Quarterly Progress Report

First Quarter, FY 2006

(October - December 2005)

Mrs. Mufaweeza Khan, founder of CWFD, in the waiting room of the Rayer Bazar clinic. Founded in 1976, this clinic was CWFD's first and is located in an urban slum in Old Dhaka. Mrs. Khan was honored in New York in November, 2005 as one of Time Magazine's "Heroes of Global Health."

NSDP

NGO Service Delivery Program

USAID
FROM THE AMERICAN PEOPLE

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The **BMS** clinic in Chanmari began offering safe delivery service in May, 2005. On December 27th, the staff there performed their 76th delivery. Pictured are proud parents, Sukhen and Mukta Rani, with the clinic's aide Parul (left) and safe delivery paramedic Anjuman Ara (right).

The NSDP NGOs

BAMANEH
Bandhan
BMS
CAMS
CWFD
CRC
DIPSHIKHA ANIRBAN
Fair Foundation
FDSR
GKSS
IMAGE
JTS
Kanchan Samity
KAJUS
MALANCHA SEBA
MMKS
NISHKRITI
PKS-Khulna
PKS-Jessore
Proshanti
PSTC
PSF
PSKS
SGS
SHIMANTIK
SOPIRET
SSKS-Sylhet
SSKS-Moulvibazar
SUPPS
SUS
Swanirvar
TILOTTAMA
UPGMS
VFWA
VPKA

Pathfinder International leads the following team of NSDP partner organizations:

- Bangladesh Center for Communication Programs (BCCP)
- CARE Bangladesh
- EMG (Emerging Markets Group)
- IntraHealth International Inc.
- Research Triangle Institute (RTI)
- Save the Children (USA)
- University Research Co., LLC. (URC).

List of Acronyms

ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
BAMANEH	Bangladesh Association for Maternal and Neonatal Health
BCCP	Bangladesh Center for Communication Programs
BMS	Bangladesh Mohila Shangha
C-IMCI	Community Integrated Management of Childhood Illness
CWFD	Concerned Women for Family Development
CYP	Couple Year Protection
DGFP	Director General of Family Planning
DGHS	Director General of Health Services
DH	Depotholder
DOTS	Directly Observed Treatment Short course
DPT	Diphtheria Part sis Tetanus
EC	Executive Committee
EPI	Expanded Program of Immunization
FDSR	Family Development Services and Research
FP	Family Planning
GIS	Geographical Information System
GoB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
HNPSP	Program
HQ	Headquarters
HR	Human Resource
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
IMCI	Integrated Management of Childhood Illness
IPC	Interpersonal Communication
IUD	Intra Uterine Device
JTS	Jatiya Tarun Shangha
KAJUS	Kalikapur Juba Shangsad
M&E	Monitoring and Evaluation
MIS	Management Information System
MMKS	Madaripur Mohila Kallyan Sangstha
MOCAT	Modified Organizational Capacity Assessment Tool
MOHFW	Ministry of Health and Family Welfare
NIPHP	National Integrated Population and Health Program
NSV	Non-Scalpel Vasectomy
PAC	Post Abortion Care

PD	Project Director
PKS	Paribar Kallyan Samity
PLTM	Permanent and Long Term Method
PM	Project Manager
PNGO	Partner NGO
POT	Program Operations Team
PRA	Participatory Rapid Appraisal
PSF	Polli Shishu Foundation
PSTC	Population Services and Training Centre
QI	Quality Improvement
QMIS	Quality Management Information System
QMS	Quality Monitoring and Supervision
RDF	Revolving Drug Fund
RTI	Research Triangle Institute
STI	Sexually Transmitted Infection
SUS	Samannita Unnayan Sangstha
TB	Tuberculosis
UNICEF	United Nations Children Fund
UPHCP	Urban Primary Health Care Program
URC	University Research Corporation
USAID	United States Agency for International Development

Introduction: Striving for Quality throughout the Smiling Sun Network

The introductory section of this report focuses on efforts to improve the quality of clinical services. The innovative Smiling Sun TV drama, *Enechhi Surjer Hashi*, (ESH) was launched in 2005, making it a significant year for NSDP's efforts to change health-seeking behavior, but demand generation activities like ESH only succeed in getting customers to make that crucial first visit to a Smiling Sun clinic. It is the quality of care they receive once inside the clinic's doors that will ensure their return for subsequent care. And although much is being done to bolster NGO sustainability, only the provision of high-quality health care will lead to an acceptable flow of clients, including the poor. If the quality of the health care services delivered by program providers falls short, other efforts to generate demand, diversify revenue and improve sustainability will have been in vain. Thus while working hard to increase demand for services and to bolster NGO sustainability, NSDP continues to emphasize the fundamental importance of providing high-quality care.

A **CWFD** paramedic counseling a nursing mother about methods of family planning

NSDP follows a holistic approach to quality improvement, focusing on improving the quality of skills Smiling Sun providers possess and improving the quality of the clinical services they provide. A range of NSDP activities address and improve quality in each area sometimes simultaneously and independently of each other but the end result is a general program-wide improvement in quality.

1. Improving the Skills of Clinical Staff

a) Decentralized Clinical Training

NSDP's decentralized training represents a novel approach to improving the skills of clinical staff. In Bangladesh there is a severe shortage both of trained providers and of government facilities in which to train them. NSDP's clinical training follows a fairly unique approach for Bangladesh: traditionally, new skills are taught by full-time, professional trainers who would themselves be taught a particular new clinical skill, and who would then go into classroom settings to teach others. But these trainers might not be expert practitioners in the skills they teach. NSDP's decentralized training follows the reverse approach. Clinical providers with long-standing, practical experience in the application of the clinical expertise to be shared with others are given teaching skills. They then become trainers and can share their clinical skills with trainees at clinical training sites. The NSDP approach, which is applied to both on-the-job training as well as group-based training is much more cost-effective and more successful in teaching clinical skills since the medical staff being trained are able to practice their new skills almost immediately in clinical settings similar (or identical) to their own. Newly trained staff then share their skills in cascade fashion, needing only limited supervision.

This decentralization of clinical skills training is also important since it is the NGOs themselves, (not NSDP headquarters staff), which now assume responsibility for training new providers. Clinical training sites have been established at clinics managed by some of the stronger NGOs. The choice of location for a clinical training site depends on several factors, including the availability of a suitable facility, and of skilled staff. But those NGOs which have successfully established training sites are then able to manage training sessions themselves. As one NGO trains providers from another NGO, inter-NGO cooperation improves and this contributes to sustainability. When the program ends the NGOs will be able to maintain these initiatives and the ability to maintain a high quality, decentralized clinical training site should make NSDP's partner NGOs attractive to future projects.

b) Mystery Clients

"Mystery Clients" --staff from one Smiling Sun clinic who masquerade as clients seeking RTI/STI, ANC, LCC and family planning service --help improve the interpersonal and counseling skills of service providers and provide an unbiased assessment of provider skills. NSDP developed different hypothetical "cases" for this role-play and provided orientations to the "actors." Of the nine mystery clients deployed in the first phase of this intervention, seven were treated well, but two were not. Although NSDP had initially expected the mystery clients might have been discriminated against as (supposedly) poor women in fact they were well-treated. The first visits focused on adequate counseling and clinical care, especially involving STI services. The visits proved very useful, and the clinics involved in the pilot strongly recommended that it be extended elsewhere.

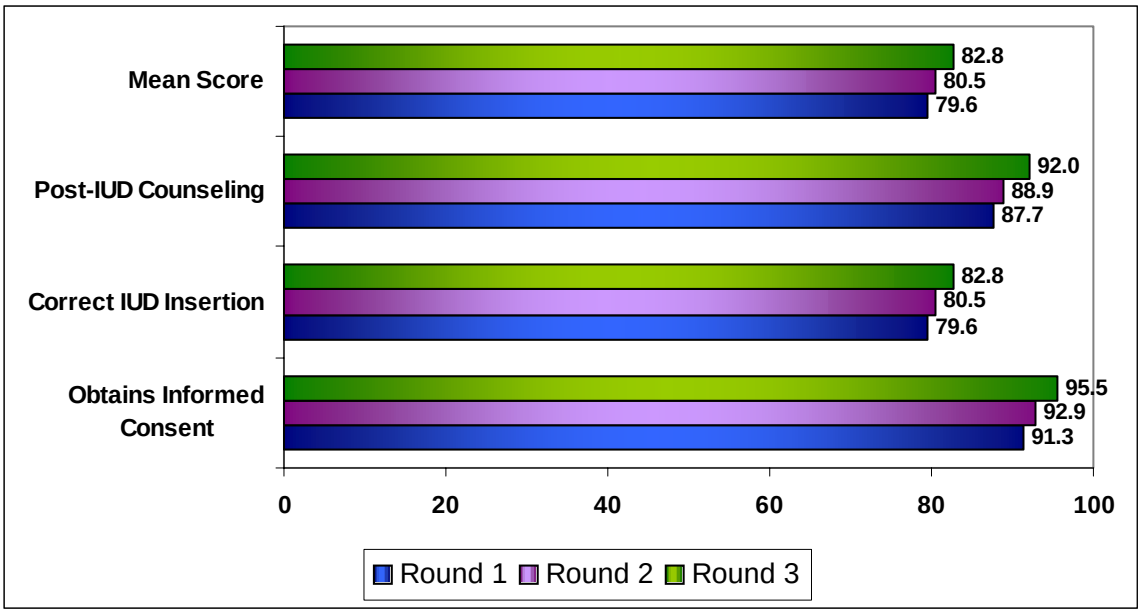
RTI/STI Treatment and HIV/AIDS Prevention: Smiling Sun NGOs Become "Partners of Choice"

There are 68 Smiling Sun clinics serving communities at high risk for sexually transmitted diseases: sex workers, drug users, rickshaw pullers, truckers, and male homosexuals. NSDP's work in improving clinical governance has helped ensure that caregivers provide non-stigmatized, quality service. All staff at the 68 clinics, which are widely dispersed throughout Bangladesh, have been oriented on STI management and these clinics are now becoming nationally recognized as providers of high-quality care. Random clinical audits employing a checklist to assess services are routinely conducted to ensure service quality. Paramedics are assessed by clinic managers who are in turn assessed by NGO headquarter staff. Two audits take place at each clinic every quarter --one for the doctor and one for a clinic paramedic. Clinic staff have undergone a ½-day training course on RTI/STI case management, and every 6 months staff receive refresher training. Client satisfaction surveys are used to assess quality of service, perception of service quality, and provider knowledge. The survey results are useful in gauging our clients' knowledge on STI/RTI issues, and in developing strategies. As a result of these efforts, program NGOs have established a national reputation for themselves as partners-of-choice in the field of RTI/STI. Now many organizations, including CARE Bangladesh, Save the Children, UNICEF, FHI, and the Population Council are contracting Smiling Sun clinics to provide RTI/STI services, since Smiling Sun clinics possess unparalleled expertise. Forming partnerships with these organizations ehances NGO sustainability.

c) Standardizing Provider Skills

Sometimes caseloads for services such as IUD insertion, for example, are too low to maintain clinical skills, which therefore tend to decline over time. NSDP works with partner NGOs to develop a cascade method of standardizing provider skills. The NGO monitoring officers, who also conduct semi-annual Quality Monitoring and Supervision (QMS) visits, now monitor and "standardize" clinical skills relevant to family planning and other reproductive health services, infection prevention and counseling. NSDP regional staff work with monitoring officers to ensure that clinical providers offer reproductive health services using only the most up-to-date knowledge and skills, meeting standards established by WHO and other international agencies. Standardization is a cost-effective way for NSDP and Smiling Sun NGOs to update minor gaps in providers' skills, without having to send staff for retraining. Patterns of weakness in clinical skills are identified and remedied by making changes in the basic training curricula. The level of skills exhibited by new clinical staff is assessed, and when necessary new staff are provided with additional training so that they meet the "Smiling Sun" standard. Again, when the project ends the NGOs will be able to sustain this approach to maintaining clinical quality through routine assessment and "realignment" of basic skills.

In early 2004, when Round 1 QMS scores showed poor scores on IUD insertion skills, NSDP established standardization and cascade protocols for RH, including IUD skills. Proficient providers were used to demonstrate and provide on-site mentoring to develop and improve the skills of new staff members. The QMS Round-3 data (October 2005) show that the improvement in provider skills for IUD service was greater between Rounds 2 and 3, than between Rounds 1 and 2.



2. Improving the Quality of Clinical Care

a) Scoring QMS

The QMS scoring system traditionally used is of greater value when used to assess quality of services provided between clinics within an NGO, rather than between NGOs because it is a self-assessment system. Inevitably, in the absence of an objective "yardstick" some NGO scores have appeared inflated relative to those of others. However, the QMS is a useful tool to monitor and address factors affecting the quality of clinical services provided at the clinics managed by each NGO.

NSDP is now implementing a process for validating scores across all NGOs in the network. A randomly selected sample of 40 clinics were chosen and the self-assessment scores assigned to each of those clinics by their own NGOs are being compared to scores they have received from an outside, or "third party" rater. When these clinics have been impartially rated, NSDP will be able to assign a scoring coefficient to the NGO-provided scores. Some deflation of some NGOs' scores is expected. NSDP intends to conduct this "scoring the scores" procedure only once. The validation coefficient will be applied to the aggregate QMS scores; the adjusted QMS score should represent a "true" aggregate QMS score were the process to be carried out externally, instead of by self-assessment.

b) Sentinel Indicators Used to Assess Quality of Care

NSDP is also introducing a "program audit" of clinical quality intended be more cost-effective and less time consuming than past QMS rounds. In the past, a team of NGO evaluators visit clinics and spends approximately two days both assessing quality and offering TA to make improvements where necessary.

The new procedure being introduced is a "program audit" which uses sentinel indicators to indicate quality in important areas of service. Program audits will be unannounced "surprise" visits and should thus be able to capture the quality of clinical practices routinely applied. Only one to two clinics per NGO will be visited on a semi-annual basis, and the results of the program audit will apply to the whole NGO, not just the clinics concerned. Because the audits are to be unannounced, NGOs will not have the ability to prepare for the evaluation team, and will therefore have an incentive to maintain quality at all clinics all the time. An NGOs' funding may be temporarily withheld if an audited clinic fails to meet standards, and their "quality action plan" fails to meet re-audit standards (at another randomly selected clinic, also unannounced). This element of the program is a significant change, since the existing QMS contains no disincentive to prevent inflating scores. The program audit system has been designed to give NGOs a financial incentive to comply with quality standards, with a minimum amount of disruption to either the NGOs' or NSDP's regular work.

The indicators used in the program audit procedure are carefully chosen clinical measures which will represent overall clinical quality. For example, when assessing the quality of a

clinic's immunization program, the sentinel indicator used may be the temperature of the refrigerator in which vaccines are stored. Indicators such as this are chosen to represent a whole range of tasks relevant to provision of a service such as immunization, which must all be carried out adequately in order to provide high-quality care. NSDP, aware that the indicators chosen will be those aspects of a clinic's program specifically targeted for improvement by NGO management, is analyzing QMS data to see which areas in particular are most in need of improvement. Sentinel indicators will be chosen to direct the focus of NGO management toward improving those areas. Indicators will be changed between program audits in order to ensure that NGOs are not able to "study for the test."

TB: Results Achieved by Improving Programmatic Quality

One example of an area in which efforts to improve quality are succeeding is NSDP's work in controlling TB. Although in the first two years of the program Smiling Sun NGOs did not comply with the National Tuberculosis Program (NTP) quality standards, in the past year NSDP's TB program has made excellent progress in several areas. Following a Performance Needs Assessment in 2004, in which NGO and NSDP staff identified the barriers to high quality service provision and developed action plans to improve quality of services, Smiling Sun NGOs made a commitment to both improving the quality of existing clinical services as well as expanding community outreach to improve case detection and treatment rates. For example, CWFD now manages one External Quality Assurance center (EQA), approved by the GoB and which is now part of the National Tuberculosis Program Quality Control system. EQAs cross-check results from microscopy centers --lab slides are checked and cross-checked by EQAs, so human and technological errors can be detected and corrected. The CWFD EQA is one of only 22 approved by the government --a significant achievement.

Over the past year Smiling Sun NGOs have made unusually rapid progress in improving the case detection rate in urban areas. The case detection rate, which measures the percentage of those likely to be infected with TB who have actually been identified, increased from 30% in 2004 to 43% in 2005. This means that NGO staff are doing a much better job working with communities to identify and treat people infected with TB. Dhalpur Clinic of PSTC tested almost 150 suspected TB patients in December 2005; most other Smiling Sun clinics test 10-20 people per month.

NSDP also assists Smiling Sun NGOs to further increase case detection and treatment, by expanding community-based service. In the near future, NSDP NGOs will offer small stipends to volunteers who will help educate the public on TB control and refer those with symptoms to the closest clinic for treatment. In addition, NSDP is working with Smiling Sun NGOs to recruit community providers, including pharmacists and GPs, to provide DOTS. Treating TB in urban areas is generally difficult because patients tend to be mobile, and drop-out rates have been high. Through community treatment centers, NGOs will make DOTS both geographically more accessible to the poor, as well as ensuring that treatment is available throughout the day. For example, TB is high in garment factories, because of very poor air quality --roughly 4% of garment workers are infected. Many garment workers work from 7:00 am to 10:00 pm, but DOTS is only available from 9:00 am to 5:00 pm. So involving of pharmacies, which are open for business beyond these times, will help increase treatment rates.

OBJECTIVE 1: EXPAND THE RANGE AND IMPROVE THE QUALITY OF THE ESSENTIAL SERVICES PACKAGE (ESP) PROVIDED BY NGOS AT THE CLINIC AND COMMUNITY LEVELS

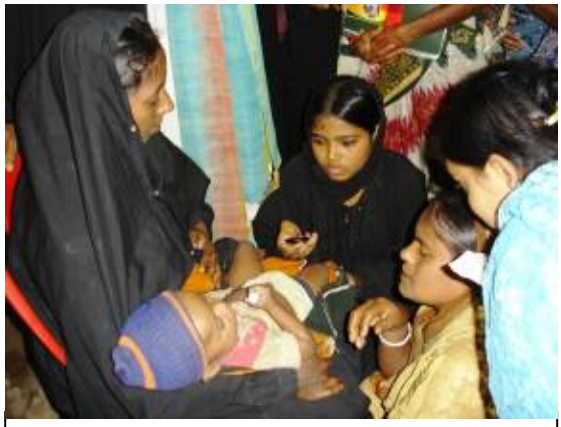
1. Community-IMCI and Facility-based IMCI Programs Strengthened

a) Refresher Training on C-IMCI for Depotholders

Refresher training on Community Integrated Management of Childhood Illness (C-IMCI) was organized for depotholders from 7 clinics. 168 depotholders were trained in December 2005. The Civil Surgeon and Deputy Director of Family Planning from Cox's Bazar noted that involvement of depotholders in managing care for children under 5 suffering from pneumonia, diarrhea and malnutrition should contribute to achieving the Millennium Development Goals.

With C-IMCI Training a Depotholder Provides Vital Care

On September 25, in Kalma, 25-day old Mim developed very rapid breathing. Her parents went to Smiling Sun depotholder, Nurjahan Begum, who works with the **Swarnivar** clinic in Lalamohon, Bhola. Nurjahan had received C-IMCI training and recognized Mim's symptoms. She referred the family to the local Upazilla health Complex, and Mim recovered. The depotholder noted that the C-IMCI training she had received helped improve her knowledge and skill in counting newborns' breathing rate, identifying dehydration, treatment of pneumonia and recognizing other danger signs including malnutrition.



Depotholders from the **FDSR** Teknaf clinic use an ARI timer to measure a newborn's respiration rate.

b) Facility-based IMCI Follow-up Training for NGO Supervisors

IMCI training includes provision for both initial skill acquisition and skill reinforcement for the clinical service providers working at facilities. However, these providers may be reluctant to begin using these skills when they first see children in their clinics; they often need help to transfer to their clinics what they have learned in the training course. Follow-up visits help reinforce training and assist with problem solving during the implementation of IMCI. Ideally, at least one follow–up visit should be conducted after the initial skill acquisition through a formal course of training.

In late November 2005, and with help from Ad-din Hospital and the GoB IMCI desk, NSDP held a 5-day training course on follow-up for 23 NGO supervisors with medical backgrounds who had also received the basic 11-day IMCI training. NGO supervisors are now capable of

conducting follow-up visits, including the follow-up for IMCI, using standardized procedures and tools to reinforce provider skills.

At the workshop NGO supervisors were also encouraged to develop their supervision skills. All staff work together to provide quality service. In addition to quality monitoring visits, there are monthly meetings in every clinic, and quarterly meetings at NGO HQs on improving service quality.

c) Decentralized Facility-based IMCI Training

Decentralized F-IMCI training helps NGO human resources practices become more sustainable. Up until December 2005 IMCI training was centralized in Dhaka at the Dhaka Shishu Hospital. In mid-December, in a government medical college hospital in Rajshahi, NSDP held its first regional11-day basic IMCI training course for 25 paramedics with help from the Ad-din Hospital and the GoB IMCI desk. By decentralizing training, NSDP saved 23% of the cost of IMCI training for the NGOs serving that region, in addition to obviating the need for travel and the associated wasted time.

2. Smiling Sun Clinics Observe "Vitamin-A Plus Campaign"

On December 22 2005, in collaboration with the GOB, the Smiling Sun clinics participated in the Vitamin-A Plus Campaign. Over 1.7 million children were given Vitamin A and 1.3 million were given Albendazole. Vitamin A supplementation is the most effective approach to reduce childhood blindness.

3. NSDP and Religious Leaders Work Together at World AIDS Day

There is a great need for improved public awareness and education about sexually transmitted diseases, especially HIV/AIDS. On World AIDS day, December 1, 2005, Smiling Sun clinics organized events aimed at raising awareness. Imams and other local religious leaders such as Madrassa principles participated in these events, which received widespread local press coverage. Many Imams helped clinics disseminate accurate information on HIV/AIDS and other STIs and RTIs. Local committee representatives of the Islamic Foundation of Bangladesh also participated. NSDP distributed materials on HIV/AIDS produced by partner organization Save the Children.

Imams participating in a discussion on HIV/AIDS organized by **SOPIRET** in Comilla.

4. Smiling Sun Clinics Help Poor Women Deliver Safely

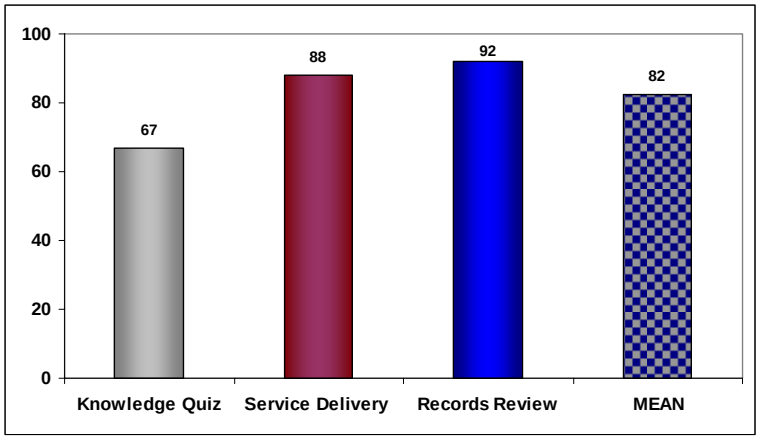
This quarter 1,007 women received skilled institutional delivery services from 16 Smiling Sun clinics. Of these clients, 413 poor women were treated free or at reduced prices. There are six emergency obstetric care clinics in the Smiling Sun network, mostly in underserved areas of the country. During the reporting period 169 women received life-saving C-sections --78 poor women received services at significantly reduced cost.

Service Providers Urge a Poor Family to Use Smiling Sun Services

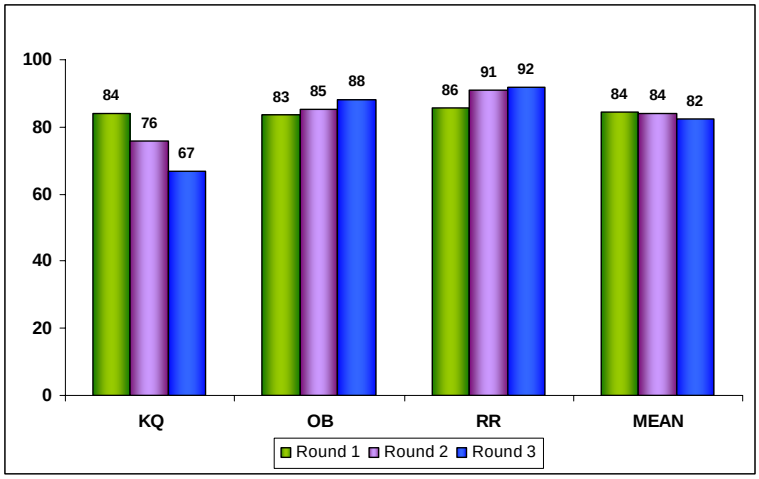
Razia Begum, 35, is a poor maidservant who lives in a small grass hut in the remote village of Patia, near Chittagong. Her husband works as a day laborer, making about Tk. 70 per day (roughly $1) –when he can find work. Both Razia and her husband had been contacted by an **FDSR** Service Promoter, and told of the importance of having a skilled birth attendant present at delivery. The family was reluctant to seek SBA help, knowing that even with some cash Razia's mother had raised by selling poultry they still couldn't afford the SBA fee. But an FDSR depotholder reassured the family. Razia gave birth at the clinic with help from an FDSR SBA, and the mother and baby are both doing well. Razia said, "Even as a poor woman like a maidservant, I received delivery services from the Smiling Sun clinic not only with reduced price but also with dignity and respect."

5. QMS Scores Help Target TA

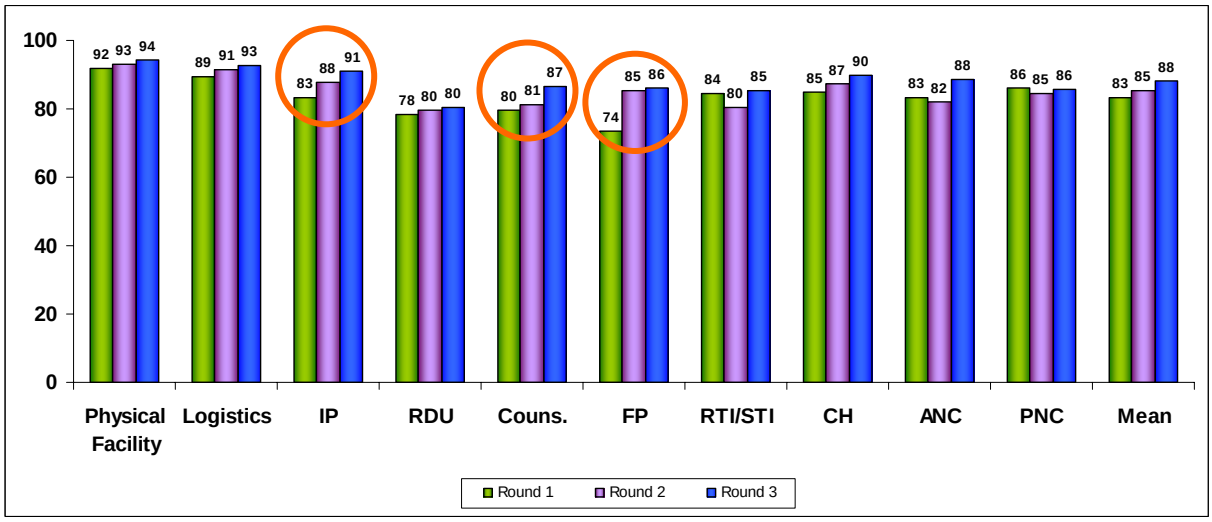
All the NGOs have completed QMS Round 3. The overall QMS score, which is an index measure of the service quality, was 82 per cent.



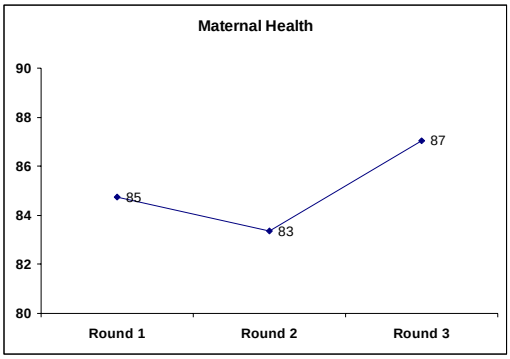
There was a 2% decrease in the QMS mean score from Round 2 to Round 3. This is because of reduction in the scores for provider knowledge. The knowledge quizzes have evolved over time from a simple to a more complex set of questions. However, overall scores for both service delivery skills and record keeping practice have improved.

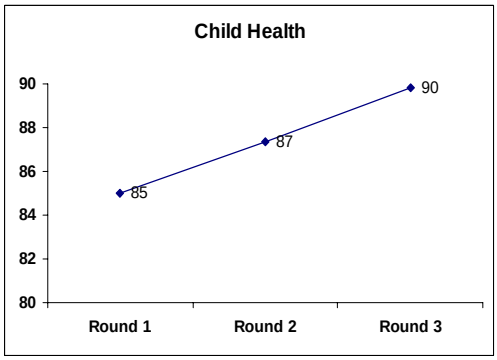


Clinics have demonstrated improvements in all indicators for clinic service delivery skills but have done better at improving infection prevention scores and those for counseling and family planning. Based on the Round 1 QMS scores, NSDP undertook intensive efforts to standardize provider service delivery skills across the network in these specific areas.



Although service delivery scores for both child and maternal health have improved over time, NSDP plans to target the next series of standardization exercises in these areas. Since the QMS process scores providers' skills based on critical aspects of service delivery, the providers will be required to achieve higher scores in the composite indicators for these services.

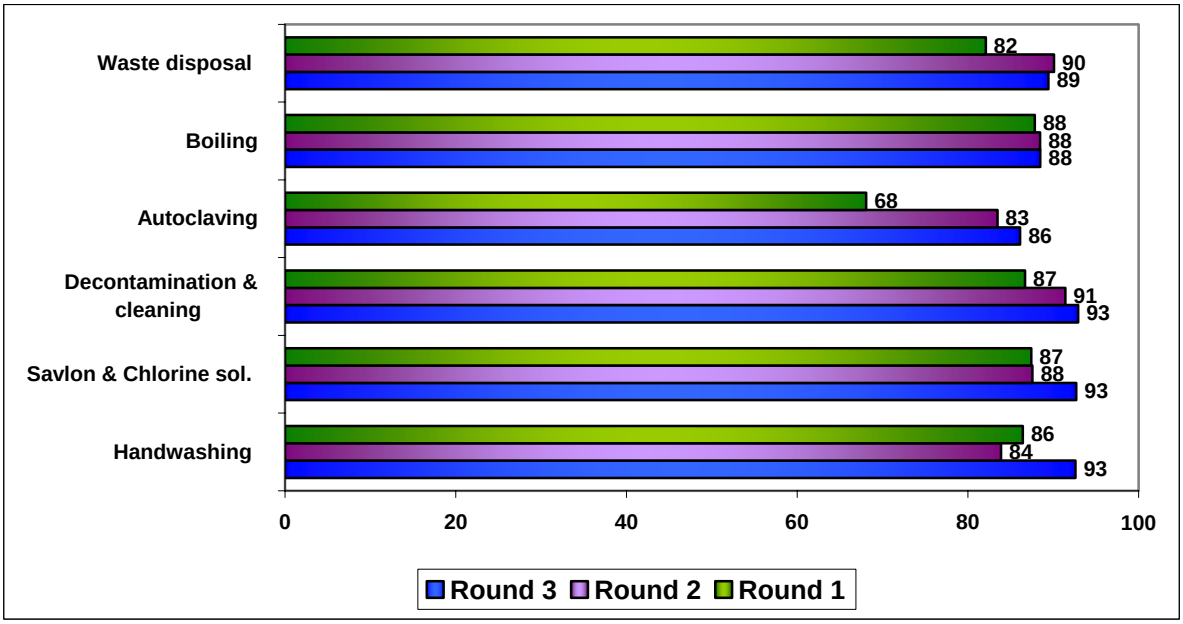




At the **Fair Foundation** clinic in Mongla service statistics show an increase in the percentage of measles completions and CYP, along with increased QMS scores. The NGOs aid that at the conclusion of QMS Round 2 neither the doctor nor the paramedic at the static clinic had been trained in basic ESP components. Following the QMS visit, the NGO arranged training for both. After the training, the NGO emphasized on-site clinical updates to improve service delivery skills and encouraged shared learning among staff. The PM and CM conducted four monthly clinical discussion sessions between QMS Round 2 and 3. The staff will continue to conduct these sessions at the clinic level for all ESP services, to ensure that provider skills are maintained.

6. Smiling Sun Clinics Clean Up

Following the cascade of standardization exercises at both NGO and clinic levels, managers and service providers alike have undertaken a "clean-up" drive focused on customer and provider safety. QMS infection prevention scores have increased (see below). Major improvements have been made in the autoclaving and waste disposal processes between Rounds 1 and 3. Providers have also become more conscious about hand-washing. Improvement was more marked between Rounds 2 and 3, which may be a direct result of the standardization on infection prevention.



The **Kanchan** clinic in Paharpur is a comprehensive clinic providing all ESP services, including C-sections, which has high client flow –an average of 4000 per month. To ensure efficient management of this high customer volume and because this is the "model" clinic for Kanchan Samity, the NGO has taken some extra measures to ensure compliance including training the medical officer in safe delivery and ensuring high quality service provision in all areas of the clinic's activities. The medical officer is also required to conduct frequent quality checks on staff, in addition to routine QMS visits and to provide on-site support to develop and maintain provider skills. The NGO also conducts bi-monthly clinical updates, fostering a culture of quality. The project director also co-facilitates some sessions.

OBJECTIVE 2: INCREASE THE USE OF THE ESSENTIAL SERVICES PACKAGE, ESPECIALLY BY THE POOR

1. Service Promotion Campaigns Increase Client Flow

In conjunction with the airing of the NSDP TV drama series, *Enechhi Surjer Hashi* (ESH), Smiling Sun clinics are conducting community mobilization campaigns to draw customers into the clinics. Broadcasting ESH on BTV adds legitimacy to the health care messages it contains since BTV, the Government channel, is well-regarded throughout Bangladesh.

The **GKSS** Sadulpur clinic held a soccer tournament, attended by over 20,000 people, in conjunction with local ESH service promotion campaigns. Clinic staff decorated the stadium, and made announcements over loud speakers about clinic services.

The campaigns educate the general public about the importance of health care, and about the range of services provided by Smiling Sun clinics. During the months the TV series airs there will be a total of 6 service promotion campaigns. This quarter, 2 services were promoted: blood pressure screenings /general health, including services for the elderly, and secondly, child health services. Customers aged 60 or older received services free of charge during the general health promotion campaign, paying only for medications. Some potential customers are unaware that clinics serve the elderly, misperceiving them as clinics for women and children only. Services are promoted by using mobile microphones, at community group meetings, by using loudspeakers at volunteer institutions and at mosques.

2. NSDP Begins Evaluation of TV Drama Campaign

This quarter we began the evaluation of the TV drama serial which is intended to measure its effectiveness at increasing client flow. Mitra and Associates are conducting the evaluation. The evaluation data will be collected in five rounds. In each round Mitra will interview community members who live in 36 Smiling Sun clinics' catchment areas. In every round, data will be obtained from three samples: firstly, a sample of customers exiting clinics will be asked if they had seen the TV drama, or if they had been motivated to visit the clinic by local-level activities. Secondly, community members who may have seen the

BMS: Dedicated to Serving the Very Poor

BMS was the first NGO to adopt the new Health Benefit Cards for very poor customers. At all 8 BMS clinics, the HBC scheme was implemented in May and June of 2005. BMS staff first started collecting donated funds and approached pharmaceutical companies for donations. community members, NGO staff and clinic staff have all made voluntary financial donations to the poor fund in order to serve those unable to pay. The BMS Executive Committee has approved transferring a lump sum from RDF profit to the poor fund. The RDF is reimbursed for costs of buying medications each month with cash from the poor fund account.

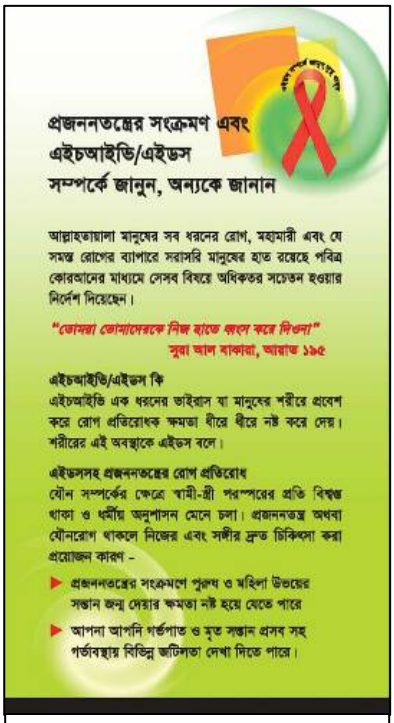
TV drama or who may have been reached by local service promotion campaigns but who do not visit Smiling Sun clinics will be asked why they choose not to come. Thirdly, Mitra will survey a sample of community members living in clinic catchment areas, who were not sampled in the second survey group to assess the effect of the TV drama in changing their behavior. In the fifth and final round, data will also be collected from non-NSDP areas. The first round of data collection is completed. The evaluation will be completed by June 2006.

3. Rafique TV Commercial Re-Aired

The TV public service announcement in which famous Bangladeshi cricketer Mohammed Rafique urges men to ensure that their wives receive adequate prenatal care was broadcast ten times in the second week of December on two TV networks. The airtime for the broadcast was purchased by Reckitt-Benckiser, the manufacturers of Dettol. Reckitt is also paying for the production of 10,000 maternal health care posters (see below) developed by NSDP which will be distributed to clinics for display in catchment areas.

4. Culturally Appropriate Health Care Materials for Imams

NSDP will again in 2006 be working closely with the Asia Foundation at Imam training sessions conducted as part of the Leadership Outreach Initiative. Last year the Imams who participated in the training sessions were briefed by Smiling Sun providers on the range of health care services offered and were taken on field trips to some of the USAID-funded clinics. The feedback from the Imams was overwhelmingly positive. NSDP has produced a series of print materials on maternal health, child health, family planning and STIs (including HIV/AIDS). Approximately 3,000 Imams will participate in 28 training sessions to be held at Imam Training Academies throughout Bangladesh in 2006. The series of sessions began in Sylhet and Dinajpur on January 1, 2006. The new NSDP print materials, attractively packaged in a folder, outline religious imperatives to provide health care services and each message is prefaced by relevant religious quotations. The majority of customers at Smiling Sun clinics are women: it is important for NSDP's messages to be conveyed by Imams since they are held in such high esteem in their communities by the men in whose hands family authority rests.



A leaflet produced for Imams to use when discussing HIV/AIDS.

A Smiling Sun Depotholder Shines in one of the Hardest-to-Reach Areas

Sandwip is a tiny island off the coast of Chittagong where Parvin Akter is a depotholder for **SUS.** Her village, Santir Hat, ("calm and quiet") has no roads and no electricity. But Parvin was determined to broadcast ESH. So one Monday she rented a TV and a car battery and turned her own front yard into a makeshift auditorium. Clinic staff discussed services and the clinic's promotional campaigns. The audience was told to pay attention to the show, since it would be followed by a quiz. They asked Parvin the dates and times of satellite sessions and much more. They asked to see the show regularly and thanked her for her initiative.

OBJECTIVE 3: INCREASE THE CAPACITY OF NGOS TO SUSTAIN CLINIC AND COMMUNITY SERVICE PROVISION

1. Unocal Foundation Builds a New Smiling Sun Clinic

Shortly before being merged with Chevron, the Unocal Foundation provided additional funds to finance the expansion of the Unocal-SSKS Smiling Sun clinic in Nabiganj. The clinic, which was initially established with help from a $78,000 grant in April 2005, has been operating in rented facilities. With this new larger grant SSKS will be able to construct a new building, on land donated by members of the community, which it will own outright. There will be significant savings, since the NGO will no longer have to rent clinic premises.

The new donation is for $110,000 and in addition to funding construction, it will allow SSKS to buy diagnostic equipment and begin offering diagnostic services. The new clinic will have an operating theater, and will offer safe delivery and emergency obstetric care including caesarean sections. Part of the funds will be used for operational funding for 27 months. The funds are also sufficient to buy one ambulance, which will facilitate timely referrals to higher level facilities.

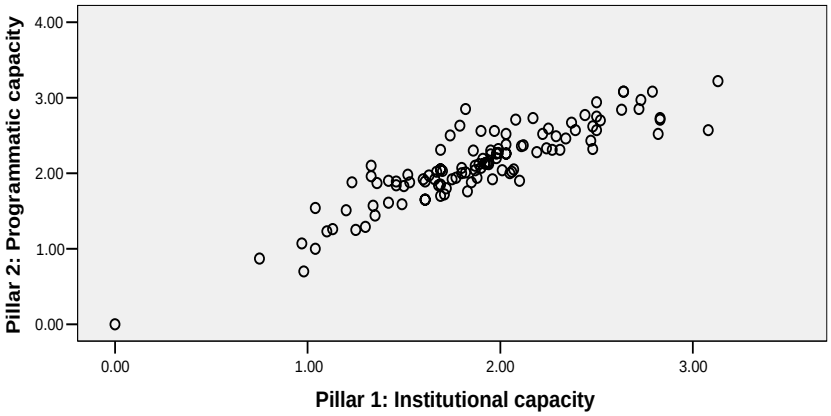
2. Accountability of NGO Executive Committee Members Addressed

NSDP has developed an "induction package" for NGO executive committee members. The material addresses issues relating to institutional, financial and programmatic sustainability. NSDP headquarters staff are orienting focus NGOs (those with high MOCAT scores deemed most likely to be able to make significant and sustainable improvements) to provide orientation and to assist with NGOs' compliance with NSDP requirements on financial and programmatic issues. This quarter three NGOs, BMS, PKS (both Kulna and Jessore) and SSKS (both Sylhet and Moulvibazar) received the induction package orientation.

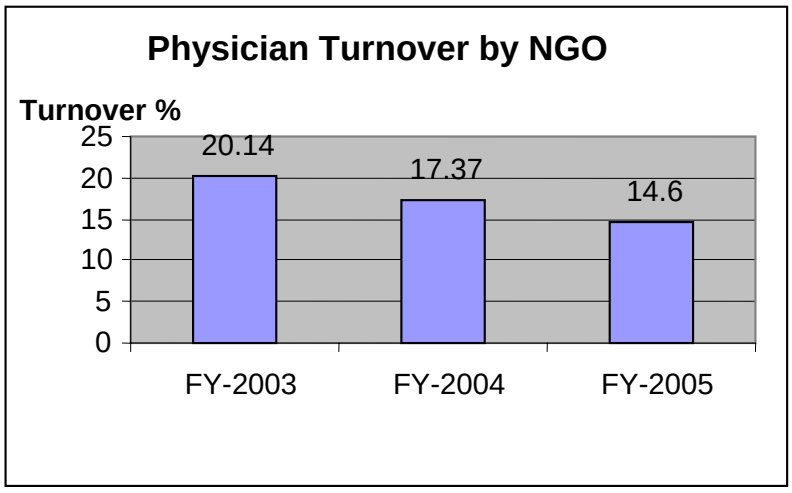
3. NGOs Complete FY 2005 MOCAT Self-Assessments

MOCAT scores increased in all 9 component areas from FY2003 to FY2005. The aggregate MOCAT score increased by 28%. NGOs use their MOCAT scoring to identify areas of weakness needing to be addressed. NGO performance is strongest in the programmatic pillar and weakest in the area of institutional sustainability. However, they are highly correlated as the graph below clearly shows. Now, one NGO is rated as mature (previously none were), 27 are classified as "expanding" (an increase from 21 last year) and 7 are "emerging" (last year 14). MOCAT composite scores have also been used to re-assign clinic management to other NSDP-approved NGOs when an NGO's grant is not renewed. The MOCAT scoring data is to be validated in 2006.

MOCAT Scores Correlated by Programmatic and Institutional Pillars



4. Staff Retention Improved



NSDP works hard with program NGOs to reduce staff turnover rates. Turnover impairs both performance and sustainability, and the cost of recruiting and retraining technical staff is high, which affects organizational financial sustainability. Since program inception the average physician turnover rate has fallen from more than 20% to 14.6% in FY 2005. Program NGOs conduct exit surveys with any staff who leave and constantly work to address causes of dissatisfaction. Through a process of sharing of best practices, successful efforts to improve retention are shared between NGOs to address turnover.

In their exit surveys staff mention, as reasons for leaving, location, lack of opportunity for private practice, benefits, lack of career development, inadequate education opportunities, and better terms of employment elsewhere. The average annual turnover rate for paramedics is 9%. Turnover is high for paramedics trained as diploma nurses from the GoB nursing school (80% urban and 45% rural). Nurses from the GoB school are in high demand relative to paramedics from private schools such as MATS and IFWV. So NSDP has been recommending recruitment of paramedics from private schools to improve staff retention. NGOs with low turnover rates, such as Swanirvar, DCPUK and MMKS, tend to be in rural areas and face less competition from other NGOs and the GoB for qualified staff. In the case of urban NGOs turnover of physicians is lower at Tilottama, Proshanti and BMS. The table below shows staff turnover rate by type of NGO (at small NGOs, both urban and rural, low turnover rates are a function of their small size –these NGOs have very few clinics and very few staff).

	Annual Turnover Rate (%) (Oct 2004 to Sep 2005)	
	Physicians	Paramedics
Large Urban NGOs	25%	15%
Large Rural NGOs	17%	19%
Medium Urban NGOs	36%	11%
Medium Rural NGOs	6.25%	10%
Small Urban NGOs	0%	0%
Small Rural NGOs	0%	2%

NGOs require technical assistance to develop comprehensive staff retention strategies including the use of diagnostic tools to help identify causes of staff turnover. In addition to the staff exit interview surveys, the tools include employee satisfaction surveys, and benefits surveys. Data from diagnostic tools is used to devise staff retention interventions such as strategic bonuses, benefits, awards, competitive salary, and consideration for the employee's choice of work location.

5. Costing Study Reveals Successes and Indicates Areas for Improvement

The costing study is producing interesting results:

1. Customer volume is less than optimal;
2. Provider-customer contact time is low;
3. There are high overhead costs;
4. Off-peak hours are little used;
5. Limited use of "cost analysis" by the NGOs and clinics.

The study also indicated that less than one fifth (14-19%) of customers actually purchase the medicines prescribed for them by NSDP providers. The study indicates that when customers visit the clinics for treatment they generally don't bring with them sufficient funds to purchase medications as well as to pay for services. The table below provides more details:

Percentage of Customers Who Buy Drugs by Location and Type of Clinic

	Static clinic		Satellite Session	
	Urban	Rural	Urban	Rural
Drugs prescribed	76	77	66	68
• All drugs purchased	14	16	16	19
• Partially purchased drugs	15	19	14	20
• No drugs purchased	47	42	36	29
No drugs prescribed	24	23	34	32
# of customers	(1190)	(600)	(530)	(490)

Remarkably, providers spend less time with each client during off-peak hours, compared with the amount of time they spend with clients when the clinics are busy. This counter-intuitive

finding holds true across the range of services, and by type of clinic (static or satellite). It may also be related to assigning days of the week or month to specific service delivery activities. At peak times, providers spend an average of 9.8 minutes with each client, compared to 7.7 minutes during off-peak hours. The study also shows that providers do not discriminate against the poor, spending approximately the same amount of time with poor and non-poor clients alike. The study has also documented the relatively high amount of time clinics spend in monitoring and reporting activity. NSDP intends to carefully examine the reporting requirements incumbent on clinics to attempt to rationalize their reporting workload.

6. Pricing Strategy Improves NGO Revenue

Some interesting data are now being generated on the effect of rationalizing clinic service charges on both cost recovery and customer flow. NSDP has analyzed data from 18 of the 29 NGOs which adjusted their service charges. The data analyzed covers the period from July-Sept 2002 to October-November 2005. (Price revisions have included both increases and decreases). At 17 NGOs cost recovery rates increased ranging from 2% to 117%. But at another NGO, the cost recovery rate declined by 14%. The average increase in cost recovery rate from price rationalization was 36%. A control group of NGOs, who did not adjust prices, experienced 17% improvement in cost recovery (one NGO in this control group experienced reduced cost recovery as well).

At the 18 NGOs whose clinics adjusted prices, customer flow increased by more than 12%. (This average figure masks wide variance: flow increased as much as 26.4%, but also, elsewhere, fell by 20%). Interestingly, at one of the 18 NGOs customer flow declined by 16% when fees were reduced. Overall, NGOs, which did not revise their prices, experienced an average decline in customer flow of 4%. Service charge revision is only one factor which may effect cost recovery and client flow.

7. Health Benefit Cards for Paying Customers Help Serve More People

This quarter the bilingual Health Benefit Card guideline was finalized and distributed to the NGOs. The guideline, which was produced following a lengthy process of consultation with NGOs, details the benefit package available when marketing HBCs to paying customers. The guidelines contain detailed promotional strategies. At workshops, held regionally, NGOs were trained in the process of implementing the HBC scheme.

At HBC workshops NGO staff were trained in NGO-specific tailoring of the HBCs. In some cases HBC pricing is even clinic-specific. HBC price-setting has been designed to allow the NGOs great flexibility, to meet local demand and generate revenue.

Two sisters suffering from fever visit the **Shimantik** clinic in Kaliganj. Because their names are listed on the HBC for the very poor (shown above) they were able to come to the clinic without their parents (or any adult) for free care.

OBJECTIVE 4: INFLUENCE POLICY, IN COORDINATION WITH OTHER DONORS, TO EXPAND THE ROLE OF NGOS AS PROVIDERS OF THE ESP

1. 2006 Work Plan Approved

The NIPHP Corporate Steering Group (CSG) met on December 4, 2005 to consider the Work Plan for FY 2006 for all the components of NIPHP. The CSG approved the NSDP Work Plan 2006 as had been recommended by the Working Group for NSDP. The NSDP Work Plan 2006 highlights sustaining services provided to the poor. Special TA will be provided to higher performing "focus" group NGOs to help them achieve rapid progress towards institutional, programmatic and financial sustainability.

2. NSDP Collaborates with UPHCP II

In all six city corporations and in five selected municipalities the GOB is launching an expanded Urban Primary Health Care Project (UPHCP II) which will run through December 2011. Coverage has been extended to include Sylhet and Barisal. In addition, Bogra, Comilla, Madhabdi, Savar and Sirajgunj municipalities will also be brought under UPHCP coverage.

NSDP NGOs have been working in these urban centers (with the exception of Madhabdi) for the last seven years. With a view to avoiding wasteful duplication of services and optimizing effective and efficient use of the resources, NSDP is negotiating a Memorandum of Understanding (MOU) with UPHCP II, similar to the MOU reached in 2002-03. The wards that NSDP NGOs would continue to serve in the above-mentioned urban areas would be delineated in the MOU, and UPHCP NGOs will not serve those wards. The MOU will provide for handing over the UPHCP-constructed clinic buildings to NSDP NGOs in the wards where the latter will be providing services.

3. MOHFW Secretary Praises NSDP's C-IMCI Work

In mid-December, with assistance from the GoB and ICMH, NSDP held a workshop at which 24 paramedics learned how to disseminate C-IMCI skills and practices to depotholders. At the closing session the Secretary of the Ministry of Health and Family Welfare, Mr. Abu Mohammed Maniruzzaman Khan, addressed the workshop and noted that the Smiling Sun clinics are leading the way in Bangladesh in implementing C-IMCI, which he said will help serve poor children in remote areas.

Mr. Abu Mohammed Maniruzzaman Khan (left) Secretary MOHFW with Prof. Abdul Hannan (center), of ICMH and Dr. Saiful Islam (right).

4. NSDP Advocates for NGO Contracting of ESD

The government and the development partners in the health sector have agreed to provide approximately $100 million for the Health, Nutrition and Population Sector Program (HNPSP) to be used for contracting ESD from NGOs. The GoB, city corporations and municipalities will explore the possibility of purchasing services from NGOs. This is an important and complex issue and NSDP is actively engaged in working with the MOHFW and the MOLGRD&C to expedite the process of diversification of service provision.

Acting U.S. Ambassador to Bangladesh Judith A. Chammas visited the **PKS** Jessore clinic in November to present the clinic with the first season of Sisimpur – the USAID-funded Bangladeshi Sesame Street. NSDP plans to purchase copies of the children's TV show for clinic waiting rooms. Seen with Ms. Chammas is Taudihur Rahman, President of PKS and a patient.

ANALYSIS OF SERVICE STATISTICS; UPDATE ON PROGRAM OPERATIONS; STATUS OF COMPLIANCE WORK

1. NSDP Service Contacts Continue to Grow

Smiling Sun providers made over 6.7 million service contacts in the first quarter of FY 06, thereby achieving 23% of the FY 06 annual goal:

NSDP Achievements Relative to Goals

Objectives	Achievement	Projection for FY06	Achievement in Q1 compared to projection for FY06	
	FY05		Achieved	% achieved
# Service contacts (million)	26.500	29.150	6.769	23%
CYP (million)	1.205	1.325	0.315	24%
CYP for non-clinical contraception	1.128	1.241	0.302	24%
# of family planning visits (million)	9.438	10.382	2.494	24%
# STI/RTI cases treated (million)	0.955	1.051	0.211	20%
# PNC 1 services provided (million)	0.253	0.278	0.061	22%
# ANC 3 (million)	0.290	0.319	0.067	21%
# TT2 doses given to women (million)	0.418	0.460	0.092	20%
Total child immunizations provided (million)	3.387	3.726	0.673	18%
# of children immunized against measles (million)	0.311	0.342	0.074	22%
# of CDD cases with some dehydration treated (million)	0.173	0.190	0.035	18%
# of children treated for pneumonia (million)	0.169	0.186	0.039	21%
# of confirmed TB cases managed for treatment	3715	4087	2366	58%
% of clients that are poor	19%	21%	18%	86%
% of cost recovery	21%	27%	20%	74%

Service contact statistics by indicator neared 25% this quarter; performance is on course to meet FY 06 goals. The table below provides a historical perspective, comparing this quarter's achievement with the first quarter of FY 05. Annual performance, both absolute and relative to goals for both FY 04 and FY 05 is shown to further illustrate programmatic growth.

NSDP Achievements Relative to Goals: Historical Perspective

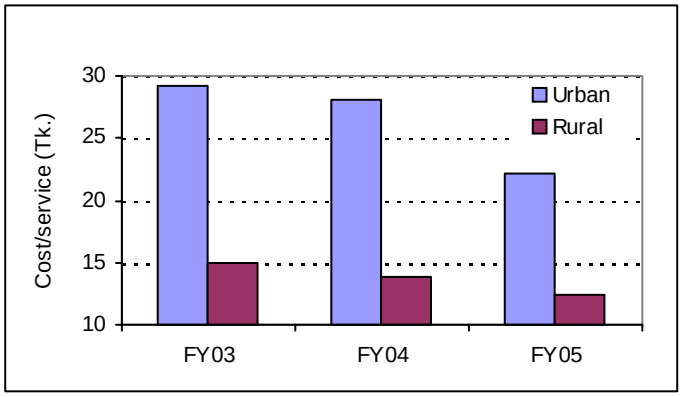
Indicators	Year					Quarter				
	FY04		FY05		% change in FY05 compared to FY04	Q1 of FY05		Q1 of FY06		% change in FY06 compared to FY05
	Achieved	*% achieved*	*Achieved*	*% achieved*		*Achieved*	*% achieved*	*Achieved*	*% achieved*	
# of service contacts (million)	24.182	96	26.600	96	10	6.439	93	6.769	93	5
% of clients that are poor	14	143	19	94	36	19	95	18	86	-5
CYP (million)	1.140	123	1.205	105	6	0.287	100	0.315	95	10
# of family planning visits (million)	9.195	102	9.489	95	3	2.309	93	2.494	96	8
Total child immunizations provided (million)	2.984	93	2.910	82	-2	0.725	82	0.673	72	-7
# of children immunized against measles (million)	0.324	89	0.328	82	1	0.079	80	0.074	86	-7
# of CDD cases with some dehydration treated (million)	0.199	81	0.170	63	-14	0.045	66	0.035	74	-21
# of children treated for pneumonia (million)	0.149	96	0.167	97	12	0.043	99	0.039	83	-9
# of PNC1 service provided (million)	0.241	86	0.253	82	5	0.064	84	0.061	88	-5
# of ANC3 service provided (million)	0.284	84	0.293	79	3	0.071	76	0.067	85	-5
# of TT2 doses given to women (million)	0.439	85	0.421	74	-4	0.100	70	0.092	80	-8
# of deliveries performed from safe-delivery centers	2554	106	3423	130	34	834	126	1016	155	22
# of women received comprehensive post-abortion care services	169	39	102	24	-40	38	36	13	13	-66
# of STI and RTI cases treated (million)	0.813	87	0.955	92	18	0.231	89	0.211	80	-8
# of confirmed TB cases managed for treatment	3285	76	4475	110	36	707	69	2366	232	235
% of cost recovery	18	78	20	80	11	19	76	20	74	5

In the first quarter of FY 06 there was significant growth in the number of service contacts to distribute contraceptives, for family planning counseling, measles immunizations, and safe delivery. Most notable was progress in TB treatment: after just one quarter, more than half of the year's target has been met. The TB case detection rate (not reflected in the tables above) increased from 30% in September, 2005 to 43%. The reasons for this improvement are as follows: firstly, all Dhaka clinic staff are now trained and involved in the national TB program. Secondly, the External Quality Assurance system was introduced in July 2005 and NSDP now operates its first EQA in Dhaka and the EQA system has been extended to include Chittagong. Presently, 80% of NSDP TB microscopy centers are covered by EQA centers and this ensures the highest level of quality in our TB services.

PAC performance has been declining significantly. This is possibly a result of greatly increased awareness of the MCP compliance requirements. It may be that providers, fearing possibly violating MCP, simply prefer to offer fewer PAC services.

2. Cost of Providing Services Continues to Fall

Cost per service has been declining throughout the project. In urban areas, cost per service declined from Tk. 29 in FY 03 to Tk. 22, in FY 05 a 24% drop. Similarly, in rural areas, cost per service declined by 17%, from Tk. 15 in FY 03 to Tk. 12 in FY 05. This represents an impressive improvement in cost reduction. Providers have increased service contacts, and this partly explains their ability to provide services less expensively --they are becoming more efficient. Although program expenditure has fallen by 17% (urban) and 1% (rural) from FY05 to FY03, the volume of service contacts has increased by 11% and 20% respectively.

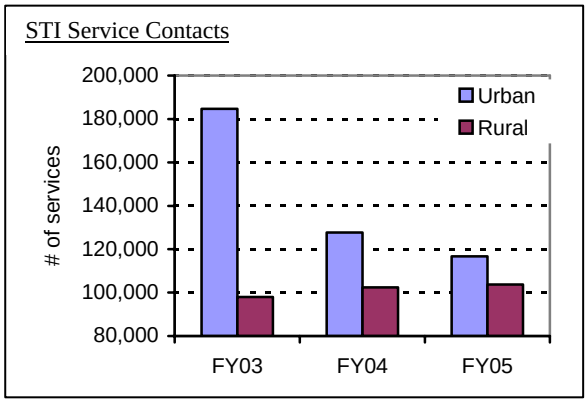


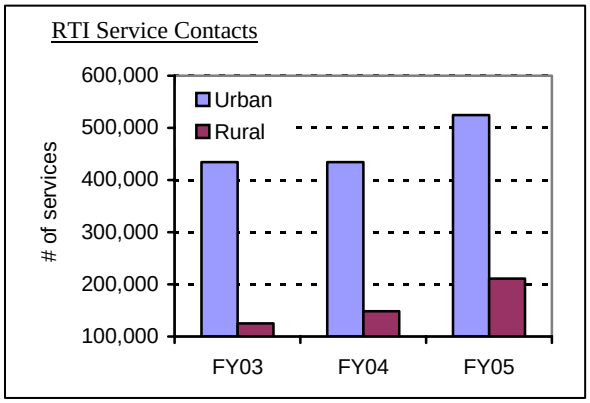
Particulars	Area	Fiscal year			% Change in FY05 compare to FY03
		FY03	*FY04*	*FY05*	
Expenditure	Urban	222,998,597.55	214,429,727.69	184,940,609.59	-17%
	Rural	233,357,043.79	235,398,385.98	231,967,564.85	-1%
	NSDP	**456,355,641.34**	**449,828,113.67**	**416,908,174.44**	-9%
Services	Urban	8,120,935	8,150,113	8,979,896	11%
	Rural	14,738,778	16,031,975	17,620,860	20%
	NSDP	**22,859,713**	**24,182,088**	**26,600,756**	16%
Cost/service	Urban	27.46	26.31	20.59	-25%
	Rural	15.83	14.68	13.16	-17%
	NSDP	**19.96**	**18.60**	**15.67**	-21%

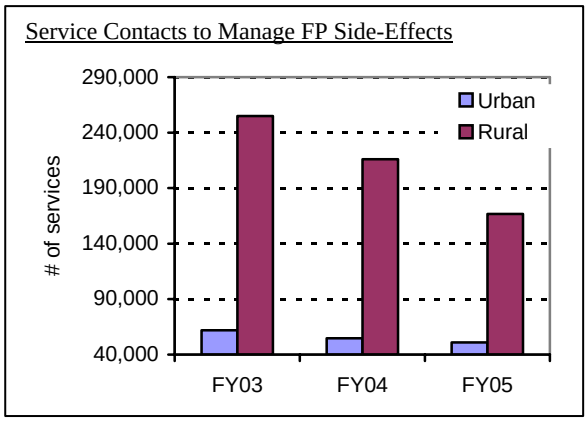
3. Service Contact Data Reflects the Success of TA

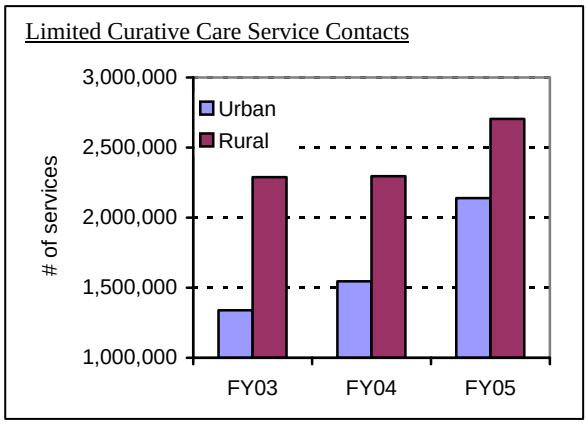
The number of customer contacts for STI service has declined, especially in urban areas. But the number of RTI services provided has steadily increased over the three fiscal years. NSDP

reproductive health staff have provided technical assistance to NGOs on quality of service and on the effective management of RTIs and STIs. The findings suggest that in earlier years RTI cases may have been treated as STIs. Limited curative care service contacts continue to increase. The number of customer service contacts related to the side effects of FP has been declining steadily. This too indicates improvement in the quality of family planning services provided.









4. NGO Support Teams Organized to Coordinate Technical Assistance

Four NGO support teams (NSTs) have now been formed, each with regional oversight responsibility. Each NST comprises three members and works with 8-12 NGOs. The teams meet with NGO executive committees and HQ staff quarterly. NSTs coordinate NGO supervision. Regional officers will now intermediate between the NSTs and NGO executive committees, and will serve as a conduit for tailored TA to NGOs. This represents a significant improvement over the earlier mechanism, under which NSDP regional staff worked more closely with individual clinics. The various NSDP technical teams will provide necessary TA, in coordination with the relevant NST Desk Officer.

5. NGO Coordination Meeting Addresses Sustainability

The first NSDP NGO coordination meeting for FY 06 was held October 17-20, 2005. The sessions focused on ways of improving NGO financial efficiency, and by sharing an overview

of the costing and incentive study. During the meeting the NGOs scheduled activities for November 2005 to February 2006 and NSDP synchronized plans with those of the NGOs. This will improve coordination significantly, save time and will help to avoid duplication of efforts. The FAM participated in the third and fourth days of the meeting. They spent time reviewing their budgets and expenditure statements, sharing the audit findings and producing guidelines to address audit problems.

6. Regional Office Mergers Enhance Efficiency

In addition to the new NST process described above, NSDP has reorganized its regional offices. The Mymensingh regional office has been closed. Staff from that office were absorbed by other regional offices which had vacancies. The Comilla and Sylhet regional offices are being merged. The Comilla office is now located in a rented building and the Sylhet regional office will shortly be joining them there in that facility.

7. System Launched to Monitor Compliance

NSDP launched its revised monitoring and reporting system and tools for monitoring compliance with the MCP, the Tiahrt Amendment and the Helms Amendment during the quarter under review. In November 2005, NGO project directors were oriented on the use of the new and revised monitoring tools developed for the MCP, Tiahrt and Helms Amendments. There is one tool for NSDP-funded clinics, one for non-USAID funded clinics, a form for recording passive responses, and a debriefing tool for use during depotholder meetings.

In addition to monitoring tools for use by NSDP NGOs, a tracking tool has been developed for NSDP regional staff to track NGO monitoring results based on visits outlined in NGO monitoring plans.

8. MCP, Tiahrt and Helms Monitoring Continues

NSDP field and HQ staff conducted 72 monitoring visits this quarter using the new clinic monitoring tool. 670 service providers were interviewed to assess their knowledge of the MCP, Tiahrt and Helms – 61 clinic managers, 9 medical officers, 214 paramedics, 105 SP/SPOs, 38 counselors, 74 clinic aids, 113 depotholders and 52 others were interviewed during this quarter.

99.1% of respondents had received orientation on MCP, Tiahrt and Helms. No service providers provided or promoted abortion or MR services as a method of family planning. 95.4% of NGO personnel are aware of the exceptions permitted under the MCP. 99.7% of NGO personnel demonstrated awareness of the consequences of violating the MCP.

NSDP has also been gathering information from all clinics pertaining to monitoring of compliance with Helms, Tiahrt and MCP since November 2005. Clinic reports indicate that about two thirds of clinics have received monitoring visits from either their NGOs' staff or NSDP. More than three quarters have held refresher courses on the requirements. 85% of

clinics have held debriefing sessions with depotholders on MCP. None of the NSDP clinics provided any passive responses nor did they refer any clients under any special circumstances.

Helms, MCP, and Tiahrt Monitoring Indicators at 308 NSDP Clinics (November, 2005) *

Indicators	Number	% of clinics
Number of clinics that provided at least one passive response	0	0
Number of clinics that provided at least one referral for MR under very special circumstance	0	0
Number of clinics that received at least one Helms, MCP, or Tiahrt monitoring visit from NGO or NSDP officials	201	65
Number of clinics that organized at least one refresher meeting about Helms, MCP, or Tiahrt	234	76
Number of clinics that organized monthly depotholder debriefing meeting on MCP (total clinics = 147)	125	85

* Excluding 4 JUSS JUSS, 4 DCPUK clinics, and the Karimpur Unocal Clinic (SSKS/M).

9. The 2005 Annual MCP Survey

This quarter we surveyed staff on their knowledge of MCP. All NGO contact staff including project directors were surveyed plus providers from a randomly selected group of 54 clinics. Staff at all 12 ADB-funded clinics and all 12 clinics funded by sources other than NSDP or ADB were also surveyed. In total there were 389 respondents. The survey findings indicated that NGO staff are aware of the MCP requirements. There are routine, frequent orientations and refresher courses on MCP. Respondents indicated an acceptable level of awareness of the exceptions allowable under MCP. However, only about 5% of respondents fully understand the "passive response" clauses of MCP. No customers have been given passive responses when asking for MR.

10. Budget

NSDP financial information will be provided to USAID under separate cover.

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