,895	$3,942,863	$4,254,272	$3,228,049	$3,630,671
Grants (total FDF)	$33,000,000	$6,275,068	$5,000,000	$7,031,551	$8,181,192
Sub Total	$46,497,895	$10,217,931	$9,254,272	$10,259,600	$11,811,863
NGO operational expenses covered with PI		$2,112,106		$2,268,325	
TOTAL		$12,330,037		$12,527,925	
	Y3 (Oct 09–Sept 10)		Y4 (Oct 10–Sept 11)		
	Y3 Estimate	Y3 Projections	Y4 Projections	Expected Balance	
Cost-reimbursement (SSFP Expenses)	$3,286,089	$3,094,861	$3,041,049	-$155	
Grants (total FDF)	$11,239,142	$9,699,996	$7,199,123	$1,255,116	
Sub Total	$14,525,231	$12,794,857	$10,240,172		
NGO operational expenses covered with PI	$1,943,112		$8,605,006		
TOTAL	$16,468,343		$18,845,178	$1,254,961	

SSFP reports that all of this balance could be consumed by SSFP's proposed 10-clinic expansion plan, which is not yet approved by USAID. Given the limited time remaining in SSFP, the assessment team believes that this expansion would be ill-advised and that SSFP should instead strengthen service delivery within its existing network.

Grants to NGOs have not been reduced year by year, as anticipated in the contract. Rather, they increased in year 2 and are expected to rise again in year 3. When asked about this, the

Chief of Party noted that grants increased because of inflation and salary adjustments. He also noted that for year 3, grants will continue to increase and that in year 4, an additional $600,000 will be required for grants if less than 65% cost recovery is achieved. The assessment team has no reason to question this explanation for divergence from the program's design, but believes it could be examined more closely during USAID's planned audit of SSFP. In any case, it is clear from the above that USAID's expectation that the franchise could replace its historic support for NGO service delivery in Bangladesh does not seem to have been realistic.

While USAID funding for grants has increased, SSFP has been successful in attracting significant financial support from several private organizations (or in some cases retaining support initiated under its predecessor programs). This indicates a potential for becoming somewhat less dependent on (if not independent of) USAID over time. See Section IV. C below.

B. PROGRAM INCOME FROM NGOS (USAID PROGRAM INCOME)

SSFP estimates that total project income will be about $19,682,000. Of this amount, $14,928,549 is slated for NGO program operations with $4,745,227 remaining for other uses. See Table 3.

TABLE 3. PROGRAM INCOME

	Y1 (Oct 07–Sept 08) actual	Y2 (Oct 08–Sept 09) actual	Y3 (Oct 09–Sept 10) estimated	Y4 (Oct 10–Sept 11) projection	TOTAL
Program income generation	$2,412,796	$3,099,254	$5,565,719	$8,605,006	$19,682,776
NGO operational expenses from PI	$2,112,106	$2,268,325	$1,943,112	$8,605,006	$14,928,549
Available program income	$300,691	$830,929	$3,622,607	$0	$4,754,227

The assessment team requested that SSFP describe the banking operations associated with grant money and PI. The Chief of Party replied that every clinic and every NGO headquarters has two bank accounts: one for grant money and another for PI. Grant money, PI, and donations (D below) are considered part of a franchise development fund (FDF). The project has $33 million for grants and estimates that it will generate about $19 million. Total FDF resources are expected to be about $52 million (33 + 19). The FDF is used to defray operational expenses and for franchise improvement and potential expansion.

Although the team's scope of work did not include review of any audits of SSFP's PI accounts, the team confirmed that an external audit dated January 31, 2008, of Concerned Women for Family Development (CWFD), one of the SSFP's principal NGOs, was conducted by ACNABIN, chartered accountants. It covered the period from October 1, 2007, to January 31, 2009.

The Chief of Party informed the team that SSFP's grants team performs field verifications and internal audits and all SSFP NGOs have been externally audited for the period of October 2007 to January 2009. Starting in April 2010, all NGOs will be audited for the period February 2009 to January 2010. If initial findings require additional probing, SSFP requests external firms to perform specific audits. SSFP also says it checks every expense voucher from every clinic and NGO in the project. In addition, SSFP receives bank statements and monthly reconciliation reports for grant money and PI from every NGO and clinic in the network, and each NGO and

clinic have separate grant and PI accounts. Although the team could not verify the accuracy of this statement, there is no reason to question it.

C. NGO USE OF FUNDS

SSFP anticipates that the NGOs will spend all of the $4,754,000 in PI across the five line items as specified in the contract with USAID. See Table 4.

TABLE 4. PROJECTED USE OF AVAILABLE PROGRAM INCOME

	Y2 (Oct 08–Sept 09) Actual		Y3 (Oct 09– Sept 10) Estimated		Y4 (Oct 10–Sept 11) Projection		Total
	PI (%)	$	PI (%)	$	PI (%)	$	$
Facilities improvement/ construction	20	-	20	950,845	20		950,845
Incentives	27	-	27	1,283,641	27		1,283,641
Advertising	19	-	19	903,303	19		903,303
Training	15	-	15	713,134	15		713,134
Crossed subsidization/ franchise development	19	-	19	903,303	19		903,303
Total	100%	-	100	4,754, 226	100	-	4,754,226

D. PROGRAM INCOME FROM "STRATEGIC PARTNERS"

SSFP reports that private entities provided $6,483,333 through December 2009. See Table 5.

The team requested that SSFP describe the management of these funds. SSFP replied that strategic partners are of two kinds: third-party payers and donors. Third-party payers pay an agreed fee for service provided; donors including Grameen Phone and British American Tobacco (Bangladesh) (BATB) provide gifts to the program. Third-party payers' payments are considered PI and are accounted for as such. They are paid after SSFP provides the payer with performance reports, and they go into the PI bank account. Donations are not counted as PI because they do not derive from services provided by the program.

Although the assessment team was unable to verify the accuracy of this information, there is no reason to question its validity.

TABLE 5. PROGRAM INCOME FROM STRATEGIC PARTNERS

Total program income generation	Grameen phone	BATB	Demand side financing	Third-party payers
FY-01 (Oct 07–Sept 08)				
BDT 161,527,873	0	BDT 1,295,102	BDT 1,645,450	BDT 158,587,321
$2,375,410	0	$19,046	$24,198	$2,332,166
Percent of total	0.00%	0.80%	1.02%	98.18%

TABLE 5. PROGRAM INCOME FROM STRATEGIC PARTNERS				
Total program income generation	**Grameen phone**	**BATB**	**Demand side financing**	**Third-party payers**
FY-02 (Oct 08–Sept 09)				
BDT 209,033,178	BDT 24,256,283	BDT 1,855,574	BDT 2,327,568	BDT 180,593,753
$3,074,017	$356,710	$27,288	$34,229	$2,655,790
Percent of total	11.60%	0.89%	1.11%	86.39%
FY-03 (Oct 09 – Dec 09)				
BDT 70,305,565	BDT 15,014,928	BDT 1,021,720	BDT 216,381	BDT 54,052,536
$1,033,905	$20,808	$15,025	$3,182	$794,890
Percent of total	21%	1%	0%	77%
Total LOP (BDT)	BDT 39,271,211	BDT 4,172,396	BDT 4,189,399	BDT 393,233,610
Total LOP ($)	$577,518	$61,359	$61,609	$5,782,847
Grand Total LOP (BDT)	**BDT 440,866,616**	**Grand Total LOP ($)**	**$6,483,333**	

Highlights of activities supported by strategic partners are as follows:

CEMEX CEMENT (Bangladesh) has contributed more than $28,000 for a clinic under construction in the cyclone-affected area of Sharonkhola in Bagherhat.

Grameen Phone is providing $577,517 to provide maternal and child health services to the poorest of the poor pregnant women at selected SSFP clinics. The agreement began in March 2009 and extends to November 2010.

Chevron will provide $320,000 under an agreement that began in October 2008 and, under a new memorandum of understanding, will be extended until September 2011 to promote and provide services in areas adjacent to three SSFP clinics in Moulvibazar and Hobigonj districts.

British American Tobacco (Bangladesh) is providing $165,000 for essential services for 6,000 families in the tobacco growing areas of Chittagong, Rangpur, and Jhenidhe districts. Initiated in October 2007 and renewed in March 2010, the agreement is scheduled to end in March 2011.

V. OUTCOME 3: INCREASED CLIENT VOLUME, COVERAGE OF THE POOR, RANGE OF SERVICES, AND QUALITY OF CARE

A. CLIENT VOLUME

During years 1 and 2, SSFP did not meet its service-delivery targets, and complete year 3 data were unavailable to the assessment team, preventing the team from drawing any firm conclusions about whether this situation has improved. However, partial year 3 data (Table 6) indicate that SSFP's reported service contacts may have been getting better.

In addition, recent data, not yet published as of the team's visit, indicate an increase in total service contacts of 33% at ultra clinics and 21% at vital clinics between the first quarter of year 1 and the first quarter of year 3.

Based on a year 2 report on service delivery and management targets (Table 6), SSFP exceeded or met expectations on indicators for active management of third stage of labor, couple years of protection, postpartum visits, and the number of staff trained in DOTS. SSFP's implementation of TB diagnosis, registration, and treatment in its DOTS program in vital clinics is a significant accomplishment.

SSFP performance has been less successful but still respectable in monitoring the quality of laboratory diagnoses for TB, maintaining DPT3 (diphtheria, pertussis, tetanus) coverage, and providing infants with antibiotics for infection.

Table 6 also shows that by the end of year 2, couple years of protection and postpartum visits within three days of birth had increased by 157% and 189%, respectively, over the 2007 baseline. However, the number of infants who received DPT3 had decreased by 11%. Year 2 end results indicate that the percent of laboratories performing TB microscopy with more than 95% correct results had decreased by 7%, and TB and DOTS is limited to a fairly small number of SSFP clinics. Through its MIS and quality assurance program, SSFP has identified and responded to these reductions in key service areas.

TABLE 6. SSFP ACHIEVEMENT OF YEAR 2 PMP TARGET ON SELECTED CLINICAL AND MANAGEMENT INDICATORS

Indicator	Baseline (2007)	Year 2 target	Year 2 achievements 10/08-9/09	Percent of target (%)
Number of women receiving active management of the third stage of labor through USG-supported programs	N/A	10,209	12,709	124
Couple years of protection in USG-supported programs (in millions)	0.9	1.295	1.41	109
Number of postpartum/newborn visits within three days of birth in USG-assisted programs	8,000	13,985	15,094	108
Number of people trained in DOTS with USG funding	44	111	111	100
Percent of USG-supported laboratories performing TB microscopy with more than 95% correct microscopy results (%)	75	82	70	85

TABLE 6. SSFP ACHIEVEMENT OF YEAR 2 PMP TARGET ON SELECTED CLINICAL AND MANAGEMENT INDICATORS				
Indicator	**Baseline (2007)**	**Year 2 target**	**Year 2 achievements 10/08-9/09**	**Percent of target (%)**
Number of children less than 12 months who received DPT3 from USG-supported programs	289,801	304,465	259,286	85
Number of infants (less than 1 year) receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	N/A	75,000	54,747	73

Indicator achievement and progress from baseline aside, the public health impact of SSFP service delivery is less than significant. The targets themselves are modest and the total catchment population is too small to make a measurable difference for Bangladesh as a whole. Although this makes no difference to the large number of individuals who receive SSFP services, nonetheless, it is perhaps not what should be expected from USAID/Bangladesh's principal health service delivery program.

Figure 3. Map of SSFP Catchment Areas

The fragmentation of SSFP catchment areas (see map for an example) and likely resultant overlap with MOH facilities may adversely affect SSFP's client volume, even in rural areas. These catchment areas were givens for SSFP—inherited from previous programs and reflective of the locations of the NGOs that USAID began working with years, and in some cases, decades ago. Rationalization of these catchment areas could result in more efficient use of MOH and NGO resources, potentially increasing SSFP client volume. The elimination of these redundancies (and probably gaps as well) could lower duplication among fixed facilities and perhaps also provide for heretofore lacking coordination between SSFP's satellite clinics and the GOB's new community clinics.

More systematic collaboration between SSFP and the large number of nontraditional, community-level providers (e.g., "village doctors," drug sellers, traditional birth attendants) found in all SSFP (and MOH) catchment areas would substantially increase SSFP's client volume and impact by providing more numerous, accessible, and more affordable entry points for patients situated closer to their homes. This has been an effective strategy for the Bangladesh Rural Advancement Committee and the Society Marketing Company, which have been able to improve the quality of the services these providers perform as well as referral to and coordination with the formal health system.

In addition, recent surveys[5] highlight some key areas where SSFP (and the MOH) must demonstrate greater focus and effectiveness to convince stakeholders that the Smiling Sun brand is relevant for Bangladesh and worthy of continued substantial USAID investment to improve the health of the poor.

In general, the 2008 baseline surveys indicate that there is not an appreciable difference in service utilization or quality between SSFP catchment areas (perhaps better described in 2008 as former NSDP areas) and MOH areas. (In urban areas, the market share for some activities at the satellite clinic level increased from 2005, but this was not reflected in the rural satellite clinics, possibly due to increased staff turnover for satellite clinics and CSPs as well as decreased promotional activities.) There are currently no data on whether this situation has changed under SSFP, but it merits serious SSFP attention. If there is no difference between what NGOs do and what the GOB does, there would seem to be no rationale for USAID to continue to invest in NGOs as opposed to the MOH, with its much larger national network and population coverage. Furthermore, while SSFP clinics have played a more influential role in contraception and preventive care services, they have not been very important to children's acute care.

According to DHS data, the most significant acute childhood illness in Bangladesh is pneumonia, which is the leading cause of death for children under age five. Pneumonia treatment, particularly at the community level and by the private sector, needs to be improved in Bangladesh. But ARI treatment still is not common in SSFP, and communication activities to increase awareness of the danger of childhood pneumonia and the need for prompt treatment has been insufficient. Children often receive care from nongraduate practitioners as well as MOH facilities, and CSPs encourage these patients to visit these practitioners when they may be closer than SSFP facilities. In addition to strengthening ARI treatment in its own facilities, SSFP should consider a more systematic collaboration, perhaps including training, for nongraduate practitioners. The MOH's introduction of haemophilus influenzae, type b vaccine will have very limited impact on child pneumonia in Bangladesh, where most pneumonia may be due to Streptococcus. Although SSFP will need to maintain currently high coverage of immunizations, oral hydration therapy, and vitamin A, these will have a smaller role in future mortality declines than treatment of pneumonia and newborn infections.

Demand for institutional deliveries is high in some areas, and vital clinics have both space and staff trained to perform normal deliveries. But normal deliveries are not performed in these clinics.

Approximately 85% of deliveries in Bangladesh occur at home[6] and involve assistance from paramedics and CSPs. The use of oral misoprostol for hemorrhage and loading-dose of magnesium sulfate for eclampsia should be systematically strengthened and expanded for home deliveries, given that timely referral to a facility often is not possible. Also, newborn follow-up is

[5]See 2007 Bangladesh Demographic and Health Survey (BDHS); 2008 Baseline Urban Bangladesh Smiling Sun Franchise Program Evaluation Survey; and 2008 Baseline Rural Bangladesh Smiling Sun Franchise Program Evaluation Survey.
[6]UNICEF. State of the World's Children, 2009.

very weak in SSFP, which is a major missed opportunity to reduce infant mortality. Postabortion care is essentially nonexistent, and better use could be made of CSPs to encourage four or more antenatal visits and postpartum visits within 72 hours and to manage asphyxia and neonatal infections. While apparently well-implemented where it is offered, DOTS for TB is offered in only a small number of SSFP clinics. All these interventions could be strengthened and expanded under SSFP.

On the other hand, it appears that the provision of Caesarean sections in some ultra clinics and some laboratory testing is being driven more by revenue considerations than client need. SSFP should take immediate steps to ensure that provision of these procedures is based solely on need.

At SSFP ultra clinics, the team noted that patients symptomatically diagnosed with TB were referred to district hospitals for laboratory diagnosis and, if confirmed, for treatment. While this appears to be GOB policy, the potential for patients to be lost during referral is clearly problematic, and treating these patients in SSFP clinics would increase client contacts and effectiveness of care for TB. SSFP's policy adviser should work with the MOH to allow SSFP clinics to provide DOTS service to individuals clinically diagnosed with TB.

It should be noted that while taking the measures noted above is likely to increase client volume and the impact of SSFP, this also will raise costs.

B. COVERAGE OF THE POOR

SSFP uses eight criteria to define poor clients. Approximately 26% of its clients are classified as poor, and Table 2 indicates that this percentage may be increasing (31% were poor in the first quarter of program year 3, comparing favorably to the 35% recorded by Pakistan's long-established Green Star program.[7]). In addition, Grameen Phone's contribution (Table 5) is focused on the poor and constitutes a significant addition to SSFP's outreach to this population. However, while serving poor clients is a significant emphasis of the program, its coverage of this population appears to be something it inherited from its predecessor programs.

SSFP's reported percentage of the poor served by its clinics appears to be in line with other social franchises. However, this is actually the percent of its clients who are poor, not the percent of the poor in its catchment areas that are served by SSFP—an important difference. Also, as in Section III. A. 6 above, the nature of aggregated MIS data makes it difficult to determine the extent to which the poor are provided with services responsive to their needs (e.g., for diarrheal diseases, which affect the poor more than affluent populations).

C. RANGE OF SERVICES

While USAID's contract with Chemonics mandates that the range of services increase, it does not say what this actually means and provides no specifics as to what is actually supposed to increase. USAID informed the team that the intention was to expand the number of clinics offering services (i.e., to expand the geographic range of services offered, not the number of different services themselves).

While SSFP has added only three[8] static clinics since the inception of the program, it has added 87 satellite sites. The team believes this emphasis on outreach sites as opposed to fixed facilities is appropriate, given the views of staff and stakeholders that people are more likely to use services provided near their homes. While SSFP has not increased the number of NGOs in the

[7]Agha et al. Evaluation of the Green Star Pilot Project. Washington, D.C.: Population Services International/Social Marketing, Pakistan, 1997.
[8]Communication from USAID/Bangladesh.

program, it has retained all but two of its original NGOs. In the case of the two that were dropped, SSFP transferred their two clinics to another NGO. The GOB has expressed interest in better coordinating static, satellite, and CSP activities with further improvements in Upazila Health Complexes and especially with the implementation of functional GOB community clinics.

Plans to add 10 clinics have not yet been approved by USAID, given the lack of an approved plan for using PI. USAID also has not allowed a proposed expansion of safe delivery or emergency obstetric care, limiting this to the upgrading of a few clinics to enable provision of these services. Proposed low-cost screening for cervical cancer was likewise limited to a few clinics because of legal issues related to the use of PI. (The addition of this service has been criticized given the lack of facilities for follow-up treatment). In sum, SSFP's expansion of the range of services has been quite limited. The team believes this is reasonable given the mission's desire to limit its financial exposure (the principal objective of SSFP), but constraints on the provision of safe deliveries and emergency obstetric care may have limited the impact of SSFP.

D. COMMUNICATION ACTIVITIES

Because the NGO clinics compete with an array of often more accessible MOH and private providers (including village doctors, drug sellers, traditional birth attendants), their impact will continue to be confined unless further efforts are made to increase demand for SSFP services. Behavior change communication (BCC) activities are generally insufficient in SSFP and need to be scaled up. Community-level activities, increased use of LAPM, ARI treatment, deliveries in facilities and newborn care are especially needed.

From the beginning, SSFP's principal communication emphasis has been branding and marketing to increase client volume. This emphasis on increasing the number of hopefully paying clients is consistent with the main thrust of the SSFP contract, which is to increase cost recovery. Efforts focused on specific health topics (e.g., LAPM and ARI) have been largely absent.

SSFP inherited the Smiling Sun brand (logo), which had been generated by SSFP's predecessor programs and used by them for about six years. SSFP realized its initial marketing task was to delink that brand from a perceived association with women and children only and use it to promise high-quality services for everyone. This repositioning was initially delayed because the "look" of all clinics had not yet been standardized and because SSFP felt some clinics, despite the quality improvement efforts of predecessor programs, had not yet reached desired levels of quality. Initial efforts were confined to changing the tag line from "Smiling Sun Family Health Clinic" to "Smiling Sun Clinic - for everyone."

It is not clear that the repositioning effort ever went much beyond this initial change, and actual communication activity to reposition the brand seems to have been minimal. Although SSFP had apparently intended to implement "comprehensive advertizing campaigns" to promote the brand, in practice, SSFP's brand-promotion activities were limited in scope and consisted mostly of the NGOs' local promotional campaigns implemented by the NGOs, paid for with their PI and sketchily described in their marketing plans. The use of mass media has been nearly non-existent under SSFP, and a planned television commercial to reinforce the "for everyone" message does not seem to have materialized. Furthermore, the effects of the repositioning are not apparent. SSFP clients overwhelmingly remain women and children, there are virtually no marketing efforts aimed at men, and the service mix is the same as under NSDP.

Most marketing and branding activity has been confined and its design and implementation was largely delayed until year 3 of the program, after SSFP contracted with the Bangladesh Center for Communication Programs (BCCP). BCCP has only worked for SSFP for about 14 months since then -- in three separate periods due to sub-contract approval problems with USAID. During the team's visit, BCCP's contract expired again and was pending renewal.

SSFP asked BCCP to assist only with specific, limited tasks. These were primarily inputs for the NGOs' local promotion campaigns. Activities included placement of the logo on print materials produced to promote service utilization, clinic openings, rallies in support of national health days or events, "health knowledge" contests, pilot health clubs, testimonials by loyal customers, and securing support from Imams under USAID's Leaders of Influence program with the Asia Foundation. These local campaigns were eventually supported by local market surveys, a brand manual, guidelines for clinic launches, posters, hand outs, badges for staff, community meetings and other local buzz. SSFP describes these campaigns as "low budget, wide reach" but they have not been evaluated and their reach and effects are essentially unknown. The team thinks it unlikely that these activities have had much effect, but there are no data to support this belief.

SSFP seems to lack skilled marketing or communication staff and, perhaps as a result, a systematic, strategic approach to marketing and communication. A late 2009 communications strategy done for SSFP by Howard Delafeld Inc. recommended a change in brand positioning to start in late 2010. "For everybody" was seen as lacking in emotional appeal and offering minimal benefits as a brand promise. SSFP's year 3 workplan (p. 13) suggests that the program "review and make necessary adjustments to the existing communication plan" and implement a mass-media campaign to strengthen the brand image "some time in 2010" but plans for this are uncertain. A TV drama is apparently planned as part of this campaign, but messages or scripts were not provided to the team and may not be developed.

In addition, several new local promotions recommended by Howard Delafield (Smiling Sun Moments, Smiling Sun Children's Corner, Make a Friend Smile, Sunrise Sunset to Sunrise hours for men, and others) are to be added between August 2010 and September 2011. Finally, plans for years 3 and 4 indicate an increased emphasis on children for brand promotion, perhaps responding to a 2007 survey conducted for SSFP by Capacity Building Services Group (CBSG) indicating that Smiling Sun clinics are favored for child illnesses. However, SSFP's plans for using the Delafield strategy and the CBSG study are not clear.

VI. BEST PRACTICES

The assessment team defines a best practice as an SSFP initiative that represents a significant contribution to the attainment of one or more anticipated program outcomes. The following meet that criterion:

1. In separating the development and management of the FMO (franchise) from the management of the USAID contract, SSFP established a structure for a local institution intended to become independent from SSFP after USAID support ends.
2. SSFP's successful negotiation with eight pharmaceutical companies on behalf of program NGOs to procure drugs and supplies at a 23% discount established clear value associated with the franchise.
3. With training from ICDDR, B, SSFP introduced its medical staff and more than 6,500 CSPs to the CADM, enabling its service providers to offer clients high-quality, evidence-based treatment for diarrhea.
4. SSFP's replacement of physicians as clinic managers by trained clinic administrators allows doctors to concentrate on service quality while managers oversee clinic operations and administration. This is a tested best practice in the management of a medical facility.
5. SSFP's extensive use of paramedics at 8,545 satellite clinics and more than 6,500 trained CSPs has enhanced and extended its provision of quality services.
6. In SSFP vital clinics, managers, physicians, paramedics, lab technicians and counselors work as a team in the consistent application of clinic-based TB-DOTS protocols. Although based on a sample of only four clinics, the team's review indicated that as few as 2% of patients fail to complete treatment. Those who do not appear for daily treatment are sought out at their homes to bring them back into the program.

VII. LESSONS LEARNED

1. A program that depends on collaboration with independent NGOs with disparate histories and traditions must be based on consensus rather than models imposed by donors or their contractors.

2. Expectations that a self-sufficient social franchise providing health services to the poor can be established in four years were unrealistic. No sustainable social franchise for health—of which there are very few or even none, depending on the definition—have achieved that level of success, and this shows no sign of happening under SSFP.

3. SSFP's franchise model places inordinate emphasis on cost recovery, with the unintended consequence that many staff view their primary mission as income generation. While largely a consequence of the program's design, this emphasis would appear misplaced given the underlying—and competing—goal of providing quality services to the poor.

4. To attain significant impact, a social franchise for health must be of sufficient size and reach and have a sufficient qualified staff to serve significant numbers of those people who contribute most to maternal and child mortality. It must be able to expand as the population grows. This involves considerable management expertise and cost, the latter of which, given the emphasis on serving the poor, would probably require donor or government financing.

5. Given the size of SSFP catchment areas and their overlap with MOH and private providers, SSFP probably serves less than the 13% of Bangladesh's population contained in those areas. Furthermore, 2008 urban and rural baseline surveys[9] [10] indicate that the market shares of key services are about the same for SSFP's NGOs and MOH facilities, indicating no clear advantage in supporting SSFP. This may not be commensurate with SSFPs status as USAID/Bangladesh's flagship health program.

[9] Lance et al. 2008 Baseline Rural Bangladesh Smiling Sun Franchise Program (BSSFP) Evaluation Survey. Chapel Hill, NC: Measure Evaluation , September 2009.
[10] Lance et al. 2008 Baseline Urban Bangladesh Smiling Sun Franchise Program (BSSFP) Evaluation Survey. Chapel Hill, NC: Measure Evaluation, September 2009.

VIII. RECOMMENDATIONS

Recommendation 1: SSFP should not expend further time and resources to establish the Smiling Sun Franchise.

Recommendation 2: SSFP should use the staff and financial resources currently devoted to establishing the franchise to establish an NGO Consortium instead. This consortium would be governed by the NGOs—which would own the Smiling Sun brand—establish their own priorities and cost-recovery targets based on these priorities, and liaise with donors and government to secure additional funds and technical assistance.

Recommendation 3: SSFP should continue to work with program NGOs on cost-recovery and business planning, but without the 70% target and with increased emphasis on those nonfinancial aspects of program sustainability noted in section III. A above.

Recommendation 4: SSFP should increase emphasis on conditions responsible for sizeable portions of preventable mortality (childhood pneumonia, safe deliveries, and newborn care) and long-term family planning.

Recommendation 5: SSFP should secure professional expertise to strengthen communication activities in line with a new MOH communication strategy and with renewed emphasis on family planning (especially LAPM), childhood pneumonia, safe deliveries, and newborn care.

Recommendation 6: SSFP should provide commodities used informally by NGO staff in home deliveries and track these deliveries and their outcomes in the program's MIS.

Recommendation 7: SSFP should assess the technical and management-development needs of individual staff and provide needs-based training as indicated.

Recommendation 8: SSFP should maximize NGOs' outreach capacity to the poor, with an increased emphasis on satellite clinics and CSPs. SSFP should (i) re-direct support for relatively cost-ineffective vital clinics so that these facilities operate more as hubs for increasing the number of satellite sites in underserved rural areas and (ii) link CSPs and NGO clinics more systematically with "village doctors," drug sellers, and traditional birth attendants.

Recommendation 9: SSFP should explore with the MOH the potential for NGOs to manage MOH community clinics in areas where the ministry is having difficulty opening these facilities.

Recommendation 10: SSFP should use its MIS and GIS capability to work with the MOH to conduct a service-mapping analysis to eliminate service-delivery redundancies and gaps at the sub-district (upazilla) levels and in urban areas where SSFP clinics are located.

Recommendation 11: SSFP should revise its structure and job descriptions to implement the above recommendations. The team does not believe that this requires early dismissal of any SSFP staff.

Implementation of these recommendations should be scheduled as follows.

TABLE 7. SMILING SUN FRANCHISE PROGRAM MID-TERM ASSESSMENT				
Proposed scheduling for assessment recommendations				
Recommendation	**Proposed scheduling (May 2010 - September 2011)**			
	Immediate	**May - September**	**October 2010 - September 2011**	
1. Stop support for franchise development			6 months	6 months
2. Facilitate development of NGO Consortium				
3. De-emphasize 70% cost-recovery in favor of nonfinancial aspects				
4. Assess training needs and provide training accordingly				
5. Strengthen BCC activities				
6. Maximize outreach to the poor				
7. LAPM, safe deliveries, newborn care, and childhood pneumonia				
8. Provide commodities for home deliveries				
9. Explore possibility of NGO management of community clinics				
10. Work with MOH on service-mapping and gap analysis				
11. Revise SSFP organization chart and job descriptions				

ANNEX 1. SCOPE OF WORK

Global Health Technical Assistance Project GH Tech
Contract No. GHS-I-00-05-00005-00
(Revised 3-26-10)

I. TITLE

Activity: Bangladesh: Smiling Sun Franchise Program (SSFP) Mid-Term Assessment

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

It is anticipated that the period of performance of this assessment will be o/a March 26 -June 2010. Total approximate time will be six weeks.

III. FUNDING SOURCE

Mission will use field support funds through GH Tech.

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

SSFP has completed two years of its operations out of a total period of four years. A midterm assessment of the program is due now. The purpose of the proposed assessment is to assess progress made by SSFP toward achieving results on its three deliverables. The key questions that will be asked are: (1) What is working in the SSFP; (2) What is not working in the SSFP; (3) What are the gaps or missed opportunities to improve overall performance of the program; and (4) What are the strategic options that USAID should consider for designing a follow-on service delivery activity for better achieving the programmatic and financial sustainability. The assessment also should identify how the Smiling Sun program could create effective linkages with other USAID-supported activities such as education, food security, and nutrition. The recommendations will feed into input for future investments for USAID and be included in a strategic planning process that the mission is planning for early May.

V. BACKGROUND

SSFP is a USAID-supported project that provides integrated family planning and health services in both urban and rural areas of Bangladesh through a network of 320 clinics, 8000 satellite clinic spots, and 6,500 CSPs. The program is funded through a bilateral contract that has been awarded to Chemonics International, which implements the program using sub-grants with 29 local NGOs. The program started October 1, 2001, and ends September 30, 2011.

The purpose of the program is to maintain and expand the availability of sustainable NGO health services and products in a way that reduces reliance on USAID funding for recurrent costs. This program will expand the availability of key family planning and health products and services to the poor, and continue achieving the population and health targets of the GOB and USAID. This program will establish a mechanism for the clinics to recover greater costs, achieve more operational efficiency, and increase client loads while still providing services to a segment of the poor population.

The program will promote responsible sovereignty, not permanent dependency. From the onset of this program, all NGOs will know that the grants provided by USAID for recurrent costs will decline and terminate over the next four years. At the end of the four year funding period

NGOs will no longer be dependent on USAID for recurrent costs while continuing to meet family planning and health targets.

The program has three performance objectives/expected outcomes:

Smiling Sun Franchise Network: A Smiling Sun Franchise network is in place and a local FMO is competently managing the franchise operation.

Service Delivery and Increase in Efficiency: Smiling Sun NGOs and their clinics continue service delivery with a reduction in grant money while continuing to provide quality services to the target population.

Expansion of the Network: NGO clinics, satellites, and community workers continue to expand the volume of clientele (especially for key ESD services), coverage of poor clients, and range of services available and quality of care.

SSFP Program Background

SSFP evolved from several precursor programs initiated by the GOB (the Health, Nutrition and Population Sector Program (HNPSP)) and by USAID (the Rural Service Delivery Project and the UFHP). The immediate past program was NGO Service Delivery Program (NSDP). The goal of NSDP was to "enable Bangladeshi NGOs to become technically and managerially self-sufficient in the provision of essential health services and to maximize NGO access to non-USAID funding for essential service delivery." NSDP was awarded as a cooperative agreement to Pathfinder International in 2002 and the project ended in 2006.

NSDP had four objectives:

1. Expand the range and improve the quality of ESD packages;
2. Increase the use of ESD packages, especially by the poor;
3. Increase the capacity of NGOs to sustain clinic and community-based service provision, institutionally and financially; and
4. Influence the GOB policy to expand the role of NGOs as providers of the ESD package.

Smiling Sun**,** the logo of current SSFP clinics, was widely recognized for affordable, high-quality care. This network of NGO services provided a potential nascent franchise operation. The development of a franchise through SSFP will ensure that the Smiling Sun network is managed by a Bangladeshi institution that will not depend on an external project/funding for its survival. While the idea of social franchising is new in Bangladesh, there is a long history of managing health services in the NGO sector, and certainly the capacity to quickly learn the skills needed to manage a social franchising operation. Systems were already in place through NSDP to conduct monitoring for service quality.

VI. SCOPE OF WORK

The assessment should examine several key issues, including the following:

1. To assess progress to date in meeting the deliverables of the SSFP contract and lessons learned for future USAID investments in continuing service delivery program.
    a. Discuss baseline and current service statistics in each of the technical domains. What were trends? Results achieved? Successes?
    b. What have been the project's major accomplishments in service delivery?

c. Have there been unexpected accomplishments as a result of the project's interventions?

d. What have been the lessons learned from implementation of the project?

e. What best practices have evolved from the project's intervention?

f. Has the project's monitoring and supervision system been effective in improving performance in a timely manner? If not, why not?

g. What was the impact of promotional and communication activities on service utilization from SSFP clinics? Were the promotional/communication strategy, scope, quality, and timing appropriate?

h. What have been the major constraints to accomplishing the expected results?

i. What is the nature and quality of the relationships between the SSFP and its local partner NGOs, MOH, Directorates of Health and Family Planning, and other USAID implementing partners?

j. Determine the extent to which SSFP has been successful in building NGO capacity on clinical skills to delivery maternal and child health, family planning, TB; monitoring and supervision, quality assurance of service, and financial management.

k. Quality of technical assistance provided to develop NGO understanding of the franchise concept and operations, and building capacity of NGO staff on service delivery technical areas (maternal health, child health, family planning, and reproductive health) including monitor and supervision and quality assurance.

l. According the contract, is the program on the right track? What were the challenges and successes?

2. To assess if the existing franchise model is appropriate for achieving programmatic and financials objectives as outlined in the SSFP contract in the context of Bangladesh.

a. In the context of Bangladesh, is the franchise model being implemented the best approach for achieving public health and financial objectives? What were the limitations/advantages of this model?

b. In the context of Bangladesh, what is the potential of this franchise model to meet financial objectives while providing free services to the poorest of the poor?

c. Should there by different approaches for urban and rural areas for achieving programmatic and financial sustainability?

d. Is the existing franchise model appropriate for developing NGO ownership of the program?

e. What is the NGOs' level of understanding about the franchise concepts and model? Is the current model acceptable to the NGOs?

f. Is there a management conflict between the FMO and the NGOs, which are guided by separate laws and have their own management? Do the current roles and responsibilities of FMO and NGOs support a mutually beneficial relationship? If not, what changes to be made?

g. If USAID decides to go with this franchise model, what changes should be made in the model to achieve both programmatic and financial objectives?

h. If working with NGOs is the desired future direction, what are future strategic directions in strengthening them?

i. What has been the success for SSFP to develop new strategic partners to help support the SSFP network?

3. Make recommendations for:

a. Short-term adjustments in SSFP that would improve performance in the remaining period of the agreement. Identify project components that could be scaled up or phased out for the greatest impact in the time remaining in the agreement.

b. Long-term recommendations for a sound and dynamic follow-on service delivery program that can respond to population and health sector priorities while being increasingly financial sustainable and meeting health needs of the poor.

c. What aspects of current project activities should be continued, scaled up, omitted, or added to substantially increase the impact of SSFP and enhance its financial sustainability in Bangladesh?

d. Based on the findings of the assessment, develop a draft scope of work outlining the strategies and approaches that the mission can use to design the next phase of the Smiling Sun program.

VII. METHODOLOGY

The assessment team will use a mixture of quantitative and qualitative approaches to gain insight on the impact of SSFP activities (mostly from quantitative) and the processes (mostly qualitative) that lead to those impacts. Sequential and iterative approaches will be used to integrate the mixture of methods and will seek varying degrees of dialogue between quantitative and qualitative traditions at all phases of the evaluation.

Background Materials Review

Prior to conducting field work, the team will review background materials such as annual and quarterly reports, indicators, requests for proposals, and other public documents related to the project.

TPM

The team will conduct a two-day team planning meeting (TPM) upon arrival in Bangladesh and before starting the in-country portion of the assessment. The TPM will review and clarify any questions on the assessment scope of work, draft an initial workplan, develop a data collection plan, finalize the assessment questions, develop the assessment report table of contents, clarify team members' roles, and assign drafting responsibilities for the assessment report. The TPM outcomes will be shared with USAID/Bangladesh and the health team will participate in sections of the TPM.

Key Assessment Steps

- Review program documents, including the program proposals, annual workplans and annual reports, technical and training materials, and the baseline survey (list and documents to be provided by the mission).

- Engage in a two-day TPM to discuss the assessment scope of work; agree on team member roles and responsibilities; clarify the assessment expectations of USAID; draft an assessment workplan; decide on methodology; develop tools/interview guides that will be used by the

team for key informant interviews and focus group discussions (FGDs); and draft a report outline.

- Conduct field visits to fixed and satellite clinics and to see the activities of CSPs (formerly depot holders).
- Conduct interviews with key informants from implementing partners, USAID, SSFP partner NGO management of project staff, other USAID implementing partners, and MOHFW counterparts at the national and local levels, UN agencies, donor organizations.
- Conduct FGDs with SSFP NGO managers, service providers, and clients.
- Have consultation meetings with GOB counterparts, NGO representation, and other stakeholders at the central and district levels.
- Prepare a presentation and debrief USAID/Bangladesh with main findings and recommendations.
- Prepare a draft report for the mission before departure from the country.
- Prepare a final report with an executive summary that includes main findings, conclusions, and recommendations for program improvements.

VIII. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT

An Illustrative Table of Level of Effort (LOE)

TL: Team Leader; International Consultant - 2: National Consultant - 2; AA: Administrative Assistant

Activity	Person Days Per Person				
	TL	International Consultant (n=1)	International Consultant (n=1)	Local Consultants (n=2)	AA (Logistics)
Preparations and review documents (to be provided by USAID), to occur out of country and prior to beginning the assessment.	3	3	3	3	5
Travel to Bangladesh	3	3	0	0	0
Team planning meeting (TPM); develop an assessment workplan and time line; develop interview/FGD questions including list of people to be interviewed, develop report outline.	2	2	2	2	2
Conduct key informant interviews and meetings.	4	4	4	4	2
Field visit for interviews/FGDs	5	5	5	5	3
Finalize outline for the report, team analysis of findings/consensus on conclusions and recommendations, prepare draft report and presentation.	3	3	3	3	0
Conduct debriefing(s) for USAID	1	1	1	1	0

Activity	Person Days Per Person				
	TL	International Consultant (n=1)	International Consultant (n=1)	Local Consultants (n=2)	AA (Logistics)
First draft submission of assessment report prior to team departing country (incorporate comments from briefings)	2	2	2	2	0
Draft submission of scope of work for the next phase of the Smiling Sun program prior to departing country.	2	2	2	2	2
Depart Bangladesh	2	2	0	0	0
USAID comments on draft (10 days)					
Assessment report finalization (based on mission's comments) - to take place out of country	6	4	2	2	0
Total LOE in person days	33	31	24	24	15

*A six-day work week is approved while the team is working in country.

The assessment team will consist of six members including a team leader. The team members should represent a balance of several types of knowledge related to MCH-FP service delivery in Bangladesh, as well as health financing including franchise planning and management, health services planning, and programming. In addition to technical members, the team will have a host country national to provide administrative and logistics support.

The technical team members must all have significant international health program experience. They should have some Bangladesh country or Asian regional experience, along with comparative experience in population health, health financing, health franchise, and MCH-FP service delivery in other countries or regions of the world. At least one member of the team must have Bangladesh experience and be familiar with the MCH-FP service delivery structure in urban and rural areas.

Some experience in conducting evaluations or assessments is expected of all members, and experience in developing strategies would be useful. Substantial experience in international health is required. Ability to conduct interviews and discussions in Bangla and provide accurate translations into English for at least one team member is essential. The logistic/support person should have basic knowledge about interview techniques and be able to provide translation services to other team members. All team members must have professional-level English speaking and writing skills.

A general idea of the responsibilities and necessary skills/experience of the team leader is described below. The contractor will propose additional team members to complement the skills of the leader. It is assumed that at least two team members will be host country nationals.

Team Leader—The team leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other members of the team. The team leader will develop tools for the assessment and a design plan and share it with USAID/Bangladesh. The team leader will develop the outline for the draft report, present the report and after incorporating USAID Bangladesh staff comments if necessary, and submit the final report to USAID/Bangladesh within the prescribed time line.

Skills/Experience

The Team Leader should have:

1. Advanced degree in health management, health finance, public health, or related field;
2. At least 10 years working experience in the field of international health;
3. Knowledge of health systems and health issues in Bangladesh;
4. A good understanding of USAID project administration;
5. Program planning, assessment/evaluation, and design experience;
6. Experience leading a team for international health program evaluations or related assignments; and
7. Excellent writing, communication, and presentation skills.

The leader will be responsible for overall management of the assessment including coordinating and packaging the deliverables in consultation with the other team members. In addition to the technical responsibilities outlined in the scope of work for the assignment, team leader responsibilities include:

Preparations

1. Finalize and negotiate with client for the team workplan for the assignment.
2. Establish assignment roles, responsibilities, and tasks for each team member.
3. Ensure that the logistics arrangements in the field are complete.

Management

1. Facilitate the TPM or work with a facilitator to set the agenda and other elements of the TPM.
2. Take the lead on preparing, coordinating team member input, submitting, revising, and finalizing the assignment report.
3. Manage the process of report writing.
4. Manage team coordination meetings in the field.
5. Coordinate the workflow and tasks and ensure that team members are working to schedule.
6. Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel, and transport is arranged, etc.)

Communications

1. Handle conflict within the team.
2. Serve as primary interface with the client and serve as the spokesperson for the team, as required.
3. Debrief the client as the assignment progresses, and organize a final debriefing.

4. Keep the GH Tech HQ staff apprised of progress challenges, work changes, team travel plans in the field, and report preparation via phone conversation or e-mail at least once a week.

5. Serve as primary interface with GH Tech in submission of draft and final reports/deliverables to GH Tech.

6. Make decisions about the safety and security of the team in consultation with the client and GH Tech HQ.

Direction

1. Assume technical direction lead as required to ensure quality and appropriateness of assignment and report content.

The expected timeframe for this task is April to June 2010. Specific start and end dates, travel dates, and due dates for deliverables will be determined in collaboration with USAID and based on the availability of the consultants, and a detailed time line will be produced during the team planning meeting. In addition, government officials from the Bangladesh MOH participate in this assessment. They also will accompany the assessment team to field sites and work alongside the team members.

IX. LOGISTICS

A six-day work week is authorized for the assessment team while in Bangladesh. USAID/Bangladesh will provide overall direction to the team and key documents and background materials (in advance of the team's arrival in country) for reading and help arrange the in-briefing and debriefing.

GH Tech will provide technical and administrative support including identification and fielding appropriate consultants. In addition, GH Tech will provide all logistical arrangements such as international flight reservations, country cable clearance, in-country travel, airport pick-up, lodging, and interpreters, as necessary. The administrative/logistics assistant will be hired to arrange field visits, key informant interviews and meetings, local travel, hotel, and appointments with stakeholders.

GH Tech will make provisions to support hotel accommodation, per diem, and domestic travel expenses including air travel for three government officials. These officials will accompany the assessment to field sites to facilitate consultative meetings with the local level GOB counterparts.

X. DELIVERABLES AND PRODUCTS

1. An assessment workplan and time line: During the TPM, the team will prepare a detailed workplan, which will include the report outline (deliverable #2) and methodologies (deliverable #3) to be used in the assessment. The workplan/methodology will be submitted to the mission for approval by the end of the meeting.

2. A detailed report outline: Illustrative outline presented below.

3. Questionnaire/guideline: For conducting key informant interview and FGD.

4. Debriefings: The full team will debrief USAID/B on their findings, conclusions and recommendations before leaving Bangladesh. A PowerPoint presentation for debriefing summarizing findings, conclusions, and recommendations will be prepared and distributed during debriefing. USAID will provide feedback during the briefing meeting and debriefing(s).

5. Draft Assessment Report: A synthesized draft report will at a minimum include the following: scope and methodology used; important findings (empirical facts collected by reviewers); conclusions (interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs). The final report will not be longer than 40 pages total, excluding the annexes.

   The assessment team will provide USAID/B with a draft report that includes all the components of the final assessment report prior to their departure from Bangladesh. USAID/B will provide comments on the draft report to the assessment team within 10 working days of receiving the draft report.

6. Draft Scope of Work: The assessment team will provide USAID/B with a draft scope of work outlining the strategies and approach that will guide USAID/B to design the next phase of the Smiling Sun program. This document will be provided to the mission prior to team departure form country. It should be no more than five pages not including the annexes.

7. Final Assessment Report: The final report will address the comments provided by USAID/B on the draft report. The team leader will revise the draft report and deliver an electronic copy of the final revised version to USAID/B within three weeks of receiving USAID feedback.

GH Tech will provide the edited and formatted final document approximately 30 days after USAID/B provides final approval of the report. The report will not be longer than 40 pages total, excluding annexes. GH Tech will provide five printed and an electronic file. GH Tech will make the results of its evaluations public on the Development Experience Clearinghouse and on its project web.

Note: If required, the team also will prepare a separate internal USAID memo that includes any procurement sensitive information or future directions. The intent of this memo is to provide the mission with procurement-sensitive information for their internal use that cannot be distributed or shared publically as part of the final assessment report.

Proposed Outline for Assessment Report (to be finalized during the TPM)

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ACKNOWLEDGEMENTS

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PRIORITIZED RECOMMENDATIONS

FUTURE DIRECTIONS

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Assessment Scope of Work

Annotated List of Documents Collected and Reviewed

Persons Contacted

XI. RELATIONSHIPS AND RESPONSIBILITIES

The assessment team will work under the technical direction of USAID/Bangladesh, Krishnapada Chakraborty.

USAID/Bangladesh will:

- Approve country clearances for travel.
- Provide the team with a general list of suggested organizations and contact information.
- Provide the team a proposed site visit plan (to prepare an accurate cost estimate).
- Arrange for initial communication with appropriate government and other organizations at the outset of the process.

The assessment team will be responsible for expanding the list of organizations and persons, and arranging meetings and appointments.

GH Tech will be responsible for all assignment-related expenses for their consultants incurred in carrying out this review including travel, transportation, lodging, and communication costs, etc.

XII. MISSION AND/OR WASHINGTON CONTACT PEOPLE/PERSON

Krishnapada Chakraborty, Contracting Officer's Technical Representative, Smiling Sun Franchise Program, USAID Bangladesh Office of Population, Health, Nutrition and Education.

Tel: 880-2-885 5500 x 2515
Cell: 01713-009879
Email: kchakraborty@usaid.gov

XIII. REFERENCES (PROJECT AND RELEVANT COUNTRY DOCUMENTS)

ANNEX A. List of Pertinent Documents (not inclusive)

1. SSFP contract
2. Annual workplans
3. Annual reports
4. Monitoring and evaluation plan
5. SSFP baseline survey findings
6. BCC plan
7. Training materials

ANNEX 2. LIST OF DOCUMENTS REVIEWED

SSFP MID-TERM ASSESSMENT—DOCUMENT REVIEW			
Document name	**Author**	**Date**	**Comments**
SSFP contract documents			
Smiling Sun Franchising Contract – USAID/Chemonics	American Embassy RCO	Copy not signed but assume September 2007?	Covers October 1, 2007 through September 30, 2011
Internal USAID documents			
Addressing Gaps in the Existing USAID/Bangladesh Health Program	Anuradha Bhattacharjee, et al, GH Tech	Dec-08	
TB Prevention and Control: USAID/Bangladesh Preliminary Findings and Recommendations	C. Powell, TB Team, USAID/Washington	Nov-09	PowerPoint presentation
TB-TDY Bangladesh - Final Report	C. Powell, TB Team, USAID/Washington	Nov-09	
USAID Bangladesh: Rebuilding Technical Leadership in Health	Bartlett, A., et al, USAID/Washington	Apr-09	
ADS Revisions: Gender Analysis	USAID/Bangladesh	Oct-09	
Guide to Gender Integration and Analysis	USAID/Bangladesh	Mar-10	
Subject: Review of gender issues (No title)	USAID	? 2010	
Improving People's Health in Bangladesh: Activity Approval Document 2008-2013	USAID/Bangladesh	Oct-10	Procurement-sensitive document
Subject: Summary of USAID/Bangladesh Health Initiatives	USAID/Bangladesh	Apr-10	Provided by mission as briefing document on all current USAID/Bangladesh health programs
Repositioning Family Planning and Population - Roundtable Discussion	USAID/Bangladesh	Mar-10	Outline of major points covered during roundtable
Nutrition Recommendations for USAID's Health Program	USAID/Bangladesh	2008?	
USAID Success Stories: Smiling Sun Program - Four Releases	USAID/Bangladesh	Various dates	
Semi-annual			
Annual reports			
Smiling Sun Franchising Program Annual Progress Report: October 1, 2007 - September 30, 2008	Chemonics	Oct-08	

SSFP MID-TERM ASSESSMENT—DOCUMENT REVIEW			
Document name	**Author**	**Date**	**Comments**
Smiling Sun Franchising Program Annual Progress Report: October 1, 2008 - September 30, 2009	Chemonics	Oct-09	
Project management documents			
Branding implementation plan and marketing plan	BSSP-Chemonics	October 2007?	
SSFP Year 1 workplan and life of project performance monitoring plan (PMP)	BSSP-Chemonics	Nov-07	
SSFP - Year 2 workplan	BSSP-Chemonics	Apr-09	
SSFP - Year 3 workplan	BSSP-Chemonics	Dec-09	Note earlier version dated October 2009
Project financial documents			
Program Income Plan (2009 -2011)	SSFP	Jan-10	
FMO-related documents			
Trust Deed of Smiling Sun Health Service Trust	SSFP	Nov-08	
Trip reports			
Bangladesh BCC Consultation	E. Fox	Oct-09	
Summary of Behavior Change Communication Roundtable Assessment	E. Fox	Oct-09	
Review USAID Population Assistance Program	*Bowers, J. et al*	*Apr-10*	*PowerPoint presentation summarizing major points of consultancy*
Surveys and health background			
2008 Baseline Rural Bangladesh Smiling Sun Franchise Program (BSSFP) Evaluation Survey	P. Lance, et al, MEASURE Evaluation and ACPR	Sep-09	
2008 Baseline Urban Bangladesh Smiling Sun Franchise Program (BSSFP) Evaluation Survey	P. Lance, et al, MEASURE Evaluation and ACPR	Sep-09	
Bangladesh Demographic and Health Survey (BDHS) 2007 - Summary	Al-Sabir, A., National Institute of Population Research and Training (NIPORT)	Mar-09	Summary of BDHS - 2007
Bangladesh Demographic and Health Survey (BDHS) 2007 - Full Report	MACRO, MITRA, and NIPORT	Mar-09	
Health Sector Profile - Version 1	World Bank, Mott McDonal Ltd.	Feb-10	Preliminary Report
GOB Reports			
Bangladesh Population Policy	MOH and Family Welfare	Oct-04	

SSFP MID-TERM ASSESSMENT—DOCUMENT REVIEW			
Document name	**Author**	**Date**	**Comments**
Revised Programme Implementation Plan: July 2003-June 2010	MOH and Family Welfare - Planning Wing	Nov-05	
Policy Dialogue	HNPSP	May-09	
Communications material			
1. Capacity building	SSFP		
1.1 Manual and handout for branding and service promotion	SSFP	Nov-08	
1.2 Manual on marketing promotions for TOT	SSFP	Jul-09	
1.3. Manual on branding	SSFP	Jul-09	
1.4 Guidebook on community mobilization	SSFP	Jan-10	
1.5 Manual on marketing planning	SSFP	Jan-10	
1.6. Training on reproductive tract and sexuality transmissible infections: Handbook for Trainees	SSFP/National Protocol	N/A	
1.7 Promotional materials users' guidelines	SSFP	Feb-09	
1.8 Guidebook on brand	SSFP	Jul-09	
1.9 Guidelines for performance-based incentives (ANC, CDD, ARI)	SSFP	Aug-09	
1.10 Guidelines for incentive program plan for quality of care and sustainability for maternal health	SSFP	Aug-09	
1.11 Guidelines on clinic launching program		N/A	
2. Campaign materials			
2.1 Guidelines for campaigns	SSFP		
2.1.1. Antenatal care	SSFP	May-09	
2.1.2 Postnatal care	SSFP	May-09	
2.1.3 Control of diarrheal diseases	SSFP	Jun-09	
2.2. Quarterly newsletter	SSFP		
2.3. Promotional films (TV commercial/spot)	SSFP	Mar-10	
2.3.1. Prevention of diarrhea (duration: 60 secs)			
2.3.2. Antenatal care (duration: 60 secs)			
2.4. Posters		Feb-10	
Clinic promotion	SSFP		
ANC: Ensure four visits	SSFP		

SSFP MID-TERM ASSESSMENT—DOCUMENT REVIEW			
Document name	**Author**	**Date**	**Comments**
CDD: Prevent diarrhea (Hand washing with soap; give zinc along with ORT; use water purifying tablets)	SSFP		
Infection Prevention (4 topics)	SSFP		
Hand washing	SSFP		
2.5. Brochures			
ANC and PNC	SSFP		
Diarrhea prevention and use of zinc	SSFP		
Cervical and breast cancer screening	SSFP		
Role of men in maternal and neonatal care	SSFP		
Polio and measles vaccinations for National Immunization Day	SSFP		
Imam sensitization under Leaders of Influence Program	SSFP		
2.6. Quality service delivery			
2.6.1 Job aids:			
Flip book on child health (including ARI, AFP/AFI)	SSFP		
Flip book on maternal health (including FP, cervical, and breast cancer screening)	SSFP		
2.7. Referral slips for community health clubs (under pilot)	SSFP		

ANNEX 3. SSFP MID-TERM ASSESSMENT LIST OF PERSONS CONTACTED

Name	Organization	Position	Location	E-mail or Telephone Number	Date
List of Respondents Interviewed					
USAID Bangladesh					
Khadijat Mojidi	USAID/Bangladesh	Office Director, OPHN	Dhaka	kmojidi@usaid.gov	4/4/2010
Krishnapada Chakraborty	USAID/Bangladesh	Project Management Specialist	Dhaka	kchakraborty@usaid.gov	4/4/2010
Kanta Jamil, PhD	USAID/Bangladesh	Results Monitoring and Evaluation Advisor	Dhaka	kjamil@usaid.gov	4/4/2010
Marcos Arevalo	USAID/Bangladesh	Senior Family Planning Advisor	Dhaka	marevalo@usaid.gov	4/4/2010
M. Eileen Devitt	USAID/Bangladesh	Financial Controller	Dhaka	mdevitt@usaid.gov	4/4/2010
Mahmuda Rahman Khan	USAID/Bangladesh	Program Officer - Gender Advisor	Dhaka		4/4/2010
M. Enamul Huq	USAID/Bangladesh	OFM, Supervisory Financial Analyst	Dhaka		4/4/2010
Kaiser Parvez Ali	USAID/Bangladesh	OAA, ASA Specialist	Dhaka		4/4/2010
Rafiqul Islam	USAID/Bangladesh	OAA, ASA Specialist	Dhaka		4/4/2010
Tofayel Alain	USAID/Bangladesh	Program Management Specialist, Food Security	Dhaka		4/4/2010
Umme Salma Jahan Meena	USAID/Bangladesh	Program Management Specialist	Dhaka		4/4/2010
Tara Simpson	USAID/Bangladesh	Health Officer	Dhaka		4/4/2010
Valerie Smith	USAID/Bangladesh	Deputy Controller	Dhaka		4/4/2010

Name	Organization	Position	Location	E-mail or Telephone Number	Date
Md. Nasiruzzaman	USAID/Bangladesh	PHNE	Dhaka		4/4/2010
Sharmina Sultana	USAID/Bangladesh	PHNE	Dhaka		4/4/2010
GOB Officials					
Professor Dr. Shah Munir	Directorate of Health Services	Director General of Health Services	Dhaka		
Dr. ABM Jahangir Alam	Director of Primary Health Care	Minister of Health and Family Welfare (MOHFW)	Dhaka		4/5/2010
Mr. M. Qayyum	Directorate of Family Planning: MOHFW	Director General	Dhaka		4/6/2010
Dr. Jafar Ahmed Hakim	Directorate of Family Planning: MOHFW	Director(MCH Services) & Line Director(MCRH)	Dhaka	jahdmch@hotmail.com	4/6/2010
Dr. Md. Saikhul Islam Helal	Program Preparation Cell, MOHFW	DGHS Representative	Dhaka	saikhul@yahoo.com	04/10/10
Dr. Fatema Begrum	Upazilla Health Center	Upazila Health & Family Planning Officer	Jaintapur		04/11/10
Md. Ismail	Upazilla Health Center	Health Inspector	Jaintapur		04/11/10
Md. Kutub Uddin	Director, Family Planning	Sylhet Div MOHFW	Sylet		4/12/2010
Dr. Md. Abdul Munim Chowdhury	Director, Health Services	Sylhet Div MOHFW	Sylet	1711823991	4/12/2010
Collaborating Agencies					
Md. Ali Reza Khan	Social Marketing Co.	Managing Director, In-Charge	Dhaka	a.reza@smc-bd.org	4/7/2010
Toslim Uddin Khan	Social Marketing Co.	Head, Research and MIS	Dhaka	toslim@sms-bd.org	4/7/2010

Name	Organization	Position	Location	E-mail or Telephone Number	Date
Kamal Hossain	Save the Children	Program Director	Dhaka	kamalh@savechildren.org	4/7/2010
Dr. Ishtiaq Mannan	Save the Children	Chief of Party (MCHIP)	Dhaka	ismannan@savechildren.org	4/7/2010
Russell Pepe	Leaders of Influence (LoI): The Asia Foundation	Chief of Party	Dhaka	rpepe@asiafound.org	4/8/2010
Mir Junayed Jamal	Leaders of Influence (LoI): The Asia Foundation	Program Oficer	Dhaka	jjamal@asiafound.org	4/8/2010
Dr. A.J. Faisal and Mayer Hashi staff	Director	Engender Health	Dhaka		4/13/2010
	Save the Children	Program Officer, PROTEEVA	Dhaka		4/8/2020
Dwijen Chandra Debnath	Save the Children	Program Oficer, MaMoni Field Operations	Sylhet	ddebnath@savechildren.org	4/11/2010
SSFP Staff					
Juan Carlos Negrette	SSFP	Chief of Party	Dhaka	jnegrette@smilingsunhealth.com	4/6/2010
Dr. Setara Rahman	SSFP	Health Specialist	Dhaka	Setara@smilingsunhealth.com	4/6/2010
Md. Mozzammel Hoque	SSFP	Senior Policy Advisor	Dhaka	Mozzammel@smilingsunhealth.com	
Md. Anwar Hossain	SSFP	Bus. Planning and Marketing Research Specialist	Dhaka	AnwarH@smilingsunhealth.com	4/6/2010

Name	Organization	Position	Location	E-mail or Telephone Number	Date
Abdul Motin	SSFP	Finance/Management FS and Monitoring Specialist	Dhaka	AbdulM@smilingsunhealth.com	4/6/2010
Arefin Amal Islam	SSFP	Health Officer	Dhaka	Arefinl@smilingsunhealth.com	4/6/2010
SSFP Board Members					
Faridur Reza Sagar	Impress Telefilm Ltd.	Managing Director	Dhaka	frs@channelitv.net	4/8/2010
Tania Amir	Amir and Amir Law Ass.	Barrister at Law	Dhaka	amir@bdmail.net	4/8/2010
Rokia Afzal Rahman	Chair, SSHS Board of Directors		Dhaka	rokiarahman@hotmail.com	4/8/2010
A.M. Ahmedullah	FAIR Foundation	Franchisee Representative	Khulna	1711-964619	4/8/2010
SSFP NGOs					
Sultan Selim Ahmed	Jatiyo Tarun Sangho(JTS)	Project Director	Dhaka	jts@agni.com	4/6/2010
S.M.Al-Hussainy	Swanirvar, Bangladesh	Chairman	Dhaka	husainy@boi-online.com	4/6/2010
Rashed Reza Chowdhury	PSTC	Project Director	Dhaka	pstc@bangla.net	
Ln. C.S.K Siddique	Samanila Unnayan	Executive Director	Chittagong	1719901952	4/7/2010
M.A. Rahim	SUPPS	President	Sreemangal	supps07@yahoo.com	4/7/2010
Md. Fazlul Haque	JTS	Chairman	Dhaka	jts@agni.com	4/7/2010
Iftekhar Uddin Chowdhury	Image	Chairman	Chittagong	chowiu@yahoo.com	4/7/2010
Rtn. Belal Ahmed	SSKS	General Secretary	Sylhet	ssks@sol-bd.com	4/7/2010

Name	Organization	Position	Location	E-mail or Telephone Number	Date
Nargis Sultana	CWFD	Project Director	Dhaka	cwforssfp@gmail.com	4/6/2010
Halbibur Rahman	BAMANEH	Project Director	Dhaka	bamaneh.HR@gmail.com	4/6/2010
Ranjit Kumar Roy	PSF	Project Director	Dhaka	PSF@bangla.net	4/6/2010
Md. Rafiqul Islam	Swanirvar Bangladesh	Project Director	Dhaka	sbnsdp@yahoo.com	4/6/2010
A.M.Ahmedullah	FAIR Foundation	President	Khulna	01711-964619	4/6/2010
M. Syedur Rahman	SSKS	Project Director	Sylhet	sskssfp@gmail.com	4/10/2010
Masudur Rahman	SSKS	Project Manager			4/10/2010
Dr. Golam Mostafa	SSKS	Monitoring Officer			4/10/2010
Abdur Rahim	Shimantik	Project Director	Sylhet	rahim525@gmail.com	4/11/2010
Dr. Joynal Uddin	Shimantik	Monitoring Officer	Sylhet		4/11/2010
NGO Health Service Staff					
Foujia Yasman	PSTC (Dhalpur Static Clinic)	Paramedic	Dhaka		4/10/2010
Abul Hasnat	PSTC (Dhalpur Static Clinic)	Clinic Manager	Dhaka		4/10/2010
Taposhi Gosh	PSTC (Dhalpur Satellite Clinic, Wings International School)	Satellite Paramedic	Dhaka		4/10/2010
Dr. Sajia Afreen	PSTC (Dhalpur Static Clinic)	Medical Officer	Dhaka		4/10/2010
Farida Begum	CWFD Smiling Sun Ultra Clinic, Gazipur	Clinic Manager	Gazipur		4/11/2010
Nurul Amin	CWFD Smiling Sun	Clinic Manager	Pallabi	csfdssfp@gmail.com	4/12/2010

Name	Organization	Position	Location	E-mail or Telephone Number	Date
	Vital Clinic, Pallabi				
Narid Frahana Chowdry	CWFD Smiling Sun Vital Clinic, Pallabi	Medical Services Officer-in-charge	Pallabi		4/12/2010
Dipu	CWFD Smiling Sun Vital Clinic, Pallabi	Paramedic	Pallabi		4/12/2010
Marzia Sultana	CWFD Smiling Sun Vital Clinic, Pallabi	Laboratory Technician	Pallabi		4/12/2010
Motaher Hossain	SSKS Smiling Sun Ultra Clinic	Clinic Manager	Sylhet		4/12/2010
Dr. Sonea Parveen	SSKS Smiling Sun Ultra Clinic	Medical Officer	Sylhet		4/12/2010
Lyon Bishwas	SSKS Smiling Sun Vital Clinic	Clinic Manager	Moulvibazar		4/10/2010
Madhuri	SSKS Smiling Sun Vital Clinic	Counselor	Moulvibazar		4/10/2010
Khodeja	SSKS SS Fixed Satellite Clinic	Paramedic	Moulvibazar		4/10/2010
Syed Abul Hasnat Jewel	Shimantik SS Vital Clinic	Clinic Manager	Jaintapur		4/11/2010
Meherunnesa	Shimantik SS Vital Clinic	Paramedic	Jaintapur		4/11/2010
Naznin Nahar	Shimantik SS Vital Clinic	Counselor	Jaintapur		4/11/2010
Rita Laila	Shimantik SS Mobile Satellite Clinic	Paramedic	Umonpur		4/11/2010

Name	Organization	Position	Location	E-mail or Telephone Number	Date
Jashimuddin	Shimantik SS Mobile Satellite Clinic	Clinic Aide	Umonpur		4/11/2010
Halima Begum	Shimantik SS Mobile Satellite Clinic	CSP	Umonpur		4/11/2010
Others					
Faruque Ahmed	Brac	Director, Brac Health Programme	Dhaka	faruque.a@brac.net	4/12/2010
Dr. Shams El-Arifeen	ICDDR,B	Senior Scientist, Child Health Unit	Dhaka	shams@icddrb.org	4/5/2010
	Urban Primary Health Care Project (ADB)	Director and staff	Dhaka		4/8/2010
Md. Shajahan and staff	Bangladesh Center for Communication Programs	Director	Dhaka		4/11/2010
Consultants					
Jerry Powers	GH Tech	Team Leader, FP Evaluation	Dhaka		04/04/10
Elizabeth Ravenholt	GH Tech	FP Evaluation	Dhaka		04/04/10
Gary Lewis	GH Tech	FP Evaluation	Dhaka		04/04/10
Md. Alaladin	GH Tech	FP Evaluation	Dhaka		04/04/10
Total Respondents	**91**				

For more information, please visit:
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