“The views in this document are those of the NSDP evaluation team member who prepared this document and do not necessarily reflect the views of USAID/Bangladesh. This document is provided as background on the evaluation of NSDP and is being made available to the public for informational purposes only. ”

Supporting Document on NSDP Sustainability

This document is an abridged version of a deliverable report on NSDP sustainability written by one member of the NSDP Evaluation team. Some of the following has been included in the Evaluation Report itself, but much was omitted as support analysis in order to make the Evaluation itself more concise and readable.

A key objective of the NSDP program is to increase the capacity of NGO's to sustain clinic and community-based service provision, institutionally and financially.

Definition of Sustainability

There are many definitions of sustainability. The working definition applied by the NSDP's team is:

> An organization's ability to define a relevant mission, follow sound management practices, and develop diversified income sources to ensure the long-term continuity of quality, community-oriented services.

The team further intends that sustainability should be a filter for all strategic, management and program decisions. Implied is the requirement to involve those impacted by those decisions, namely the clients and their communities, in the decision-making process; and the objective that decision-makers consider the long-term, broad impact of decisions, both within and outside the organization. They recognize that to achieve sustainability, the NGO's need to take ownership of the sustainability process – that is, that NGO's must consciously desire and systematically work toward the achievement of sustainability.

We would add another dimension to this challenge: that health services provided through this project continue to be provided in achieved and preferably increased levels of volume, range and quality with diminished support from USAID.

The Challenge of Achieving Sustainability

The design and context of the project itself limits the capacity of NGO's to achieve sustainability of their services in several important ways:

1. The services offered have limited potential for cost-recovery. The focus and emphasis of the services provided are largely restricted to RH, FP, and the ESP, which have limited potential for cost-recovery.

    - **Permanent Long Term Methods** of family planning are on the decline nationally, and the ability NSDP NGO's to attract clients for those services is limited by competition from the GOB itself which offers compensation for loss of income and travel expenses to clients seeking those services.

    - **Other contraceptive methods** are generally subsidized and offered at low prices to stimulate acceptance and increased CYP's as a higher priority than sustainability.

    - **Safe deliveries** offer great potential for attracting clients for a wide range of services, but that wider range doesn't really exist. Safe deliveries implies well equipped and well managed clinics, with highly trained and qualified staff working under strict service delivery protocols. While having a baby is a common and natural occurrence, it is not without risk, and complications and mistakes can lead to maternal mortality which can cast a negative shadow on the clinic and NGO's. For

these reasons, the expansion of delivery services has been appropriately cautious. Furthermore, most clients cannot afford prices covering the full cost of this relatively expensive service even where it is offered, requiring important cross-subsidies from donors and other services.

- **IMCI.** While some services offered within the IMCI package are curative and chargeable, many are preventive, educational, etc., limiting the potential for cost-recovery.

- **Post-Abortion Care.** As a result of the MCP**,** NSDP clinics are strictly forbidden to provide abortions, and therefore presumably the demand for post-abortion services, particularly in the rural areas is limited. In fact, only 8 of 314 static clinics even offer this service, and only 82 cases were served in FY 05.

- **Tuberculosis**. This is an excellent service for improving case detection and DOTS, but has limited cost-recovery potential.

- **HIV/AIDS Coordination**. STI services have the potential to generate some income in clinics where lab services and drugs are offered. Ironically, neither of the latter services is supported by the project itself, but through resources provided through the previous project.

2. **Curative Services are greatly restricted**. It is true that the range of services offered includes IMCI and some curative services, including treatment of diarrhea and ARI in children, but curative health services are largely excluded from the project design. The intent of exclusion becomes glaringly apparent in the description of services to be provided as described in the Cooperative Agreement Following relatively detailed descriptions of each of the first seven services, is added, almost as an afterthought: Limited Curative Care (LCC), described in a single sentence:

   > "While the first priority will be given to higher priority ESP services, adequately staffed static and satellite clinics will perform Limited Curative Care, as feasible."

   We recognize and appreciate that the emphasis on RH, FP, and ESP are necessitated by the source of USAID funding (Population). Nevertheless, this limited focus impairs the ability of the NGO's to provide sustainable services without donor support by not recognizing that RH, FP and the ESP represent only a portion of the range of health services needed and desired by the under-served target population; and alone, generally do not represent a sufficient volume of chargeable services to generate high levels of cost-recovery to replace donor support.

   It is clear from the volume of clients and services provided through the network of NGO's that people do seek out the services provided. It is, however, important to recognize that these "priority services" are those designated by the GOB and USAID, and not necessarily those of the client population. Clients also, and perhaps primarily, seek out health services not for preventive programs, but for curative services. The fact

that customer contacts for LLC jumped 26% between FY04 and FY05 as project restrictions on these services eased, clearly demonstrates the preferential demand for these services.

It has been clearly demonstrated in other health care organizations supported by USAID[1], that the provision of RH, FP, and ESP within a broader range of services, particularly curative services, attracts larger volumes of patients to attend clinics, as well as greatly improves cost-recovery since curative services are usually not optional and patients are willing to pay for them, cross-subsidizing preventive services.

It is worth mentioning three other factors which stimulate cost-recovery demonstrated in numerous health programs world-wide: for reasons of convenience, patients seek health care services in settings where a wide range of services are available; particularly in potentially life threatening or life-impacting situations, they will seek out the best quality services they can afford; and are particularly attracted to health services where they can obtain medicines. It should be further noted that sales of medicines and laboratory tests are usually important sources of cost-recovery which cross-subsidize other less lucrative services.

3. The project stipulates that services should be directed toward the poor. It is important to note that it does not stipulate that project services be accessible to the "poorest of the poor," the "Least Advantaged" (LA), although for reasons of equity there is a deliberate attempt by most of the NSDP NGO's not to exclude anyone from services. These efforts are supported strongly by the project team, and practically made compulsory by the GOB which has deliberately assigned the NSDP to catchment areas where the population is under-served and poor, and its own coverage is limited.

4. Formal and informal policies of USAID have also limited the ability and capacity to offer services. These include discouraging the provision of services beyond those specified in the Cooperative Agreement, restrictive use of "program income" and the MCP. These will be discussed in detail below.

[1] These include in the direct experience of one of the Evaluation Team members, model NGO's such as Prosalud in Bolivia, MaxSalud in Peru, and Profamilia in Nicaragua. RH and FP can be sustainable in large urban clinics as demonstrated by the Reproductive Health Association of Cambodia, but are much less sustainable in decentralized settings.

SUMMARY OF EXISTING NSDP NGOs

NGO	Catchment Population (millions)	Total Service Contacts (millions)	Static Clinics			Satellite Services				Depot Holders		Staffing			
			# Clinics	Services/ Clinic /Day	Total Services 05	# Satellite Teams	# Satellite Points	Customers /Session	Total Services 05	# Depot Holders	Total # Services Provided	# MDs	# Para-medics	# Prof. Staff	# Admin Staff
BAMANEH	0.749	1.331	10	60	185,497	22	410	74	493,457	386	652,108	2	38	127	22
BANDHAN	0.109	0.167	2	39	22,662	4	72	58	64,516	73	79,897	0	6	20	4
BMS	2.052	0.531	8	86	209,073	16	92	50	322,119	0	-	10	28	78	9
CAMS	0.284	0.235	6	72	128,527	10	62	46	106,709	0	-	6	16	51	6
CRC	0.148	0.185	2	51	29,774	4	74	53	57,337	76	97,744	0	6	20	5
CWFD	1.499	0.798	19	77	408,645	38	229	34	374,729	19	14,960	30	59	172	34
DIPSHIKHA ANIRBAN	0.050	0.04	1	55	15,840	2	24	64	24,612	0	-	2	3	8	2
FAIR FOUNDATION	0.425	0.614	10	95	279,799	19	124	46	333,863	0	-	10	30	92	13
FDSR	0.500	1.213	12	74	261,903	25	419	77	608,364	343	342,609	2	40	98	26
GKSS	0.249	0.472	4	45	52,431	8	153	55	135,767	154	283,615	0	12	42	10
IMAGE	0.583	0.306	7	72	129,594	13	69	40	176,354	0	-	6	21	76	12
JTS	1.331	2.498	21	60	370,577	63	823	72	1,075,043	823	1,052,205	1	63	241	29
KAJUS	0.061	0.068	2	56	32,619	4	31	34	35,847	0	-	2	6	19	3
KANCHAN	0.363	0.468	8	64	150,366	19	97	41	317,704	0	-	9	30	93	18
MALANCHA	0.217	0.195	3	65	56,855	11	123	47	129,900	22	8,456	3	16	46	5
MMKS	0.368	0.798	6	64	127,143	15	252	64	332,564	263	338,671	6	21	74	15
NISHKRITI	1.260	0.455	7	92	172,160	21	108	39	282,444	0	-	7	31	90	17
PKS-Jessore	0.218	0.462	5	134	196,344	12	99	47	265,237	0	-	6	18	48	6
PKS-Khulna	0.592	0.907	13	105	406,539	27	162	40	500,790	0	-	15	51	147	15
PROSHANTI	0.217	0.096	5	52	75,772	3	20	17	20,274	0	1	0	9	34	6
PSF	0.691	2.486	24	51	330,325	51	832	59	1,008,435	810	1,147,276	5	77	265	52
PSKS	0.248	0.436	5	60	86,750	11	181	46	154,098	122	195,326	6	16	55	10
PSTC	0.831	0.967	16	97	455,421	26	147	45	497,369	20	13,978	13	48	151	39
SGS	0.235	0.367	4	44	51,139	10	164	57	161,325	166	154,565	0	14	49	10
SHIMANTIK	1.500	0.603	6	34	57,003	18	320	40	219,578	334	326,654	0	24	86	8
SOPIRET	0.278	0.654	8	42	98,655	16	298	51	287,733	307	267,837	0	24	88	19
SSKS-Moulavibazar	0.103	0.164	3	62	54,219	8	37	35	110,011	0	-	3	11	39	7
SSKS-Sylhet	0.214	0.345	9	89	234,892	10	36	44	109,991	0	-	9	21	58	10
SUPPS	0.010	0.093	1	86	24,729	2	36	42	31,553	45	36,724	1	4	11	2
SUS	0.376	0.383	5	39	62,001	11	204	40	155,116	221	165,807	0	17	58	14
SWANIRVAR	3.025	5.318	48	42	556,552	109	1658	43	1,903,117	1598	2,793,758	14	164	566	103
TILOTTAMA	0.665	0.709	14	64	260,752	27	170	41	447,850	0	-	15	44	133	22
UPGMS	0.376	0.226	6	57	100,578	12	134	32	125,614	0	-	6	18	53	14
VFWA	0.190	0.226	5	67	97,906	10	111	40	128,441	0	-	3	15	43	12
VPKA	0.222	0.359	4	37	43,032	10	169	49	154,777	175	161,561	0	14	47	9
Total	**20.2**	**25.2**	**309**	**2290**	**5,826,074**	**667**	**7,940**	**1,662**	**11,152,638**	**5,957**	**8,133,752**	**192**	**1,015**	**3,278**	**588**

MOCAT

As implied in the NSDP team's definition of sustainability, the long-term sustainability of the health services offered is dependent on the capacity of the NGO's to develop and maintain those services. A critical question to be answered is whether the NGO's have achieved this capacity or are likely to do so by the end of the project in September, 2007.

The primary instrument for measuring organizational capacity is the MOCAT, the Modified Organizational Assessment Tool, an improved version of OCAT developed in South Africa and required by the Cooperative Agreement. The MOCAT is organized in the following fashion:

Pillars of Sustainability	Components of Sustainability	Organizational Elements
Institutional Sustainability	Governance	Board of Directors
		Mission/Vision
		Leadership
	Management Practice	Organization Structure
		Strategic Planning
		Program Planning
		Operations
		Mgmt Style
	Human Resources	HR Policy
		Recruitment
		Gender
Programmatic Sustainability	Customer Focus	Customer Needs
		Customer Reach
	Quality of Service	Culture of Quality
		Customer Service
	External Relations	Marketing/PR
		Community Relations
		NGO/Pvt Sector
		Gov't Relations
		Funder/Donor
Financial Sustainability	Financial Management	Accounting
		Budget
		Inventory
		Financial Reporting
	Cost Consciousness	Expense Mgmt
		Procurement
	Revenue Stability	Strategy
		Service Fees
		Local Income
		External Financing

The MOCAT measures each of the Components of Sustainability through a series of 179 questions related to the Organizational Elements, scored on a sliding scale. The composite score of each Component are added to yield a quantitative measure of their respective Pillar of Sustainability. Possible scores for each Pillar range from 0-4. The three Pillars are then averaged to produce a composite score in terms of overall sustainability. The overall scores are then used to classify each NGO as Nascent, Emerging, Expanding, or Mature. The higher the level, presumably the more sustainable is the NGO. The various stages are described as:

Nascent (0-1):	The earliest stages of organizational development with its major systems either rudimentary or non-existent.
Emerging (1-2):	Developing capacity. Basic structures and systems are in place and functioning
Expanding (2-3):	The NGO has a track record of achievement. Its systems and processes are developed and functioning and it is connected to its constituency.
Mature (3-4):	The NGO is fully functioning and sustainable with a diversified resource base, multiple partnership relationships and varied regional and/or national networks.

The range of organizational elements considered in the MOCAT is quite broad. However, measuring sustainability of widely differing organizations is difficult and imprecise. It is not our purpose to evaluate MOCAT itself, but interpretation of the scores requires some understanding of the limitations inherent in this instrument which we have noticed. First, all measurements are treated as equal – which may not be appropriate as some may be more important than others. Furthermore, there may be some over-riding characteristic of an NGO which is not included, but for which mitigate or even eliminate all chance of sustainability – such as compliance with the MCP or misuse of project funds.

Secondly, the questions are both objective and subjective. As a consequence, different people could score questions differently.

MOCAT focuses only on the NSDP health component, and particularly in the case of large, diversified NGO's, ignores the capacity of the NGO's themselves. This paints a false picture of the real capacity to manage programs. For example, PSTC scores as an Expanding organization, and it is in terms of health. However, it has been around for a long time, has very strong management, was essentially the equivalent to NSDP itself in terms of grants management, and is in every way a Mature organization.

More important, MOCAT treats all organizations the same regardless of size and complexity. Specifically, the weakest Pillar is probably the Programmatic Pillar since neither the numbers of service delivery points nor the range of services offered in each is taken into consideration. Thus, an urban system with a large number of static clinics and relatively few Satellite clinics and depot holders is treated the same as a small rural NGO with one or two static clinics and a moderate outreach program.

Note that the MOCAT focuses on the health care component of each NGO, ignoring support to other sectors, and consequently other strengths or weaknesses of NGO's. It does not, for

example, pick up on the fact that many of the NSDP NGO's are essentially small family businesses.

That said, the MOCAT is useful, not for its precise scores, but for providing a general portrait of the level of development of the capacity of each NGO to sustain its healthcare program; and a way of quantifying apparent changes in that capacity over time. It has proven useful to help identify specific areas which require strengthening, and help focus the technical assistance effort. Supplemented with additional information, it is then useful for assessing the overall capacity for sustainability. MOCAT has also proven useful as a tool to help orient NGO's on where they are weak and what they need to focus on in terms of strengthening their management.

During the first 18 months of the project, the NSPD Sustainability Team focused largely on establishing a MOCAT baseline, and identifying those aspects of each NGO which required strengthening and support. In practice, this meant that the 2-person team first carried out the MOCAT baseline for 19 NGO's during the first 8 months of the project; and then provided some limited support to those NGO's before proceeding with the MOCAT baseline for the remaining 21 NGO's. This took considerable time as 30-page reports were prepared for each NGO. The focus of spending so much time and effort into establishing a baseline certainly has detracted from the ability of the project team to address the issues identified, and is probably one of the principal reasons why the support in the early years was focused on the clinic level rather than the NGO's themselves.

Subsequent scores for 2004 and 2005 were self-administered by NGO's. In many cases, the scores were simply augmented slightly to indicate improvement. Questionable results were sometimes checked by the Sustainability Team. The tabulated results are the following two pages.

According to MOCAT scores, virtually all NSDP NGO's can be classified as either Emerging or Expanding. None are truly mature, at least not in terms of their health care system. Interpretation of the scores, however, requires additional inputs. Two additional indicators are included on the Summary page. One is the MOCAT point improvement. The second is the % improvement. These scores are highly dependent on where the NGO started on the MOCAT scale in 2003. Those which started at low levels have the potential to demonstrate improvement, and some such as Dipshikha Anirban, Manlancha, and SUS appear to have improved. Others which are far larger and more stable such as CFWD and PSTC show little improvement, in part because NSDP has done little to enhance the sustainability of well-established NGO's themselves.

It is also important to observe the consistency of improvement across all Pillars over time. This is summarized in the comment column of the Summary page. Presumably NSDP can hope that with continued assistance (and pressure); those NGO's demonstrating the potential, willingness, and ability to improve across the board, will continue to do so. For others such as CRC, BMS, GKSS, MMKS, Proshanti, SGS, Shimantik, and VPKA, the MOCAT scores suggest their inability to improve their management over the past two years which is critical since they began at relative low levels.

It is important to remember that most of the NSPD NGO's have a long history, much of it completely dependent on donors, particularly USAID. This is a difficult pattern to break.

From the MOCAT results, it is safe to say that NGO's are generally stronger than they were at the beginning of the project. Whether they are sustainable without significant donor support is another matter. This will be discussed in more detail below.

Lessons Learned with respect to MOCAT:

- According to MOCAT, with the exception of a few relatively small NGO's, management has improved somewhat since the beginning of the project.

- MOCAT provides a useful framework for quantifying organizational development, but interpretation should focus on specific areas and relative growth rather than precise scores.

- Used alone, MOCAT is not always a good predictor of organizational capacity. Within NSDP its focus was on the NSDP health program, and particularly with well established NGO's, fails to recognize the organizational strengths of the NGO itself. Thus, to label an NGO which has been around for decades and has multiple programs as "emerging", paints a false impression. MOCAT must always be supplemented with first-hand knowledge of the character and context of the NGO, particularly its leadership.

- MOCAT proved to be a useful tool for helping NGO's understand where they needed strengthening. This also helped direct the focus of technical assistance.

- MOCAT should be used as a *rapid assessment tool*, not a study framework. Far too much time was dedicated to measurement with MOCAT. NSDP used MOCAT to produce 40-page studies on each NGO, which significantly detracted from the actual strengthening of the NGO's themselves.

Pillar wise MOCAT scores by NGO: 2003, 2004 and 2005

NGO	Pillar 1: Institutional capacity			Pillar 2: Programmatic capacity			Pillar 3: Financial capacity			Composite MOCAT Scores		
	FY03	*FY04*	*FY05*	*FY03*	*FY04*	*FY05*	*FY03*	*FY04*	*FY05*	*FY03*	*FY04*	*FY05*
BAMANEH	1.68	2.06	2.48	1.84	2.02	2.32	1.55	1.89	2.34	1.69	1.99	2.38
BANDHAN	1.83	1.96	2.05	1.76	1.92	2	1.67	1.96	2.06	1.75	1.95	2.04
BMS	1.33	1.69	1.69	2.1	2.31	2.05	1.48	1.59	1.88	1.64	1.86	1.87
CAMS	1.74	2.64	2.64	2.5	3.08	3.08	1.9	2.48	2.48	2.04	2.74	2.74
CRC	1.04	1.25	1.3	1	1.25	1.29	0.6	0.9	1.27	0.87	1.13	1.29
CWFD	2.27	2.83	2.83	2.31	2.71	2.73	2.55	2.81	2.81	2.38	2.78	2.79
DCPUK	1.67	1.69	1.69	2.02	2.05	2.05	1.85	1.88	1.88	1.84	1.87	1.87
DIPSHIKHA ANIRBAN	1.35	1.69	1.95	1.44	1.7	2.3	1.21	1.53	2.14	1.33	1.64	2.13
FAIR FOUNDATION	1.77	2.11	2.39	1.94	2.36	2.57	1.74	2.43	2.65	1.82	2.3	2.54
FDSR	1.75	2.01	2.47	1.92	2.04	2.43	2	2.02	2.48	1.89	2.02	2.46
GKSS	1.5	1.53	2.1	1.83	1.88	1.9	1.72	2	2.15	1.68	1.8	2.05
IMAGE	1.8	1.93	2.24	2	2.13	2.33	1.84	1.94	2.75	1.88	2	2.44
JTS	1.9	2.08	1.97	2.56	2.71	2.56	2.1	2.19	2.08	2.18	2.33	2.2
JUSSS	1.13	1.61	1.71	1.26	1.89	1.72	1.39	1.87	1.55	1.26	1.79	1.66
KAJUS	1.87	1.98	1.99	2.04	2.26	2.32	1.62	1.77	1.88	1.84	2	2.07
KANCHAN	1.36	2.19	2.29	1.87	2.28	2.49	1.65	2.13	2.39	1.63	2.2	2.39
MALANCHA	1.2	1.04	2.37	1.51	1.54	2.67	1.51	1.55	2.17	1.41	1.37	2.4
MMKS	1.98	2.03	2.12	2.2	2.38	2.37	1.74	1.83	1.87	1.97	2.08	2.12
NISHKRITI	1.7	2.22	2.44	2.03	2.52	2.77	2.05	2.56	2.81	1.92	2.43	2.67
PKS	1.69	1.87	1.91	1.85	2.1	2.19	1.65	1.92	1.97	1.73	1.96	2.02
PROSHANTI	2.5	3.13	3.08	2.57	3.22	2.57	2.12	2.65	2.61	2.39	3	2.75
PSF	1.82	1.94	1.99	2.01	2.12	2.27	1.68	1.81	1.85	1.84	1.96	2.04
PSKS	1.34	2.5	2.79	1.57	2.94	3.08	1.77	3.24	3.34	1.56	2.89	3.07
PSTC	2.48	2.52	2.72	2.62	2.7	2.85	2.63	2.68	2.75	2.57	2.63	2.77
SGS	1.94	2.03	2.03	2.15	2.26	2.26	1.94	2.04	1.96	2.01	2.11	2.08
SHIMANTIK	1.61	1.61	1.88	1.65	1.65	1.94	1.82	1.82	1.93	1.69	1.69	1.92
SOPIRET	1.66	1.8	1.86	1.92	2.07	2.3	1.86	2	2.12	1.82	1.96	2.09
SSKS	1.46	1.95	2.5	1.84	2.25	2.75	1.7	2.25	2.75	1.67	2.15	2.67
SUPPS	1.49	1.6	1.85	1.59	1.92	1.88	1.43	2.12	1.68	1.5	1.88	1.81
SUS	0.97	1.1	1.63	1.07	1.23	1.97	0.9	1.33	1.93	0.98	1.22	1.84
SWANIRVAR	2.31	2.34	2.82	2.31	2.46	2.52	2.15	2.28	2.81	2.26	2.36	2.71
TILOTTAMA	1.33	1.79	1.82	1.96	2.63	2.85	1.71	2.29	2.37	1.67	2.24	2.34
UPGMS	1.42	1.46	2.25	1.9	1.89	2.59	1.72	1.95	2.86	1.68	1.77	2.57
VFWA	1.42	1.52	1.89	1.61	1.98	2.12	1.85	2.22	2.59	1.62	1.91	2.2
VPKA	1.9	1.92	1.92	2.07	2.13	2.13	2.03	2.33	2.33	2	2.13	2.13

Summary of MOCAT Scores

	MOCAT Composite Scores			MOCAT Classification		MOCAT Increase		
NGO	FY03	FY04	FY05	FY03	FY05	Points	%	Comments
BAMANEH	1.69	1.99	2.38	Emerging	Emerging	0.69	41%	Improvement in all 3Ps
BANDHAN	1.75	1.95	2.04	Emerging	Marginally Expanding	0.29	17%	Marginally improved
BMS	1.64	1.86	1.87	Emerging	Emerging	0.23	14%	No improvement P1 & decrease in P2 in 05; marginal improvement in P3
CAMS	2.04	2.74	2.74	Marginally Expanding	Expanding	0.70	34%	No improvement in 05. Risk of termination for financial malfeasance.
CRC	0.87	1.13	1.29	Nascent	Emerging	0.42	48%	Marginally improved, but still very weak
CWFD	2.38	2.78	2.79	Expanding	Expanding	0.41	17%	Little apparent improvement but among the strongest
DCPUK	1.84	1.87	1.87	Emerging	Emerging	0.03	2%	No change
DIPSHIKHA ANIRBAN	1.33	1.64	2.13	Emerging	Expanding	0.80	60%	Some improvement in all 3 Ps
FAIR FOUNDATION	1.82	2.3	2.54	Emerging	Expanding	0.72	40%	Improvement in all 3Ps
FDSR	1.89	2.02	2.46	Emerging	Expanding	0.57	30%	Improvement in all 3Ps
GKSS	1.68	1.8	2.05	Emerging	Marginally Expanding	0.37	22%	Some improvement in Ps 1 & 3; no improvement in P2
IMAGE	1.88	2	2.44	Emerging	Expanding	0.56	30%	Most improvement in P3
JTS	2.18	2.33	2.2	Emerging	Emerging	0.02	1%	No apparent improvement, but a long history in other sectors
JUSSS	1.26	1.79	1.66	Emerging	Emerging	0.40	32%	Marginal improvements in all 3 Ps
KAJUS	1.84	2	2.07	Emerging	Marginally Expanding	0.23	13%	Slight improvement in all 3 Ps
KANCHAN	1.63	2.2	2.39	Emerging	Emerging	0.76	47%	Fair improvement in all 3 Ps
MALANCHA	1.41	1.37	2.4	Emerging	Emerging	0.99	70%	Good improvement in all 3 Ps
MMKS	1.97	2.08	2.12	Emerging	Marginally Expanding	0.15	8%	No real improvement
NISHKRITI	1.92	2.43	2.67	Emerging	Expanding	0.75	39%	Fair improvement in all 3 Ps
PKS	1.73	1.96	2.02	Emerging	Marginally Expanding	0.29	17%	Slight improvement in all 3 Ps.
PROSHANTI	2.39	3	2.75	Emerging	Emerging	0.36	15%	Some improvement P1& P3; good improvement P2 in 04, but fell back in 05 to 03 level;
PSF	1.84	1.96	2.04	Emerging	Emerging	0.20	11%	Marginal improvements in all 3 Ps
PSKS	1.56	2.89	3.07	Expanding	Marginally Mature	1.51	97%	Good improvement in all 3 Ps
PSTC	2.57	2.63	2.77	Expanding	Expanding	0.20	8%	Slight improvement in all 3 Ps
SGS	2.01	2.11	2.08	Marginally Expanding	Marginally Expanding	0.07	3%	No real improvement
SHIMANTIK	1.69	1.69	1.92	Emerging	Emerging	0.23	14%	No real improvement
SOPIRET	1.82	1.96	2.09	Emerging	Marginally Expanding	0.27	15%	Slight improvement in all 3Ps
SSKS	1.67	2.15	2.67	Emerging	Expanding	1.00	60%	Good improvement in all 3 Ps
SUPPS	1.5	1.88	1.81	Emerging	Emerging	0.31	21%	Slight improvement in all 3 Ps
SUS	0.98	1.22	1.84	Nascent	Emerging	0.86	88%	Good improvement in all 3 Ps
SWANIRVAR	2.26	2.36	2.71	Expanding	Expanding	0.45	20%	Some improvement in all 3 Ps. Probably the strongest NGO
TILOTTAMA	1.67	2.24	2.34	Emerging	Expanding	0.67	40%	Fairly good improvement in all 3 Ps
UPGMS	1.68	1.77	2.57	Emerging	Expanding	0.89	53%	Good improvement in all 3 Ps
VFWA	1.62	1.91	2.2	Emerging	Expanding	0.58	36%	Fair improvement in all 3 Ps
VPKA	2	2.13	2.13	Marginally Expanding	Marginally Expanding	0.13	6%	No change

Serving the Poor

While the Cooperative Agreement certainly encourages serving the poor, this is not emphasized as one of the principal objectives. Nevertheless, one of the first activities of NSDP was an effort to create a safety net for the poor. In retrospect, this focus seems somewhat misplaced. While no one disputes the need to serve the poor, particularly the Least Advantaged (LA), it would seem that the initial stress should have been on developing the capacity of the NGO's to offer high quality services, move toward sustainability, and then focus on providing a safety net for the poor.

The NSDP MIS identifies the percentage of clients who are classified as poor. In 2005, 19% were classified as poor, an increase of about 1% over 2004. In Bangladesh, however, "poor" is a relative term: most people in the lower two quintiles of the economic spectrum could be classified as poor on almost any standard.

There is clearly an effort to reach the poor throughout the Smiling Sun network. During the testing of the Performance Reimbursement Scheme (discussed below), the clinics involved in the Performance Reimbursement Scheme increased coverage to the poor 182% in a six-month period. But even the control group increased 150%.

Table 1: Number of least advantaged customers served

Group of NGO's	Number of clinics	Previous 5-month (Oct04-Feb05)	Pilot period (Mar05-Aug05)	%change
Intervention (CWFD, DCPUK, PKS/Khulna, Swanirvar)	7	7,380	20,781	182%
Control (BMS, Fair Foundation, JTS)	6	2,388	6,045	153%

The Measure Evaluation reported the following distribution of NSDP clients for Ante-Natal services.

Table 2: Estimated Distribution of NSDP clients for Ante-Natal services

Economic Percentile	% in each percentile	
	Urban	Rural
1	27.6%	18.2%
2	28.7%	22.4%
3	18.6%	21.8%
4	14.5%	20.9%
5	5.2%	16.6%
Total	100.0%	100.0%

The same Survey shows a slightly different profile for BCG vaccinations, but we feel that antenatal services are more representative of significant chargeable services. Immediately we

can see that well over half of the urban clients and an expected 40% of the rural clients fall in the lower two quintiles. Assuming that ante-natal care is representative of other chargeable services, three other conclusions can be drawn from these figures:

- NSDP services are reaching the very poor.
- The urban poor use a disproportional amount of Smiling Sun services, but given other alternative sources of services, the numbers drop off as incomes rise.
- Perhaps due to the lack of alternative sources of services, the distribution of services in the rural areas is fairly even among the range of incomes in the country.
- More than 20% of the clients come from the highest economic quintile, suggesting increased opportunities for enhancing cost-recovery by pricing strategies adjusted to the capacity to pay.

Support for the Poor

As a first step, considerable effort was expended on actually identifying the poor – for the initial objective of ensuring that they were not excluded from services. This was coupled with strategies to introduce health cards for both paying and non-paying customers – basically a pre-payment scheme as a means of attracting customers. The LA's are given cards free; those able to pay are charged a relatively small amount (Tk 20) with a small co-payment (Tk 3); and those customers more able to pay are charged a higher fee for the card (Tk 100) and a higher co-payment (Tk 20).[2] Non-card holders are supposed to pay the full price of services. Cards are good for one year and cover anyone in the immediate family actually listed on the card.

The communities are generally involved in deciding who should be exempted from paying, which is one reason it takes so much effort to identify the poor. Communities must be stimulated and organized to take on this task.

While these schemes have been introduced in 17 NGO's, there are few cards actually in use. As a means of retaining customers, they seem to have had little effect, since customer loyalty seems to have been generally high without them. In retrospect, this general lack of success is probably due not only to the ability to pay, and possible resistance to annual renewal, but to the limited range of services offered, many of which are preventive in any case. Should services be expanded to include curative care, this whole concept should be reexamined, particularly for expanded use in businesses such as garment factories. Furthermore, this effort requires a constant follow-up due to births, deaths, immigration, etc. This is best left to the community at this stage.

Nevertheless, the exercise has had an important side effect: the identification of the poor makes it easier to implement a cross-subsidy scheme which stimulates and compensates NGO's for serving the poor, as described below.

Other sources of support for the poor are community funds and the Revolving Drug Funds. Table 3 demonstrates the experience to date. Thirteen NGO's and their communities associated

[2] These were the charges established at SSKS. Presumably other NGO's have a similar scheme.

with about a quarter of all NSDP clinics have provided additional support to ensure services to the poor. The Islamic pillar of Zakat is also a source of support for health care in some communities. This clearly demonstrates their commitment to serving the Least Advantaged (LA).

Community Funds, however, must be replenished, and this may not be sustainable. Furthermore, logic suggests that they are more viable in communities with a mixed income distribution with some individuals able to contribute. This will eliminate this possibility for the poorest communities.

Revolving drug fund have also been a source of support in some communities. These are, in fact, not really community funds, but are donations of drugs by the NGO's themselves. This is an important source of support since there is anecdotal evidence that the poor often do not come to clinics if no free drugs are available. Tk 300,000 may not seem like much money during an 11-month period, but a crude estimate of RDF profits over all NSDP clinics suggest that this may represent a third of the RDF profits in the clinics which provide them. The capacity of various clinics to provide this support varies significantly throughout the NSDP system, and even within individual NGO's. Centralizing RDF's at the NGO level would facilitate redistribution of excess RDF profits to help ensure access to drug and services of all LA's.

Table 3

Cost Sharing to Serving Very Poor (April '04-June '05)					
Rural/Urban	NGO (clinic # in parenthesis)	Amount of fund raised to serve very poor (in taka)			
		Community fund	RDF cumulative profit	Other sources	**Total**
U	CWFD (14)	84,836	11,108	1,760	97,704
U	Fair Foundation (10)	16,885	83,574	420	100,879
U	FDSR (13)	58,210	9,881	7,673	75,764
U	Kanchan Samity (4)	10,804	9,890	164	20,858
U	UPGMSR (6)	5,804	46,448	-	52,252
U	VFWA (5)	70,000	-	3,320	73,320
U	Dipshikha Anirban (1)	1,000	13,852	-	14,852
U	PKS_Khulna (11)	14,933	640	1,065	16,638
Urban 8 NGO's	64 clinics	262,472	175,393	14,402	452,267
R	DCPUK (3)	53,487	935	4,550	58,972
R	JTS (3)	5,411	30,447	1,092	36,949
R	Swanirvar (3)	10,775	82	340	11,197
R	Shimantik (6)	-	87,134	1,732	88,866
R	JUSSS (4)	1,000	3,000	3,000	7,000
Rural 5 NGO's	19 clinics	70,673	121,598	10,714	202,984
13 NGO's	**83 clinics**	**333,144**	**296,991**	**25,116**	**655,251**

The Capacity of the NSDP Clients to Pay for Services

A critical element of NGO sustainability, particularly without donor support, is the capacity of clients to pay for products and services. To attempt to determine this, we first need to examine the context of Bangladesh. . While Table 4 does not follow the quintile distribution, we can observe that an estimated 22.8% of the urban population and 38.1% of the rural has an annual family income below Tk 24,000. Since the first quintile represents the lowest 20% of the population in terms of income, we can estimate that upper limit of that quintile for the urban population is probably about Tk 20,000, while the rural limit is probably much lower, perhaps less than Tk 12,000 per year.

Table 4: % of the Population at Various Income Levels[3]

Yearly Household Income (Taka)	Urban	Rural	Weighted Average*
1 – 24,000	22.8	38.1	34.3
24,001 – 48,000	32.7	35.9	35.1
48,001 – 72,000	18.0	13.9	14.9
72,001 – 96,000	9.0	4.5	5.6
96,001 +	17.5	7.6	10.1
Mean	70,896	46,848	52,860
Median	48,000	36,000	39,000

* Assumes 25% Urban, 75% Rural

WHO has suggested that most people in the developing world spend about 3% of their total income on health care. For poor Bangladeshis, it is probably less, although episodically they may pay more for births and emergencies, further driving themselves into a vicious cycle of poverty. If we estimate 2% of their family income could be spent for health care, this suggests that in the lowest quintile, an urban family's disposable income for health care is probably less than Tk 400 per year; and a rural family's less than Tk 240 per year.

Toward the upper levels of the first quintile, clients are probably willing and able to make partial payments, but the lowest 10% of the population is clearly destitute and cannot be expected to pay for services. Indeed, the incapacity to pay the full cost of some services probably extends well into the second quintile, particularly in the rural areas.

Finally, actual monetary figures on the economic distribution of ante-natal clients shown in Table 4 can be applied. Given this economic distribution and ability to recover costs from the clients, NSDP NGO's may still need at least 30% of costs of their services subsidized in one form or another. This means either provision of drugs, FP supplies, and other supplies by the GOB or someone else; cross-subsidies within their individual network of services or within the total NSDP network; or support from outside sources such as USAID, other donors, or the

[3] National Media Survey, Social Marketing Company, 2002.

communities; serious efforts at cost containment; or more likely, some combination of all of these strategies.

Lessons Learned with respect to serving the poor:

- NDSP services are reaching the poor, although it is not clear how well the LA's are being served.

- There is some anecdotal evidence that without access to free medicines, at least some LA's will not attend clinic services, even if they are free-of-charge.

- Community Funds can help support the poor, but probably only in communities with a mixed economic structure. Since they are voluntary, the sustainability of these Funds is questionable; and almost certainly not available in the poorest communities.

- Provision of drugs to the LA's is a critical element to ensuring their access to primary health care services. Centralizing RDF's at the NGO level would facilitate redistribution of excess RDF profits to help ensure access to drug and services of all LA's. Because of the differences in the populations served by NGO's, particularly the rural NGO's, a mechanism is required to redistribute funds across the entire Smiling Sun network to ensure that no LA's are left out. A potential mechanism is the Performance Reimbursement Scheme discussed below.

- Health Cards have not proven to be a particularly useful mechanism for ensuring services to the poor. A great deal of effort was placed by the project in identifying the poor for this purpose. Now that it is done, and the mechanism is established, the task of updating identification of the non-paying clients should be left to the communities.

- At least 30% of all Smiling Sun costs must be subsidized in one manner or another, and most likely through a combination of mechanisms. These include donor funding, but also include cross-subsidies within and across NSDP NGO's, support from communities, in-kind provision of commodities, and other sources. The more non-donor support is stimulated, the easier and safer it will be for USAID to withdraw without losing the tremendous investment already made.

Strategies and Activities Supporting Sustainability

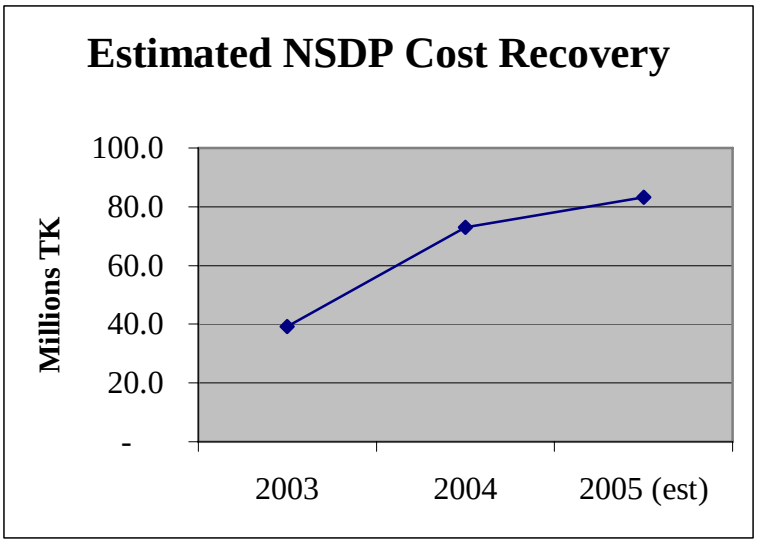
During the first two years of this project, despite the apparent goal of making the NGO's organizationally stronger and more sustainable, the emphasis of the TA team was to provide support directly to the clinic and service delivery levels. Part of this emphasis was due to the fact that the Sustainability Team spent the first year trying to determine what the NGO's needed rather than giving them much support. The fact that most service delivery indicators rose in 2003 and 2004 suggests that this effort was fairly effective and commendable, but in many cases did little to enhance the sense of ownership of the NGO's or their capacity to manage their

networks. It must be remembered that this focus was merely an extension of at least 5 years of dependency of these NGO's on USAID funding.

Cost-recovery

The percent of cost-recovery for the entire NSDP network increased from **17% in FY 03 to 20% in FY 05**. The reported level of cost-recovery for individual NGO's range from about 10% to 30%. Individual clinics report as high as 70%, but they are the exception. These rates exclude cost-recovery from Revolving Drug Funds which is an important source of income.

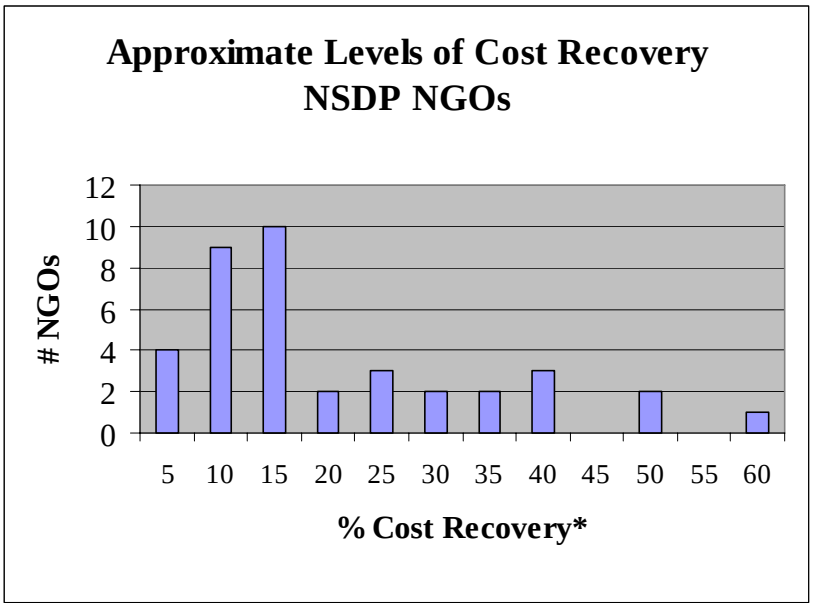
Figure 1



It is important to remember that the rates themselves represent the relationship between generated income and USAID expenditures. In general, actual USAID grants and program income expenditures for each NGO have been diminishing each year. Therefore, some of the apparent gain in cost-recovery is due to lower expenditure rates, rather than an increase in generated income. Nevertheless, as shown in Figure 1, the actual amount of cost-recovery funds has increased significantly since the beginning of the project.[4]

[4] Note that these figures are drawn from a project database for each clinic, and may not be complete for 2003. The data are for calendar years, not fiscal years, and 05 is a prorated estimated for the year based on figures from Jan. to Aug. In reality, cost-recovery for 2005 may be somewhat higher.

Figure 2



Most of this increase, however, is due to significant levels of cost-recovery in a few strong NGO's. Figure 2 shows the approximate distribution of cost-recovery in 40 NGO's, some of which have now been incorporated into other NGO's.. The average is 20%, but half are 15% or below.

Unsurprisingly, cost-recovery for rural NGO's is less than for urban NGO's. In 2003, the average rural NGO recovered about 75% of the average urban NGO. Since the urban NGO's have doctors and can offer a wider range and more complex chargeable services, the gap between urban and rural is likely to widen. For this reason, strategies cross-subsidizing rural services from urban services should be encouraged.

On the other hand, the previous analysis demonstrates that, ignoring drugs, the percentage levels of cost-recovery rates are in reality lower than those reported for a very simple reason: they are calculated on the basis of spending by USAID, and ignore the contributions from other sources which increases somewhat the denominator.

Cost-recovery rates are distorted in other ways. Accounting is done on a cash basis, and all expenditures are written off as costs for the present year, including capital expenses such as equipment which will be used over several years. At the NGO level, this practice probably has little impact, but it can make interpretation of cost-recovery levels of individual clinics extremely voluble from one year to the next.

Furthermore, given the state of business practices in Bangladesh, would it not be surprising if some money were diverted for non-project purposes. Non-reporting is made particularly difficult to detect because of partial payments made for services for which there is no established rate.

Cost-recovery rates and amounts are also a function of the number of poor being served. As much of the emphasis of the project has been on serving the poor, and to date, no viable mechanism for paying for these clients has been introduced, growth in cost-recovery has been delayed.

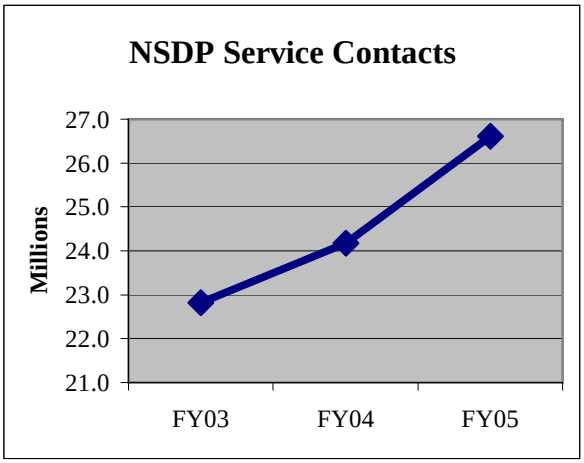
To date, most NSDP efforts at improving cost-recovery have depended on 5 inter-related strategies:

- Expanding the volume of services
- Expanding the range of services
- Improving the quality of services
- Modifying pricing policies
- Stimulating cost-consciousness
- Marketing

Measured by the reported percentage increase of cost-recovery, the overall combination of these strategies has yielded unimpressive results. However, a number of concrete strategies are only now being introduced, and impressive gains should be evident by the end of FY 06. Additionally, a strategy has been tested which could solve a number of critical problems, including cross-subsidies to provide payment for the poor. All of these strategies are discussed briefly below. Note that they are very closely linked and mutually dependent.

Expanding the Volume of Services

Figure 3



Expanding the volume of services is approached in two ways: increase and retain the number of clients; and increase the range of services. Until now, the effort has been principally on the former which has been somewhat successful. As shown in Figure 3, service contacts have risen over the past three years. This increase has certainly contributed to cost-recovery, but most are not chargeable services or produce much revenue. A number of urban static clinics, where the greatest potential for cost-recovery resides, have actually experienced a decline in terms of patient contacts due to competition. Other potentially lucrative services in the ESP have also declined. They include ante-natal visits and long-term and permanent family planning methods.

To put the potential of cost-recovery from the ESP package alone in perspective, Table 6 shows the growth of four important and potentially lucrative services. All demonstrate some growth, but together represent less than 40% of total customer contacts. The most striking increase is that of Limited Curative Care which jumped 26% in FY05 alone[5]. This is a clear indication of where demand for services really lies: people seek care for curative services, and are willing to pay for those services. That service alone is responsible for much of the growth of cost-recovery, and suggest that in order to attract more customers, a wider range of services should be offered, particularly curative care.

Table 6

[5] Some of this jump is attributable to an increase in distribution of ORS by Depotholders.

Services	Customer Contacts			Percent Change	
	FY03	FY04	FY05*	FY03 Vs FY04	FY04 Vs FY05
Total child immunizations	2,976,317	3,044,453	3,432,420	2%	13%
CDD treatment	1,763,714	1,904,364	2,029,420	8%	7%
Pneumonia treatment	137,168	149,420	167,333	9%	12%
Limited Curative Care	3,626,708	3,839,688	4,842,438	6%	26%

The impact of these services is understated because all require drugs or vaccines. Drug sales are not included in the cost-recovery figures; and while the provision of vaccines is included, the value of the vaccines themselves are not presently included in the cost of services as they are donated by the GOB.

Expanding the Range of Services

As stated and demonstrated above, the key to achieving much higher levels of cost-recovery is to offer a wide range of services, particularly curative care. The myopic vision of the project and many of the NGO's themselves has largely precluded that until recently. With expanded curative services, sales for drugs and lab tests will rise. Equally important, the presence of a wide range of services will attract more customers who will then expand actual patient contacts by seeking multiple services.

Delivery services have been introduced in 16 clinics; and programs of home deliveries are being considered. This is an excellent way of attracting clients, as whole packages of services including pre- and post-natal care, lab tests, sonograms, and neonatal care can be offered. Assuming high quality services are available and the pricing accessible, it is natural that the woman returns for other priority ESP services and pediatric services. Rather than detract from the emphasis on ESP services, the provision of curative services and safe deliveries actually encourage greater volumes of USAID-priority services.

Some of the more entrepreneurial urban NGO's have already recognized these relationships, and are actively seeking to expand services. Rather than refer patients requiring caesarian sections to GOB hospitals or private clinics, they are starting to provide this service in-house, contracting specialist staff on a per-case basis. In doing so, the prices are set to cover costs, but are below those of private clinics, yielding impressive demand, and greatly enhancing cost-recovery.[6] This success and the availability of capacity encourage other secondary-level surgery. While expansion of these services should be encouraged, they should only be offered when conditions are appropriate and high risk cases are avoided.

Likewise, other primary care services, particularly pediatrics and gynecology complement the ESP package. Local specialists can be contracted on a per-patient or per-session basis. Such expansion is just getting started, and depends largely on permission of USAID and NSDP to use

[6] SSK-S presently offers C-sections for TK 10,000 which private clinics charge TK 20-30,000. With costs estimated at about TK 6,000, 20 C-sections a month generates surplus revenue of TK 80,000 per month which can then be used to cross-subsidize other services and clients.

generated income to finance them. Restricting the use of program income to provide these services damages both the provision of ESP services by limiting contacts, as well as the prospects for financial sustainability.

A useful intervention would be to communicate successful introduction of specific new services among NGO's, either through meeting, visits, newsletters, or all three.

Enhancing the Quality of Services

Absolutely key to attracting and maintaining a clientele is quality of services. It has been demonstrated world-wide that patients will seek the best services they can afford, and if they have other options, will avoid low-quality services. Several activities need to be emphasized, particularly as services are expanded: the existence of protocols and training, the retention of professional staff, attitude toward the patient, teamwork, supervision, etc. The NSDP project team has done some work in all of these areas, but this is a continuous process, and NGO's must be staffed to insure their own quality of services if they expect to attract and retain clients as well as succeed with financial sustainability.

Physician Retention

One of the problems affecting quality and performance, and therefore sustainability has been a high turnover of medical staff, particularly physicians. Since program inception the average physician turnover rate has fallen from more than 20% to 14.6% in FY 2005, but this disguises the fact that for some of the smaller NGO's, the loss of two physicians may represent half their medical staff.

NSDP has spent considerable time and effort and money training physicians, and when those physicians leave, that investment is lost, as is the relationship established with the patients. Recruitment costs include the gap in services provided, as well as the need to retrain physicians.

Apparently one of the main reasons for physician turnover is the opportunity to accept a government position. Despite lower pay, job stability is a primary factor, as well as the opportunity to carry out private practice after hours. This highlights one of the inherent weaknesses in small NGO's: they do not have a solid track record and cannot guarantee a long career. This is one of the reasons why to become more sustainable, NGO's need to be relatively large and stable.

On the other hand, in an urban setting there is more competition, so without organizational loyalty, physicians jump from one organization to another. Clearly, they need to be offered competitive incentive packages to avoid high turnover.

The recent cost study pointed out an interesting phenomenon: physicians spend about 40% of their time doing administrative work. This is a poor use of their skills, and probably an additional stimulus for leaving. We reviewed the administrative workload, and indeed, each medical program has series of indicator records requirements that physicians must address. Ironically, the larger busier clinics suffer the most since they generate more patients and thus more paperwork, and consequently have less time to devote to paperwork. At least some physicians delegate the administrative tasks to other staff members, particularly the counselor, but that is also not a good use of his/her time.

NSDP staff recognizes these problems, and the overall reduction demonstrates an effort to cope with them. We would further encourage the computerization of forms, at least for the larger clinics, and an additional administrative/data entry person.

We also do not subscribe to policies of hiring retired physicians except as a stop-gap, as in terms of sustainability, it is obviously better to hire someone willing to remain for a number of years. Furthermore, the tendency to recommend non-physician "clinic managers" seems to us counter-productive: this is confusing the management and the administrative functions. The physician, because of his/her authority and skills will always assume leadership, but administrative tasks can certainly be delegated.

Modifying Pricing Policies

At the beginning of NSDP, the NGO's had already established pricing policies. The Project Team, however, recognized early on that these schedules were less than ideal in terms of attracting paying and non-paying clients, covering costs, subsidizing clients able to pay, being competitive, etc. Thus within the first months of the project, the Finance team began to work with the NGO's as a group and then individual NGO's to establish more appropriate pricing policies, considering factors such as the existing price, competitors' prices, the willingness and ability to pay, the quality of services, the cost of services, the clinic location, etc.

This has been a long gradual process which continues to this day. In fact, the recent completion of the Service Cost study provides a wide range of additional inputs which can and should be used to reexamine pricing strategies once again.

These efforts have both stimulated the number of clients seeking services and enhanced cost-recovery. The latter has been demonstrated through the use of regression analyses: at a 99% confidence level, the estimated impact of price changes is a 4.5% increase.

Particularly in those clinics which offer delivery services, we suggest exploring the possibility of discounted packages which includes not only the delivery, but combinations of ante- and post-natal services, lab tests, sonograms, and neonatal services. This would not only increase the provision of these services, but would enhance the overall quality of the birthing process.

Cost Consciousness

Clearly one of the strategies of cost-recovery is to reduce the cost of services. The Sustainability Team has tried to stimulate a culture of cost consciousness through the use of MOCAT. It is not clear that this has taken root despite Project Team claims that costs per service have been reduced by 21% between 2003 and 2005. Reductions in cost/service can be expected from spreading fixed costs over a larger service base. Some fixed costs were also probably reduced through the consolidation of the services of 8 NGO's into other NGO's – itself an important argument for continued consolidation. The percentage reduction, however, is difficult to interpret since the product mix undoubtedly changed during the process, and only USAID costs are considered.

More impressive than the claim of a culture of cost consciousness or level of reduction is the fact that the primary fixed cost, personnel until now has been based on a standard staffing pattern with little regard for the service volume at each service point, particularly the static clinics. The

NGO's recognize this anomaly, and applaud the NSDP's recent decision to allow adjustments to the staffing of each clinic. This should indeed result in more cost-effective services.

Marketing

With the exception of the last, all of the strategies listed above are critical to attract larger volumes of customers, and might be considered indirect marketing. Beyond those strategies are direct marketing strategies. Until recently, direct marketing has not been a major emphasis, but has certainly been present. Perhaps the primary strategy has been to attract visible and influential community leaders to the Executive Committees of the NGO's. Their visibility, support (and sometimes money), has certainly enhanced the image of the Smiling Sun.

In addition to the participation of Mrs. Khan of CFWD as one of the most dynamic, influential and internationally recognized people in health care, NSDP has been successful during the past year in attracting two other widely recognized and influential icons in Bangladesh society:

Mohammed Rafique, probably the most popular sports personality in Bangladesh, signed a contract to become NSDP's spokesperson on maternal and neonatal health care. He is being used to convey messages directed at Bangladeshi men, who so often hold authority in Bangladeshi society. Rafique filmed a TV public service announcement which was broadcast nationally seven times (at the end of August and early September) during cricket matches in which Rafique played. In the ad, Rafique urges men to prepare as thoroughly for the impending births of their children as he does for every match.

Early in 2005, the famous Bangladeshi actress, Joya Ahsan, became NSDP's Brand Ambassador for the Smiling Sun. Her image now appears on a large number of NSDP's print materials, including billboards, posters and brochures. In addition to her function as a celebrity spokesperson for the Smiling Sun clinics, she is seen as the embodiment of the very high level of health care provided by Smiling Sun physicians and paramedics, since she stars in the 26-episode TV series as Ayesha, a paramedic at a Smiling Sun clinic.

Participation of these two icons, as well as public support from many GOB officials, have stimulated newspaper articles, publications, testimonials, and have all helped both NSDP and strengthened the branding the Smiling Sun network. This is social marketing and branding at its highest level, and NSDP is to be recognized and congratulated for these successful efforts.

The social marketing drama series is excellent, not only in its own right as a high quality educational and marketing tool, but for the lead-ins it provides to promote appropriate health behaviors and the Smiling Sun brand through other marketing strategies such as posters and pricing strategies. We have noted, however, that at least in the sample of clinics we visited, that a large volume of the printed materials seem to remain in the clinics. This brightens up the clinics, but does little to advertise them. The NGO's need more guidance on marketing strategies.

Another excellent marketing strategy has been the involvement of Imams in training related to the rationale behind the ESP and the services provided in the package. As influential leaders, they can have a tremendous positive impact on acceptance of services by the community.[7]

While social marketing efforts have been very successful at establishing the Smiling Sun brand and attracting clients to Smiling Sun clinics on a national level, little attention has been given to direct marketing at the clinic level. The introduction of expanded services offers the opportunity for launching aggressive marketing campaigns for each clinic, announcing to the community it serves the availability of the expanded range of services, and thus attracting and capturing a wider range of clients for all services. Note that these marketing campaigns should emphasize the Smiling Sun – and not the NGO's.

Lessons Learned with respect to Cost-recovery

- Cost-recovery is increasing among most NSDP NGO's. It is, of course, most difficult for the rural NGO's who serve relatively poorer populations.

- Because of the nature of NSDP targeted services, cost-recovery potential is severely limited for two reasons: the services themselves are largely preventive, and will never generate large amounts of income, particularly if significant numbers of poor, unpaying clients are served; and a the narrow range of services excludes much curative care which has a high demand, and thus, for those curative and other services not currently offer in Smiling Sun clinics, people seek services elsewhere.

- The capacity for cost-recovery varies between NGO's and clinics. Mechanisms must be established to ensure an equitable distribution of resources, particularly to serve the poor, within NGO networks, and between the NGO's in the Smiling Sun network.

- Offering a wider range of services particularly curative services will attract more clients to Smiling Sun clinics, generate more cost-recovery to improve sustainability, and at the same time, generate increased demand for NSDP priority services.

- Particularly where competition is present, quality of care is critical to attract and retain a large clientele. Particularly as services expand, this component must be strengthened, and supervision from the NGO level enhanced.

- Improved quality includes the constancy of well-trained, supervised staff, particularly doctors and paramedics who have developed a strong clientele. It is more cost-effective to pay them at competitive levels than to forego services, have reductions in quality, and costs of recruiting and training. Well established NGO's might well experiment with innovative payment schemes.

[7] Anecdotally, one Imam in Syhlet who had received the training, was actually given a vasectomy by a Smiling Sun female doctor.

- Efforts to brand and attract clients to the Smiling Sun network have been hugely successful, and should be continued. This type of social marketing requires a continual presence, and is worth the investment.

- Staffing must be adjusted to the volume of services at each service point. The former NSDP policy of "one-size-fits-all" has proven to be less than optimal in terms of cost-effectiveness.

- Little attention has been paid to marketing the services of individual clinics. This needs to be strengthened to attract a wider range of clients for all services.

The Performance Reimbursement Scheme

Perhaps the most innovative activity of NSDP has been the concept of the Health Equity Fund. This concept is designed to deal with three challenges to program sustainability:

1. Stimulating services to those who are unable to pay
2. Stimulating cost-recovery to enhance sustainability
3. Shifting some cost-recovery funds away from "program income" so that NGO's have more flexibility for supporting their health programs.

The scheme is relatively simple: the increment of generated income from one year to the next is redistributed in the following manner:

- 50% to the Equity Fund
- 25% to the NGO for use in the health program
- 25% as an incentive to NGO personnel for increasing cost-recovery

The Equity Fund is then redistributed across the entire network to cross-subsidize services provided to the poor. In essence, the large urban NGO's, particularly those serving relatively few poor, will subsidize other NGO's which serve more poor. This stimulates NGO's to serve the poor since indirectly, the poor become "paying customers".

The concept was piloted for 6 months in a quasi-experimental design for 8 NGO's (4 urban and 4 rural), divided into an intervention group with 72 clinics and a control group with 39. The results of the pilot were impressive: the increase in cost-recovery in the intervention group was double that of the control group; and compared with the previous six-month period, the number of LA's served went up 41% in the intervention group, while services to LA's in the control group decreased 20%. Anecdotally, the NGO's themselves were pleased with the scheme, and the control group requested to be included.

One weakness of the system is that it is based on the increment of cost-recovery over a given period. Without expansion of services into a wider range of primary care, the limits of cost-recovery will probably be reached in a relatively short time. The possibility to expand services will alleviate this potential obstacle in the medium term. Nevertheless, to be run successfully,

the accounting should probably be carried out quarterly rather than biannually. If done this way, however, there will likely be quarters with lower cost-recovery due to seasonality factors, which would virtually eliminate contributions to the scheme during that period.

Another weakness is that the scheme does not include reimbursement for the provision of drugs. This is an important omission since we have observed that the poor may avoid services without that provision.

Despite these short-comings, the Scheme has proven its potential for demonstrating the potential achievement of what we perceive to be its two primary objectives: creating a mechanism to cross-subsidize across the Smiling Sun network, and stimulating higher levels of cost-recovery. A modified formula should be determined which will provide sufficient funds to cover the expenses of services provided to the poor across participating NGO's, including drugs.
For these important reasons, we feel that the scheme should be further tested and refined on a larger scale between now and the end of the project. This would help detect and deal with potential problems such as seasonality of patient volume, assess the administrative burden and improve tools and procedures to speed up the process, better detect tendencies to over-report serving the poor, as well better understand as the real amounts of money required to cross-subsidize the poor.

An inherent weakness of any financing scheme cutting across NGO's is that a centralized organization is required to manage the accounting of the Equity Fund itself. At present, that organization is the NSDP project. We consider the basic idea to be an excellent one, and given the potential of this scheme to serve increasing numbers of the poor while increasing cost-recovery, we recommend reestablishment and expansion of the scheme to approximately 10 NGO's during the final phase of the project. This is within the capacity of the project with 8 NGO's already identified, so this could be done reasonably quickly. Because the project will terminate at the end of September, 2007, this expanded test could probably be implemented for somewhat more than a year before it would necessarily have to be suspended at least 3 months prior to the termination of the project to complete the final accounting.

Assuming that the scheme is judged successful by the end of this second test period, it should be implemented on a full-scale during the next project. To avoid the problem of managing the fund through a project which will inevitably disappear, it would make more sense to create a centralized body to manage the fund, as well as other aspects of the Smiling Sun network. The scheme will clearly work best as the pool of clinics and services is increased – much in the same way as large pools of clients spread the risk of insurance. For this reason, eventually it may be useful and perhaps necessary to create a formal franchise network to lock all participating NGO's into the scheme, enabling them to standardize quality of services delivered, procure centrally, etc.

Lessons Learned with respect to the Performance Reimbursement Scheme

- Despite some shortcomings, the Performance Reimbursement Scheme has proven its potential for demonstrating the potential achievement of what we perceive to be its two primary objectives: creating a mechanism to cross-subsidize across the Smiling Sun

network; and stimulating higher levels of cost-recovery.

- In order to further stimulate cost-recovery, services to the poor, and further test modifications, the Performance Reimbursement Scheme should be refined and implemented within an expanded group of NGO's and clinics during the remainder of the project. Some refinements might include:

    - Elimination of the 25% remitted to the NGO from "program income" – which under the present USAID interpretation of approval procedures for "program income" is unnecessary and would simply complicate the procedure.

    - The conception and testing of a mechanism more indicative than incremental cost-recovery upon which to base contributions to the Equity Fund and employee incentives.

    - The inclusion of the cost of drugs to the poor in the scheme.

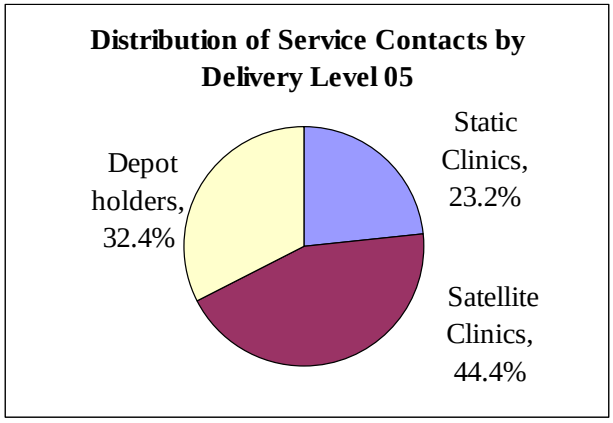
- Assuming that the Performance Reimbursement Scheme is eventually deemed a success, it will be important to maintain intact the participation of the stronger Smiling Sun NGO's and clinics in order to be able to cross-subsidize those requiring financial support to serve the poor. In the long term, this probably requires a mechanism to lock all participating NGO's into a franchise arrangement, without which the stronger NGO's might opt out.

Cost of Services

The recent cost study provides estimations of standard costs of services based on a sample of clinics and satellite spots. This is a good starting point, particularly in terms of direct costs, but indirect costs of service provision will vary significantly from clinic to clinic and between satellites depending on a number of factors including the mix of services, the volume of services, staffing patterns, staffing administrative time, etc. For this reason, it is not possible to accurately calculate the cost of provision of each service at different service delivery levels. NSDP is attempting to achieve this, however, through application of the CORE costing model which was taught to a pilot NGO (Fair Foundation) during the period of this evaluation. This will assist them in assessing their pricing.

From a programmatic and planning point of view, it is more useful to try to understand the relative cost-effectiveness of services offered between NGO's in order to identify the most cost-effective models among them. This effort is thwarted somewhat by the fact that the project maintains accounts by a small number of line items, but not by cost center – in this case meaning, static clinics, satellite clinics, depotholders, and central office expenses. Thus, line items are a mix of expenses incurred at all of these levels, and it is impossible to easily obtain, for example, the cost of central administration or the average cost of running a clinic..

Figure 4



As an easily available proxy, NSDP reports the cost per service contact. This is simply the total USAID cost (program income + grant) divided by the number of service contacts during a given period. This indicator is meaningless because it ignores resources from other sources; and is greatly influenced not only by the mix of services offered at each level, but the relative numbers of service contacts at each level.

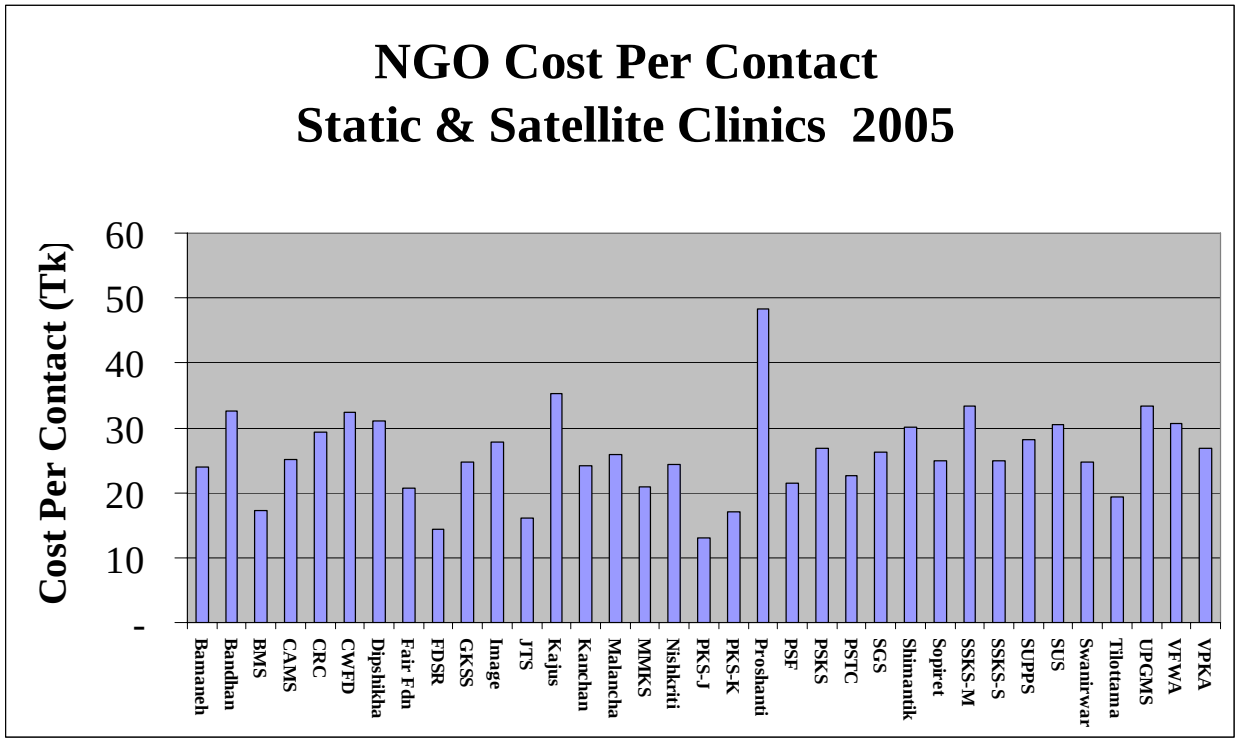
To better understand the services provided by each NGO, Table 7 is derived from the NGO Summary Table above. The distribution of total service contacts by service delivery level for 2005 is presented in Figure 4. It is important to recognize that there are great differences in the type, mix, and quality of service contacts at each level. And while Figure 4 presents the averages for each level, the distributions vary significantly between NGO's: the percentage of services provided at the static clinics varied between 78.9% at Proshanti to only 9.4% at Shimantik; for satellite clinics, between 67.9% at Kanchan to 21.1% at Proshanti. Very few depotholder services are offered by urban NGO's, but most rural NGO's offer 40% to 50% of their services at that level.

Table 7

NGO	Total Contacts	% of Service Contacts		
		Static Clinics	Satellite Clinics	Depot Holders
BAMANEH	1,331,062	13.9%	37.1%	49.0%
BANDHAN	167,075	13.6%	38.6%	47.8%
BMS	531,192	39.4%	60.6%	0.0%
CAMS	235,236	54.6%	45.4%	0.0%
CRC	184,855	16.1%	31.0%	52.9%
CWFD	798,334	51.2%	46.9%	1.9%
DIPSHIKHA ANIRBAN	40,452	39.2%	60.8%	0.0%
FAIR FOUNDATION	613,662	45.6%	54.4%	0.0%
FDSR	1,212,876	21.6%	50.2%	28.2%
GKSS	471,813	11.1%	28.8%	60.1%
IMAGE	305,948	42.4%	57.6%	0.0%
JTS	2,497,825	14.8%	43.0%	42.1%
KAJUS	68,466	47.6%	52.4%	0.0%
KANCHAN	468,070	32.1%	67.9%	0.0%
MALANCHA	195,211	29.1%	66.5%	4.3%
MMKS	798,378	15.9%	41.7%	42.4%
NISHKRITI	454,604	37.9%	62.1%	0.0%
PKS-Jessore	461,581	42.5%	57.5%	0.0%
PKS-Khulna	907,329	44.8%	55.2%	0.0%
PROSHANTI	96,047	78.9%	21.1%	0.0%
PSF	2,486,036	13.3%	40.6%	46.1%
PSKS	436,174	19.9%	35.3%	44.8%
PSTC	966,768	47.1%	51.4%	1.4%
SGS	367,029	13.9%	44.0%	42.1%
SHIMANTIK	603,235	9.4%	36.4%	54.2%
SOPIRET	654,225	15.1%	44.0%	40.9%
SSKS-Moulavibazar	164,230	33.0%	67.0%	0.0%
SSKS-Sylhet	344,883	68.1%	31.9%	0.0%
SUPPS	93,006	26.6%	33.9%	39.5%
SUS	382,924	16.2%	40.5%	43.3%
SWANIRVAR	5,253,427	10.6%	36.2%	53.2%
TILOTTAMA	708,602	36.8%	63.2%	0.0%
UPGMS	226,192	44.5%	55.5%	0.0%
VFWA	226,347	43.3%	56.7%	0.0%
VPKA	359,370	12.0%	43.1%	45.0%
Total	**25,112,464**	**23.2%**	**44.4%**	**32.4%**

Taking total USAID expenditures (grants + program income) for NGO's for 2005, and adjusting for the negligible monthly honoraria provided to Depotholders, and dividing it by the total number of service contacts at the static and satellite clinic level, yields an estimate of Cost Per Contact at those service delivery levels. The results are shown in Figure 5.

Figure 5



Most NGO's fall roughly into the Tk 20 – Tk 30 range. One NGO, Proshanti, has a cost per contact four times higher than the least expensive, PKS-Jessore, probably in part because Proshanti has a higher percentage of services provided through static clinics than any of the other NGO's. In principle, one would think that since satellite clinics have apparently lower costs than static clinics, those NGO's having a higher percentage of services provided through satellite clinics would have lower a cost per contact. As Figure 5 shows, however, that doesn't necessarily seem to be the case. Proshanti is, of course, the point at the upper right-hand corner, but for most, the relationship between the % mix between static clinics and satellite clinics doesn't seem to be strong. This can probably be explained in part by the fact that not all of the static clinics have doctors; and because some satellite clinics are widely dispersed with relatively few clients while some urban clinics are very busy.

Figure 5

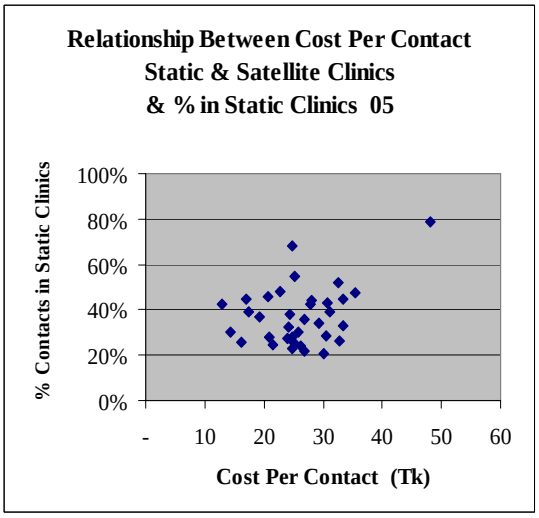
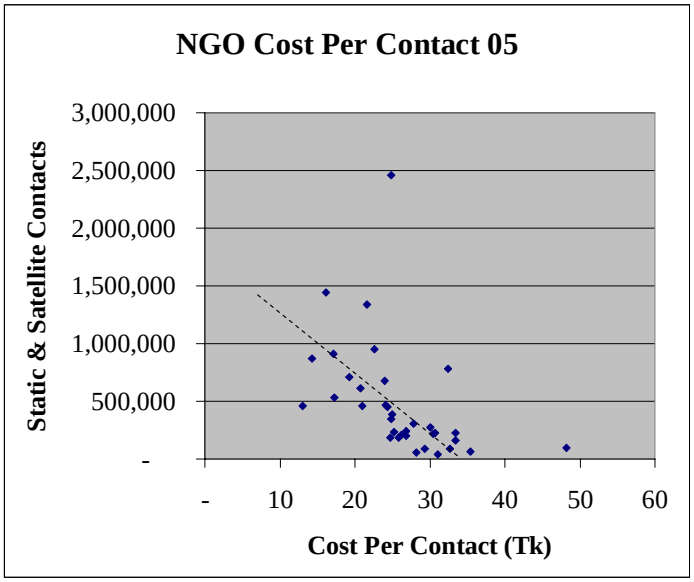


Figure 6



Finally, to shed a little more light on the matter, in Figure 6, the volume of service contacts is related with the cost per contact. Particularly among the higher performing NGO's, there does seem to be a relationship between lower cost per contact and higher volume as suggested by the dotted line. The exception to this tendency is the highest point which is Swanirvar. This large NGO is presumably utilizing a different delivery model than the others.

The cluster of low-volume NGO's at around Tk 30 per contact is probably indicative of similar fixed costs – which is not surprising: the model has been a standard staffing model regardless of service volume; and a standard administrative structure despite the size of the NGO's.

More revealing are Figures HH and HK which also compare customer contacts, but arranged cumulatively. Figure HH prepared by the NSDP team shows total contacts, including the depotholder contacts; and budget figures. In this case, 60% of the budget produces 70% of the contacts. Equally, if not more important, 70% of the total contacts can apparently be produced by only 12 NGO's using 60% of USAID's budget.

This graph presents a somewhat distorted picture, however, for two reasons. First, as explained above, as valuable as the depotholders may be in terms of total contacts, they are supported primarily by the GOB in terms of commodities and vaccines, and by the NGO's in terms of drugs, and so the cost to USAID is negligible. Secondly, budgets are not fully executed, and so distort the picture still farther. The graph is also slightly out-dated since two of the main performers (JUSSS and DCPUK) have been terminated and their services absorbed by others.

Figure 8 takes these two factors into consideration by focusing on the static and satellite clinics as in the case of all other graphs in this section. Here the relationship between expenditures and customer contacts is much closer: 60% of the budget provides 65% of the contacts, but again, this is produced by only 12 NGO's. These graphs also demonstrate that the elimination of a few NGO's would not have a significant affect on either expenditures or contacts. It would, however, be greatly easier for a technical assistance team to support – which in fact is what NSDP is now doing: focusing on the 14 top performers, and largely ignoring the rest.

Figure 7

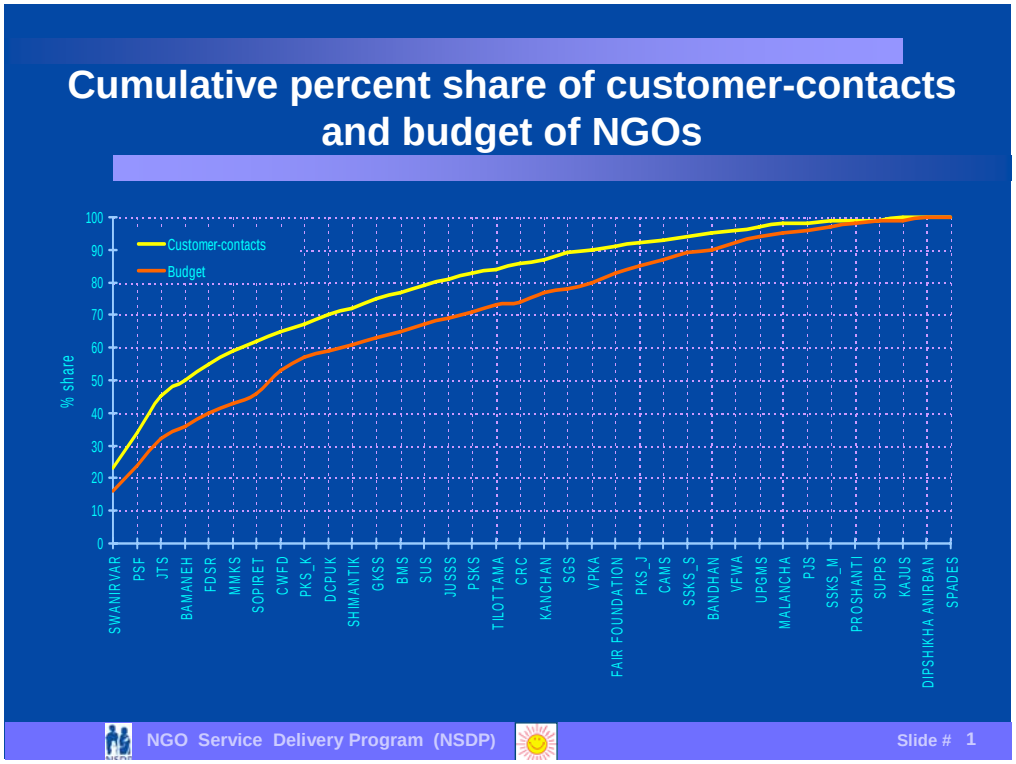
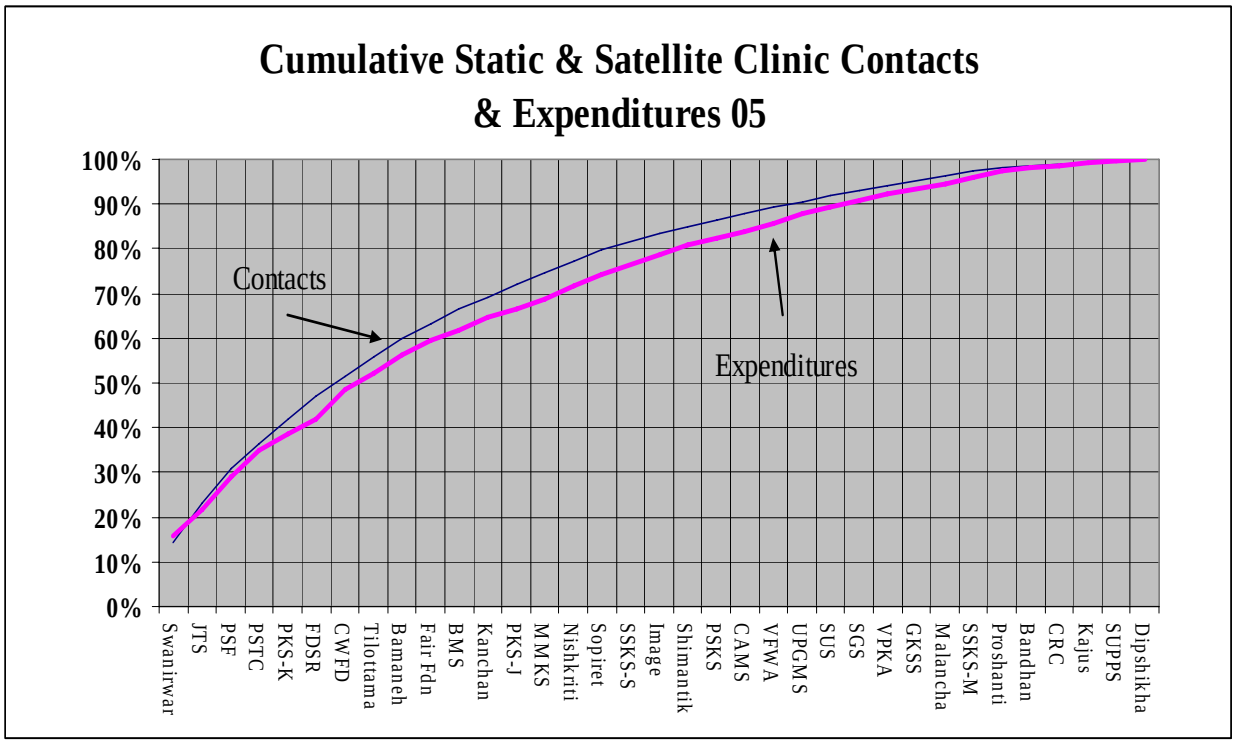


Figure 8



Lessons Learned with respect to Expenditures on NGO's:

- USAID expenditures at the depotholder level are negligible. Most of the value at that level is supported by the GOB and the NGO's.

- Expenditures per contact at the Static and Satellite closely follow the level of expenditures. The gap between the two is wider when USAID expenditures (grant + program income) are compared with total contacts, including depotholders.

- 22 NGO's provide 90% of the patient contacts at the static and satellite clinic level expending about 86% of grant and program income funds. This suggests that theoretically, a full third of the NGO's could be eliminated with minimal impact on the numbers of patient contacts. This said, the impact on the communities served by any NGO's in the bottom third could be serious with their elimination, and obviously incorporation of services into the stronger NGO's could be preferable.

- Part of the reason that cost per contact does not significantly reduce with increases in volume of services, particularly for the smaller NGO's is that fixed costs are relatively high. This is a result of two factors: first, the staffing pattern has been standard for all clinics regardless of volume; and secondly, each NGO must have its own administrative structure to support the service delivery structure. Recent rationalization of staffing patterns will help cost-effectiveness of service delivery. Reduction of the number of NGO's served would reduce the fixed administration costs.

- With the expansion of services, the cost structure as well as the levels of cost-recovery will change.

USAID Funding to NGO's

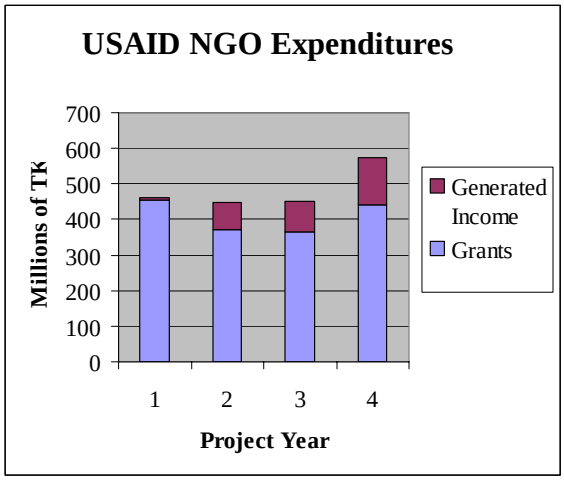
USAID funding is defined as a combination of grant money and "program income" – revenue generated through cost-recovery. The latter is drawn from accounts which accumulate money received from cost-recovery. Once grants are approved, NGO's are free to spend those funds. Effectively, the same rule applies to "program funds", but rather than an annual submission, expenditures of these funds are solicited for specifically justified purposes.

Figure 9 provides a summary of USAID expenditures during the project. Year 4 extends to September, 2006, and is therefore a projection. From this graph, we can observe that grant monies declined somewhat over the second and third years, but is expected to return to the first year level during FY 06.

Expenses in FY 06 are also expected to increase because the project permitted a broader use of generated income on the basis of "feasibility studies" justifying the utilization of "program income." Not all NGO's completed these extensive documents, but many did, leading to construction of 11 clinics, the purchase of ultra-sound machines, etc. Operating expenses also

went up due to inflation. Note that the graph above is somewhat distorted because it is shown in Taka which has inflated about 17% against the US$ in the past 2 years.

Figure 9



It is interesting to note that most of the equipment currently in use throughout the Smiling Sun network was, in fact, provided by USAID under earlier projects. By all rights, much of the value of that equipment should probably already be completely depreciated, and some will have to be replaced.

Due to the anomalies of project funding mentioned above, and the need to set aside a cushion of program income as protection against transitional problems (discussed below), the use of program income may decline somewhat. On the other hand, a more liberal policy of the use of program income may also stimulate additional expenditures required to expand services and generate more revenue.

It is important to point out that confidence in the NGO's to appropriately use their generated income is one of the things which seriously inhibits the sustainability of the NGO's themselves. There is a risk involved that funds will be misused, but the only way to "graduate" NGO's is to gradually allow them more freedom to actually develop and manage their health systems. For this reason, we suggest that rather than requiring complex analyses and feasibilities plans, requests for use of program income by NGO's be a short justification satisfactory to NSDP.

Lessons Learned in reference to financial support to NGO's

- A relatively small number of NGO's provide most of the service contacts and consume most of the budget. It would be more cost-effective to work with fewer NGO's both in terms of diminishing costs per service contact as the volume of services grows, but in terms of the ability of the TA to support NGO's. At present, recognizing this last fact, the NSDP concentrates on the 14 "focus" NGO's to enhance the cost-effectiveness of their own services – leaving the others much on their own.

- The cost-effectiveness of the smaller NGO's has been limited by relatively high fixed costs for administration. Cost-effectiveness of the overall Smiling Sun network would be enhanced by merging NGO's or incorporating services offered by the smaller NGO's into larger, more robust NGO's.

- Total expenditures during the first three years of the project remained relatively constant, driven in part by a restricted focus of support on limited range of services designated by the project. Expenditures have risen in FY 06 due to a gradual liberalization of that

policy, but the increase is largely financed through utilization of program income.

- The use of program income should be further liberalized to stimulate additional cost-recovery and growth of all services, as well as increase the sense of ownership of the NGO's of their health systems in terms of responsibility for sustainability.

Other Sources of Income

In an effort to reduce dependency on USAID funding, NSDP staff has encouraged NGO's to seek other sources of funding. Manuals, in fact, have been developed to help them do so. Obtaining funds from other donors, however, is not easy, particularly since NSDP is viewed as a USAID creation. Furthermore, it is the larger NGO's which can successfully diversify their funding – and in doing so, risk attracting money from ADB which may make them candidates for Mexico City Policy violations, thus eliminating them from the NSDP network.

Beyond some limited community contributions and contributions from the NGO's themselves, some other sources of funding are the following:

GOB

The GOB is actually an important source of resources, particularly for family planning commodities and vaccines. The contribution these items make to service provision as well as cost-recovery has been conveniently ignored by USAID – which has assumed credit for all inputs.

There is, however, a serious problem in relation to the provision of these commodities: each clinic must "reaffiliate" with the GOB every two years, a process which takes up to two months. In the intervening period, no commodities are provided. While this process is ostensively to control quality, in reality it is a bureaucratic procedure to extort money from the NGO's. There is also sometimes a shifting of catchment areas at the convenience of local governments approved by the DG of Family Planning and the DG of Health. These actions disrupt services, may dislocate staff, and affect the cost-effectiveness of service delivery.

Individual NGO's have no leverage with the GOB in this matter, and so we urge USAID to use its leverage to alleviate these problems by insisting on the stability of catchment areas; and make affiliation either on the basis of NGO's and/or extend the affiliation to at least 4-5 years. In the longer term, an association or the Smiling Sun franchise of the NSDP clinics could pressure the GOB for these policies.

Lessons Learned with respect the GOB funding

- GOB commodities and policies are also critical for reaching service delivery targets, and two chronic problems have negatively affected both cost-recovery and CYP's. GOB compensation to patients seeking PLTM has encouraged patients away from the NSDP network which does not offer such compensation.

- The biennial requirement of affiliation of each clinic poses a large administrative burden on the NGO's, and renders them ineligible to receive commodities when not affiliated, a process which takes up to six months and is primarily a mechanism to extract money from the NGO's. NGO's have no leverage, and it would help if USAID could negotiate a longer period of affiliation and/or affiliation at the NGO level.

Revolving Drugs Funds (RDF)

In 1998, the Social Marketing Company passed seed money for Revolving Drug Funds to the now NSDP NGO's. The original seed money totaled about $175,000, and in the past 6-7 years has grown to a value of about $1.25 millions, of which about 30% ($375,000) are drug inventories, and 70% ($875,000) is cash. Through this mechanism, NGO's cover the costs of drugs provided for curative services, principally beyond the scope of the NSDP project, although limited medicines the treat STI's, ARI, diarrhea, etc. may also be provided.

Clearly the RDF's are a success and help attract clients to clinics and satellite spots. What is also true, however, is that the RDF's are largely *unmanaged*. NSDP has assisted in arranging favorable procurement contracts with 12 pharmaceutical producers, from which NGO's as well as individual clinics purchase what they apparently require. However, there is no one at the clinic level – and apparently no one at the NGO level who has any pharmaceutical training beyond the doctors and paramedics. A rough estimate of commodity value sold each month is $42,000. This suggests that there are probably about 9 months of stock in inventories, some of which is reported to be expired. It is also noteworthy that the RDF's are established at the clinic level and not the NGO level. This limits the possibility of cross-subsidies between clinics since drugs represent a major source of income.

We are not aware of the legal requirements for the dispensing of drugs in Bangladesh, but would be surprised if such requirements do not exist. At minimum, NGO's could use help for managing their inventories, and probably should consider centralizing their RDF's to achieve better supervision of drug procurement, utilization, supervision, and cost-effectiveness.

We would encourage NGO's to consider using some of this money to expand services. Since there is, of course, a danger that opening this floodgate will stimulate the use of too much money, particularly if services expand and both a somewhat wider range and greater volume of drugs will be required, NSDP should establish a policy that use of those funds be approved by NSDP itself. The purpose of this control is not so much to restrict its use as to prevent misuse and avoid overuse. This is a training process which needs to be coupled with better management of the drugs.

Lessons Learned with Respect to RDF's

- Drugs are typically an excellent source of income for primary care services as people are generally willing to pay for drugs. The NSDP network is no exception: the combined value of the RDF's has grown more than 700% in the last 6-7 years.

- For reasons which are unclear, NSDP has operated on a policy that RDF money should only be used for purchase of drugs (and provision of free drugs for the poor). The result is a cash surplus of about $875,000 scattered in hundreds of bank accounts which can be used to cross-subsidize other services.

- Management of the RDF's presently is left to each individual clinic, which often also purchases its own drugs. We estimate that there is throughout the Smiling Sun network approximately 9 months of drug inventory, suggesting that there are management problems. The capacity of each clinic to generate income from the RDF also varies. A better system would be to centralize the RDF accounts to the NGO which could also do bulk purchasing of drugs for its services.

- Once the RDF's are centralized, some funds could be used to expand and cross-subsidize other services. Decisions on how and where to spend the money should be left up to the NGO, but given their general lack of management experience, and the need to insure the continued integrity of the RDF's themselves, it would be unwise to simply open the floodgates. For this reason NSDP personnel should guide and approve NGO decisions to use these funds during the remaining life of this project.

Corporate Contributions

NSDP has actively pursued linkages with the corporate world throughout most of the project. Satellite clinics were established in about 100 garment factories through several strong, urban NGO's. Unfortunately, those NGO's were terminated due to MCP violations, and the number has now been reduced to 42.

On a different scale, with the assistance of NSDP, SSKS in Syhlet has developed a partnership with Chevron to develop a clinic to serve the populations of two villages where many of the Chevron employees and their families live. The community has donated the land, and Chevron has thus far provided $188,000 to construct and equip the clinic. Clearly one of the attractive features of this clinic will be the provision of a full range of primary care services. During our evaluation, Chevron announced that it would support a second clinic as well.

Within the context of NSDP, one or two clinics are not particularly significant, but the principal value is not the addition of a single clinic, but the successful model of working with a corporate sponsor – which is undoubtedly an important reason why Chevron was willing to expand to another clinic. This model should prove useful for attracting other similar partnerships in the future.

Lessons Learned with respect to corporate contributions

- Corporate contributions are possible and should be pursued. While their monetary contribution is not presently significant in term of the whole Smiling Sun network, examples are likely to attract additional sponsorships.

NGO Administration

Clearly the NGO's must maintain an accurate and detailed accounting of project-related expenditures. NSDP theoretically strengthens the NGO's capacity to do this by funding various positions to create a separate administration unit specifically to manage NSDP-related funds, as well as keep track of the RDF funds. This, however, does relatively little to strengthen the NGO's themselves since rather than integrate project management with other NGO activities, it is deliberately kept separate.

In reality, much administration is not carried out by the NGO's at all, but by each individual clinic. Service statistics as well as financial accounting are actually produced by the clinics, and simply consolidated at the NGO level. This procedure is a by-product of the cost-recovery and RDF systems which require daily deposit of funds in local bank accounts. As a consequence, both cost-recovery and the RDF are decentralized to the clinic level which has resulted in the creation of at least 1,400 bank accounts. This procedure virtually eliminates the possibility of cross-subsidies within each NGO's network; and makes administration much more cumbersome and difficult.

Centralization of these funds at the NGO level would greatly facilitate administration and allow NGO management a much strengthened ability to "manage" their own networks through cross-subsidies. There has been some reluctance on the part of NSDP and USAID to pursue this centralization, fearing that centralizing funds will make them more vulnerable to abuse and misuse. This is a possibility, but the present procedure of decentralized funds ignores the difficulty of monitoring the use and abuse of hundreds of small accounts. Centralization of these funds would also strengthen the ownership of the NGO's of their networks and health programs.

Lessons Learned in relation to NGO administration

- Efforts should be made to integrate project administration into the existing administrative structure of the NGO. This is likely to be more cost-effective and sustainable.

- The cost-recovery and RDF funds should be centralized at the NGO level to permit cross-subsidies throughout each NGO network. This will also facilitate application of the Performance Reimbursement Scheme.

- It is probably less risky to allow use of program funds to support the development and expansion of health services than to allow it to lie dormant in large amounts in various bank accounts, tempting misuse.

- Local banks are not necessarily reliable institutions in which to deposit funds. During the evaluation, we observed a case where a powerful family managing one of the NSDP NGO's, succeeding in using its influence to withdraw funds despite project and bank prohibitions.[8] While local bank accounts may be required for practical purposes, funds

[8] This was resolved immediately through threats of censure made by the project director, but illustrates the danger of centralizing funds

could be transferred periodically to a reliable bank at the district level, preferably a recognized international bank.

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