Mid-Term Review Report of MSI's EC Block Grant Project

Conducted for:

Marie Stopes (MS) Clinic Society
6/2 Block F, Lalmatia
Dhaka 1207

Conducted by:

CAPACITY BUILDING SERVICE GROUP (CBSG)
6/1 Block-B (Ground floor)
Lalmatia, Dhaka 1207
Phone: 8155672, 9131027
Email: cbsg@bdonline.com

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Abbreviation, Acronyms and Definitions

ANC	Antenatal Care
BCC	Behavioral Change Communication
BDT	Bangladesh Taka (Currency)
CBAG	Community Based Advocacy Group
CBSG	Capacity Building Service Group
CCR	Client's Charter of Rights
EC	European Commission
FGD	Focus Group Discussion
FP	Family Planning
HCRF	Health Consumers Right Forum
HO	Head Office
MDG	Millennium Development Goal
MIS	Management Information System
MSCS	Marie Stopes Clinic Society
MSI	Marie Stopes International
MSV	Marie Stopes Volunteer
MTR	Mid-term Review
N/A	Not Applicable
NGO	Non Government Organization
OT	Operations Theatre
PNC	Postnatal Care
RBA	Right Based Approach
RC	Referral Clinic
RH	Reproductive Health
RLC	Radio Listeners Club
SDP	Service Delivery Points
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
ToR	Terms of Reference
UMC	Upgraded Mini Clinic
YP	Youth Programme

Acknowledgement

Capacity Building Service Group (CBSG) has conducted the Mid-term review of the EC block grant project of Marie Stopes in March 2008. This report is the result of a co-operative and mutually supportive exercise between CBSG and MSCS staff of all level.

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Special thanks are also given to Dr. Yasmin H. Ahmed, Managing Director, MSCS and Dr. Reena Yasmin, Director, Services, for extending their full support and providing constructive input during inception meeting, field work and subsequent consultations. We would like to take this opportunity to recognize the contribution of all referral center based staff who have been very instrumental in the whole MTR. It was refreshing to meet each one of them personally and professionally extremely satisfying as they share the unique view of serving the poor people in our country.

Finally, while acknowledging the valuable inputs of all the above, CBSG stands by the data, analysis and conclusions reached from the review and believes them to be a sound response to the information available. However, CBSG recognizes that the findings, analysis, and conclusion including any errors and omissions contained within this report are of its own.

Table of contents

Executive Summery

The project "**Improving the health and SRH status of the poor, most vulnerable and under served populations in selected urban areas of Bangladesh"** is a three-year project funded by European Commission (EC) under Block Grant. The project was designed based on Marie Stopes' ongoing project components that were implemented in three major cities of Bangladesh and with different target groups. As many as seven components make the EC block grant project as a whole – of them five components are related to direct service delivery and the remaining two components deal with policy advocacy and the integration of the rights-based approach in service delivery. The project under review has been in operation for two years. The MTR made an attempt to look at progress in terms of quality and quantity, assess the relevance, effectiveness, efficiency and sustainability of the program components and to suggest strategies as to how best the project can focus the remaining time and resources to optimize the results and to capture any lessons learned in the process.

The project components are being implemented with an outreach approach through the existing network of Marie Stopes' referral clinics. In all three project districts Marie Stopes has establishments with referral clinics and management structures. The project components are being effectively implemented as outreach of the respective referral clinics. This implementation strategy enables Marie Stopes to organize and operate this project with a slim structure.

The MTR found that the project has made a significant contribution to enhance access to health services in general and SRH services in particular for the most vulnerable groups such as homeless people, adolescents and the people working in hazardous occupations, allowing them to access quality health care with minimum cost at their convenience. Upgraded mini clinics (UMCs) have evolved as a community based and sustainable service delivery model for women and children. These mini clinics have created enormous opportunities for the low-income groups to access quality SRH services at an affordable price.

An improvement in health seeking behaviour has been observed in the catchments area. Even the homeless pregnant women are seeking ANC and PNC in large numbers from the Marie Stopes mobile clinics. Introduction of the voucher scheme is a value added service to the homeless pregnant women to ensure safe delivery. Sustained levels of community mobilization and awareness building activities are making an impact on the health seeking behavior of poor and marginalized groups. Adolescents and youth are increasingly seeking healthcare and they are overcoming social sigma built around SRH issues. An enabling environment has been created for the young boys and girls to come to the YP centres and learn about reproductive health and the related life skills.

Male are an important part of SRH issues and some of them are coming to obtain healthcare from the Marie Stopes centres but their numbers are far less than what the project aims to accomplish. The existing mechanismz to involve males are not functioning as anticipated. Marie Stopes has created excellent facilities and structures at the referral clinics to serve the male client. Nonetheless the flow of male clients remains far from adequate. Mobilization and awareness among the male clients remains low. There are process deficiencies noticed in mobilization of men.

Advocacy initiatives taken under this project have made some solid ground to sensitize the government machineries on clients' charters of rights and made the government proactive to implement the CCR. With the government's recent endorsement of the Citizen Charter for health sector - where CCR issues remains embedded, has created a new opportunity for advocacy. Marie Stopes will require redesigning its advocacy strategy including the network strengthening to take advantage of the citizen charter.

The integration of RBA within the framework of service delivery in effect increased the impact of the programme both on accessing quality services as well as health seeking behaviour. Marie Stopes' health services are perceived as friendly, client focused and respectful. Clients feel empowered here to get quality services. RBA at Marie Stopes is a very innovative as well as pragmatic way of conceptualization and application in the context of service delivery. This is indeed a method of improving corporate governance and client focus service delivery. However, the progress of various components remains below target. There have been delays encountered initially that caused low

performance against ambitious target in the first year which has implications for the second year as well. The progress in the second year is relatively better but still below the target. Given the current reality, there will be further improvement of implementation rate in the third year but not as much as planned in the project document. It is now widely accepted within Marie Stopes that the project targets were set rather ambitiously. It needs to be adjusted at a realistic level. Marie Stopes should reflect on its capability, resources and set more realistic targets for EC block grant components.

Cost is a major indicator of efficiency. Cost per unit of services at the SDP level is reasonably low compared to similar services in the private and public sector. Low overheads and a good service utilization rate have enabled the project to provide relatively low cost services. Service cost can be reduced further with the increase in utilization rate. Service utilization is yet to reach the optimum level, particularly in male clinics, UMCs and YP centres. More marketing and mobilization are expected to bring in more clients and thereby reduce the cost further. Improved management and monitoring in community level awareness and service promotion should be a priority for the remaining period of the project. This will not only improve the service-dispensing rate but also will reduce the unit cost significantly.

SRH services are heavily subsidized both in public and NGO clinics. It would be unrealistic to assume the financial sustainability of the whole package of components under the EC block grant. However, some of the components have bright prospects to become sustainable health service mechanisms. The upgraded mini clinic is an innovative service delivery mechanism that has the brightest prospects of becoming a sustainable community level SRH service delivery model. Some of the UMCs have already achieved a high degree of sustainability. Other UMCs will improve overtime, as the gestation period in the health sector is generally long. Likewise, health services for the factory workers are a sustainable approach as Marie Stopes has been able to realize the marginal cost of services. Some improvements in revenue collection will enable recovery of the full cost of factory level health services.

Besides the two components mentioned above, there are some other innovative models of SRH delivery such as YP centres, homeless program, hazardous occupational healthcare etc. which can be replicated but there are few prospects of financial sustainability. These components have created enormous benefits to the most vulnerable sections of society but these groups can hardly pay for health services. They need incentives to ensure access to healthcare and improve their health-seeking behaviour. Therefore these components required continued external support for at least the short to medium term.

The MTR team found that Marie Stopes is as organization concerned about quality and that it strives to innovate sustainable health service delivery mechanisms for poor and marginalized people. It has successfully developed and implemented a sustainable SRH service delivery model from community to factory level. Besides, a number of unique SRH service delivery models have been developed for high-risk groups such as homeless people, adolescents and people in hazardous occupations. The good work of Marie Stopes should not only continue but also be scaled up to provide benefits to many more people who do not have access to quality health services especially SRH services.

Besides program component specific measures, the MTR strongly suggests the following measures for further improvement of the EC Block Grant project:

- Marie Stopes needs to accelerate program implementation during the remaining project period to accomplish the target and set the project target more realistically after review the service demand and Marie Stopes' service dispensing capability. The start up process needs to be fine-tuned and further accelerated in new projects.
- Project components need to be further integrated and focused on particular geographical areas or population groups. This will reduce management complexity and improve implementation and impact.
- Awareness building and mobilization activities need to be planned and designed based on a clear and well-thought communication strategy. Monitoring of mobilization events and activities needs further improvement and thrust.

1 INTRODUCTION

The project "**Improving the health and SRH status of the poor, most vulnerable and under served populations in selected urban areas of Bangladesh"** funded by the European Commission (EC) under the Block Grant funding mechanism, is designed in line with the EC's Country Strategy Paper (CSP), related National Indicative Plan (NIP) and Health, Nutrition and Population Sector Programme (HNPSP) for Bangladesh as it seeks to contribute to the MDGs through the objective of improving the SRH status of the poor, most vulnerable and underserved women, men and young people of Bangladesh. This project is expected to reach some of the most disadvantaged, needy and poorest sectors of the population living in urban areas in Bangladesh.

Marie Stopes (MS) Bangladesh with the support of MSI has been implementing the project centering around 6 of its referral clinics in Dhaka, Chittagong and Khulna metropolitan cities. The project includes seven components and focuses on increasing access to quality SRH and primary health care services, providing information and promoting rights of the homeless and floating population, female and adolescent slum dwellers (including those working in hazardous occupations) and female workers in garments and fish processing industries. The project also endeavours to increase male involvement in SRH. The last two components of the project focus on promoting quality of care amongst service providers and recipients and promoting a Right Based Approach (RBA) amongst clients and service providers in the target areas.

Marie Stopes, a large national NGO of Bangladesh, has been implementing since 1988 a number of health service delivery programmes in both rural and urban areas of the country. The NGO, as compared to other NGOs conducting similar activities, has some distinguishing features: first, its efforts are devoted to achieving the ultimate objective of health service delivery – increased use of healthcare, and not just carrying out campaigns for educating and motivating people. It efficiently operates a large number of service delivery points, in addition to organizing and motivating poor people to use appropriate healthcare. Second, its cost recovery is quite high, creating a unique example for the entire NGO sub-sector. Third, in its approach it attaches a high emphasis on ensuring quality of care, encouraging citizen voice and client participation, and enhancing providers' accountability to the clients.

The project under review has been in operation for two years. At this stage, MSI and MSCS intend to review and assess the progress of the project in terms of quantity and quality vis-à-vis the challenges encountered and the measures taken to address the challenges. The MTR would identify strategies as to how best the project can focus the remaining time, and resources to optimize the results and capture any lessons learned in the process. The specific objectives of the MTR are:

- Review project progress in relation to stated objectives and indicators
- Identity ways and means to achieve output and purpose if the progress is not satisfactory
- Identify gaps and constraints and any lessons learnt during this period
- Analyse whether and how project may replicate

The review is forward looking and focused on identifying future priorities. In that, the scope of work included:

- Review project documents
- Discuss and meet Senior management team and staff responsible for implementing EC block grant project.
- Field visit
- Report writing and workshops with the beneficiaries

1.1 Methodology

CGSG has adopted participatory and interactive methods throughout the process while adhering to the methodology as specified in the ToR. This was further fine-tuned in consultation with the senior management of Marie Stopes. We have thought over the proposed methodology and found that there

was scope to improve the methodology in order to enhance the range and quality of information collected . Finally, following methodologies were adopted to conduct the Mid Term Review:

Document Review: This included review of project documents, work plan, progress reports, documentation of various events and project outcomes and any other documentation done on the project so far. This helped us to understand the project, and to prepare questions for the review mission, which was shared and finalized in the inception meeting with the relevant people of Marie Stopes.

Inception Meeting: A half-day inception meeting was organised with the management of the project to fine-tune the methodology and to agree on the scope of the review based on the understanding of document review. The draft review questions were developed and shared with the MSCS project team.

Project Performance Review Workshop and Meetings: These events were organized with the main functionaries of the project to review the performance. These meetings helped the MTR team to capture the progress of the project in terms of quantity and quality vis-à-vis the challenges encountered and the measures taken to address the challenges.

Field visits and reality check: The MTR team physically visited five out of six referral clinics of Dhaka and Chittagong. During the visit the team met with all stakeholders including staff, project beneficiaries both individually (depth interview) as well as in groups (FGDs) to gather information based on the review questions. In all 18 semi-structured FGDs were conducted in several clinic locations in Dhaka and Chittagong. Out of 18, fourteen were conducted with clients/beneficiaries and rest was with service providers and factory owners/staff.

Exit Interview: The MTR team carried out 30 exit interviews with clients. These interviews were very informative and useful to assess client satisfaction vis-à-vis service quality delivered from the SDPs.

Key Informants Interview (KII)

The MTR team has interviewed some of the key stakeholders of the project. They included: various support group members, community leaders, Doctors, Garments Factory management, Garments workers and hazardous factory owners.

Debriefing session: The mission shared the preliminary findings of the review with the MSCS management and invites their inputs as well as comments on the review findings including suggestions.

The matrix below presented component-wise visit schedule along with task accomplished by the MTR team:

Sl.	Program/Event	Place and Date	Task accomplished
1	Inception meeting with MSCS management	MSCS Head Office at Lalmatia (25/03/08)	▪ Meet with MD and other key project staff ▪ Agreed on the methodology of the MTR ▪ Perspective beyond ToR
2	Referral Clinic based program	Chittagong I (25/03/08) Dhaka I & II (29/3/08) Dhaka III (30/3/08)	▪ Observe service delivery mechanism ▪ Review and observe record keeping system ▪ Exit interview with client ▪ KII with PO and service providers
3	UMC based program	Paharpur under Chittagong I (25/03/08) Kamrangir char under Dhaka I & II (29/3/08)	▪ Observe service delivery ▪ FGDs with client ▪ FGDs with PSC members ▪ FGD with female adolescents/youth
4	Youth Program	Hazardous Program at Shyampur under Dhaka III Paharpur under Chittagong I Kamrangir Char under Dhaka -I	▪ Observe service delivery ▪ FGDs with client ▪ FGDs with PSC members ▪ FGD with female adolescents/youth
5	Homeless Program	Sholosahar under Chittagong I (25/3/08) High Court Spot under Dhaka I (30/3/08)	▪ Observe service delivery ▪ FGDs with client ▪ FGDs with PSC members ▪ Exit interviews ▪ Case studies
6	Health Card Component	Meher garments under Chittagong-I (25/3/08) Chery garments under Dhaka II (30/3/08)	▪ Observe service delivery ▪ Observe BCC activities ▪ KII with management staff ▪ FGDs with client
7	Male Component	Chittagong I (25/03/08) Dhaka I & II (29/3/08 and 6/4/08) Dhaka III (30/3/08 and 10/04/08)	▪ Discussed with RLC members ▪ Observe service delivery facilities ▪ Discuss with service providers ▪ Review comments books
8	Review of recording, monitoring and reporting system and verification of service statistics	Dhaka-I and Dhaka III	▪ Observe clinic activities ▪ Review recoding, registers and reporting system ▪ Conduct exit interviews
9	RBA and	CBSG office on 01/4/08	▪ Discuss with the RBA program

Sl.	Program/Event	Place and Date	Task accomplished
	Advocacy components		managers and Senior management team
10	Debriefing with MSCS management and key staff	MSCS Head Office (3/4/08)	▪ Shared preliminary findings ▪ Understand additional information needs
11	Review of monitoring system and data quality of service statistics	MSCS Head Office (20/04/08)	▪ Observe client flow and record performance data ▪ Exit interview with clients ▪ Review monitoring and recording system at referral clinics and head office

1.2 Limitation of the MTR

The MTR team is under the impression that the time allocated for the MTR was not adequate for an in-depth review of field level awareness and mobilization activities of the project. The team mostly worked with secondary data. However, it has used a rapid observation technique on a sample basis to verify the service statistics.

1.3 Report Structure

The report is presented in 11 sections with an executive summary at the beginning. Section one included introduction, methodology adopted and limitations of the review. Sections two to eight describe component wise findings and analysis, nine provides a brief review of monitoring and service statistics, section ten presents the overall assessment and conclusions and recommendations are presented in section eleven.

2 COMPONENT ONE: ENABLING THE HOMELESS POOR IN THE TARGET AREA TO ACCESS QUALITY SRH SERVICES

Marie Stopes have developed a unique and innovative service delivery mechanism for the floating population of the big urban cities. The services are rendered periodically through a mobile van in selected spots within the referral clinic catchments areas at night i.e. from 7:00 pm to 9:00 pm. Services for the homeless people are rendered from eight SDPs. In these sites, clinical services are provided to homeless female clients while male sessions are conducted adjacent to the mobile van in a makeshift tent. During the MTR, following issues were looked at while conducting the review.

Findings and Analysis

2.1 Access to health care

There are no empirical statistics as to how many people are actually homeless in Dhaka, Chittagong and Khulna. But there is a general estimate that the number is quite significant and more importantly the number is steadily growing. There is no concerted rehabilitation program for homeless people. Instead, law-enforcing agencies occasionally evict them resulting in their relocation to another place.

Generally homeless people are marked as “high-risk” groups from a law and order point of view as well as health point of view. They bear the risk of causing public health concerns in the society. A number of NGOs are working with the homeless population on HIV/AIDs issues. Generally there is no targeted approach to ensure their health service needs. Public hospitals remain the only option for them to receive health services. But the hidden cost of healthcare in public hospitals and the service delivery timing effectively exclude them from receiving health services. They cannot get to private hospitals and clinics due to their high cost. Therefore homeless people do not have any access to healthcare services, even though they bear the greatest risk of public health disaster.

Marie Stopes’ homeless program has brought about an innovation in the context of providing healthcare services to the homeless people. The mobile clinic and service provision at night have for the first time in Bangladesh provided client-friendly access to health services for the homeless people. This needs to be reckoned as **a bold step** in the context of risks and uncertainties associated with such an endeavour. Provision of services in a convenient way (place and time) is not enough for the homeless people. Provision of subsidised health services and free medicine has effectively ensured access to health services to the homeless people. Marie Stopes’ homeless program’s success is based on three distinct yet intertwined elements i.e. place, time and cost. MS has combined the three elements in a very innovative way that ensures health services to a section of the urban homeless people but not all. The majority of homeless people, however, remain outside of health service provision. MS’ initiatives are bold yet inadequate in the context of total need. MS’ existing limited facilities and human resources would be major constraints to ensuring basic services to all the homeless people. Having said that, it has been very successful in developing proven methods of health service delivery to urban homeless people.

Service structures and mechanisms are essentially gender-sensitive, which is consistent with the MS organizational motives and preferences. However, male clients have expressed some dissatisfaction over the service arrangements and scope of services. Existing services are primarily tuned to the reproductive health needs of the female patient. Male patients with general health problem sometime find the facilities inadequate for them.

2.2 Extent and coverage among homeless people

The 1997 census counted "floating population" at 14,999 in Dhaka city and another 17,082 in other metropolitan areas. Islam *el al*[1] estimated the number of street dwellers in 105 locations of Dhaka city at 11,500. There has been no recent data of the "floating population" in major urban centres like Dhaka, Chittagong and Khulna. As the urban centres are experiencing tremendous growth (at about 6% per annum), so is the growth of the "floating population". We find by extrapolation from the above data that on average about 215 floating population dwellers in each spot.

Marie Stopes's mobile services render homeless health services only in 6 locations in Dhaka city (4 locations under EC block grant) and four spots in Chittagong and Khulna. Marie Stopes renders services in location of high concentration of homeless people (gestimate is about 600-1500 in each spot)[2], nonetheless a large number of homeless people still remain outside the reach of these health services. Except for Marie Stopes, health service provision for the homeless people is almost non-existent. Currently MS' health services could reach around 10-15% of the floating population of the three cities through its mobile van. Therefore, there is a need for Marie Stopes to replicate its model and extend health services to the other settlement areas of homeless people. Having said that, service coverage within the existing catchments areas found to be very high particularly for ANC and PNC. A recent ICDDR,B study found that only 28% pregnant women sought ANC services and 82% of them received ANC from Marie Stopes mobile health services. These figures indicate that, Marie Stopes coverage for ANC and PNC is very significant within the catchments area. Over last two years, Marie Stopes have rendered about 35,000 services (not necessarily 35,000 person) among the homeless, and it has distributed 1204 vouchers mostly for delivery care including ANC. In other words only 3.5% cases, a voucher was provided. Marie Stopes' penetration for other health services (general health, child health and male health) among the homeless people is also quite significant within its existing catchments area. Marie Stopes is receiving a huge number of repeat clients from among the existing clients which manifests in high level of service dispensation.

2.3 Demand for health services

For the homeless people neither there has not been any access for health services nor any demand for that. Awareness has been particularly very low. At best they would go to a local pharmacy or a traditional healer for health problems. In the early days MS' mobile clinic services received a poor response from the homeless people. Now the response from them is relatively good, particularly the response from women is encouraging. Male patient are coming to the mobile clinic, but in fewer numbers.

MS have initiated targeted BCC activities to disseminate information to the homeless people. It has used a number of information dissemination measures including interactive events such as direct contact, group meetings, slide shows, dramas etc. Exist interviews with the clients suggest that they are well informed about the MS services. Besides, project annual reports suggest that a large number of floating people have been reached through non-interactive media such as posters, leaflets, and pamphlets. Given that the literacy level of the target population is low, reading material has the least

[1] Islam et al (1997). Addressing the urban Poverty Agenda in Bangladesh: Critical Issues and 1995 Survey Finding. Dhaka: Asian Development Bank

[2] Marie Stopes' uses the term 'homeless" not as strictly as census. A good number of the clients comes to service centre who are not completely homeless, but live in squatters that are far worse than any recognized slums.

impact. Interactive and two-way communication ensures much more understanding, behavioural change and influencing in health seeking behaviour.

The BCC activities coupled with the mobilization effort of local volunteers have created a significant demand for the health services. Given the high mobility of the homeless people, a sustained level of BCC activities is needed. Service recipients and the local volunteers play a magnificent motivational role particularly for the new comers. Having said that there is a definite need for interactive information dissemination and BCC not only at the service delivery point but also at the place where the floating people live.

2.4 Integration of RBA in homeless program

MS' program approach calls for ensuring health rights for the service recipient. Criteria set for the homeless population encompasses the most vulnerable segment of the urban population. It has ensured free medical services to them. In order to address complicated cases, MS have initiated voucher scheme that ensures the critical health services to the homeless people.

Homeless people are regarded as respectful clients from reception to the service delivery. Service providers were found adequately sensitive to the particular need of the homeless people. They listen to their health problem with adequate attention and provide all possible support within their limited capacity. There was clear sense of empowerment noticed among the homeless people while receiving services at the mobile unit. MS staff were around to provide them with information as well as clarifications to their queries. This shows a major change in service providers' attitude towards the clients in particular to the poor and disadvantaged.

2.5 Potentials and challenges to replicate the model

Currently the homeless program is being implemented in a very small scale given the magnitude of demand. We can only imagine the further scale up of the need due to continuous influx of people in the urban areas particularly big urban centres. Therefore enhancing service delivery for this segment of population will be inevitable in the near future.

MS has developed a unique model of health service delivery system for the homeless population. The system is very much tuned to their needs. The model can easily be scaled up to cover more population especially in Dhaka and Chittagong city. MS has developed organizational capacities to organize and implement mobile service delivery system.

Major challenge for the model to replicate is the high start up cost and sustained level of subsidy. Indeed the whole program in designed on subsidy and incentive packages – free healthcare service, free medicine, voucher scheme and so on. There is a need to research on their willingness to pay as well as ability to pay. Based on the findings of the study, it may plan a differential approach to offer subsidy and gradually impose fees.

2.6 Progress of major activities against targets

- Service provision for homeless/floating population in 3 cities (Dhaka, Chittagong and Khulna) through 8 service delivery points (SDPs) as per plan.
- 14,378 people (through 730 sessions) in the year one and 19,128 people (through 768 sessions) in year two were provided with services against annual target of 33,600 (plus 20% annual incremental). Achievement rate on an average is about 50%. Therefore, targets need to be rearticulated in the context of MS service delivery capacity.
- Only 48 in the year one and 1204 services were provided through voucher scheme which is again far below the target (16% of homeless clients were supposed to be referred). Late start may be a reason but the trend is good.
- Staff training need assessment was conducted in year one and training programme are being implemented accordingly.

2.7 Recommendation for the Homeless component

- A study should be planned to assess clients' willingness and ability to pay to determine a pricing strategy for health services
- Considering the demand for services and capacity of mobile vans, several more homeless spots could be covered in Chittagong.
- Seating and reception for male patients could be improved a bit to match with similar facilities provided for the female clients.

Jahanara Begum, a thirty-eight year old housewife in Chittagong, had a bad impression about private health clinic. But her idea changed almost instantly after visiting the MS clinic. She expressed, "doctors' and other staff's behavior at the MS clinic is very pleasing. I can discuss my health issues freely." She also took her daughter to the clinic for menstruation problem. Her daughter has now improved a lot.

COMPONENT TWO: ENABLING FEMALE SLUM-DWELLERS IN THE TARGET AREAS TO REALISE THEIR SRH AND RIGHTS

Marie Stopes operate mini clinics at the community level to make SRH services available to the catchment population, in particular slum dwellers. With the support of the EC block grant eight (8) such clinics were upgraded to offer value-added SRH services including small-scale clinical services such as MR and IUD insertion. Full time and qualified paramedics is the main feature in the UMCs. General health and SRH services remain the major services available at the UMCs. In addition, immunization and family planning services are also rendered from the UMCs. Attempts are being made to provide services to the male client by offering weekly qualified doctors services.

UMC is an innovative model of community based health services. With a very small structure and limited physical facilities, the range of services it offers is indeed commendable. During the MTR, following issues were looked at in some length.

Findings and Analysis

2.8 Targeting and approach

Upgraded Mini Clinic (UMC) is a feasible option for the community people, particularly the women to receive quality health services with convenience and at minimum cost. On an average a clinic receives around 25-30 clients per day. A few of them are MR and IUD clients. Given the capacity of the clinic, this number is good considering the service combination.

The UMCs initially have targeted the slum dweller women as the potential clients. But in reality many more women from the community (non slum dwellers with relatively higher income group) than the slum dwellers are coming to these centres to receive health services. This indicates that the quality of healthcare at the UMCs is acceptable and attractive to the local community. It might be a risk factor in limiting the access of slum dwellers. The increased cost of services at the UMCs already have had some effect on the accessibility for poor women, although Marie Strops subsidy scheme remains functional at these clinics. The effect of pricing on accessibility remains at the minimum due to subsidy provision and its decision-making authority at the mini clinic level – i.e. the paramedic has the prerogative to decide whom she would give subsidy after reviewing individual cases.

The clinic stays open from 9.00 AM to 3.30 PM from Saturday through Thursday. Clinic days and the timings are rather standard and set by Marie Stopes' management. The standard timing and clinic days schedule might have an impact on accessibility as some people particularly the working - women may not take advantages of UMCs. A more flexible approach in setting clinic times and days based on local needs might increase client flow. However, it requires some experimentation including local level consultation to revise the schedule for clinic day openings and times.

2.9 Awareness on SRH issues

Extensive mechanisms are in place to conduct awareness rising sessions and events at the community level. Three MSVs were recruited and trained to conduct awareness raising activities. A host of BCC materials were designed and used to complement awareness rising. The flow of client from the community shows that a level of awareness has been raised among the community people about the UMC services. However, the volume of customers still remains far below the project targets. This indicates that there still gaps in creating effective demand for services

Marie Stopes have three MSVs to conduct awareness raising activities at the community. By design, one of them may stay back at the clinic to assist the paramedic. But the service level requires them to assist the paramedic at the mini clinic on full time basis. Therefore they have hardly any time left for community level mobilization and awareness development work. The MSVs are assigned as volunteers but they work almost like full time employee. We felt that one of them could be recognized as an employee of Marie Stopes with possible designation as 'Clinic Aide". In that time bound efforts are need to be put in place for community level awareness development. Having said that, satisfied clients'

referral was seen to be the most effective means for effective demand creation. Therefore informal networking with the satisfied client group can add value in community awareness and demand creation.

2.10 Sustainability of Upgraded mini clinic

Upgraded mini clinics have already accomplished a good level of service utilization. Service statistics show that the demand for clinic services is on the rise and so is their income. Financial sustainability of SRH related services is generally low in Bangladesh as these services are highly subsidized by public sector as well as NGO service facilities. In this backdrop, the UMCs under Marie Stopes have accomplished considerable income to cost ratio within the two years period. Following table provides the performance of the eight UMCs in terms of Income to cost ratio. The table reveals that two UMCs have most recovered the cost in just two years time.

Table-1: Income to cost ratio of Eight UMCs at the end of second year

Name of the UMC	Income to cost ratio
Kamrangirchar UMC - Dhaka	80 - 86%
Shaympur UMC – Dhaka	58 – 62%
Fatullah UMC – Dhaka	58 – 62%
Chonpara UMC – Dhaka	90 - 95%
Bagmara UMC – Khulna	38 - 42%
Notun Bazar UMC – Khunla	35 – 40%
Ispahani UMC – Chittagong	48 – 52%
Chotopool UMC –Chittagong	50 – 56%

Significant differences in income to cost ratio can be noticed in the above table so are the prospect of UMCs sustainability. Dhaka based UMCs are doing considerably better than other clinics. Empirical evidence suggests that client flow, particularly MR clients determines the income level. A comparative analysis among the clinics reveals some key features, which might have some relation with the clinic sustainability, which include:

- High concentration of population around the clinic
- Lack of alternative service providers around clinic area
- Relatively better off economically
- Technical skills and communication ability of the paramedics

However, Marie Stopes may take a full-blown operational research to determine what makes a UMC sustainable.

Health systems generally have long gestation periods before they reach sustainability. Some of the clinics have accomplished above 80% income to cost ratio. With an increased client flow, this ratio is expected to improve further in the future. But ultimate target of achieving full sustainability within three years timeframe seems to be a difficult proposition. But some clinics may achieve this target especially where client flow is good and in particularly where MR cases are relatively high. Income for service fees can also contribute to clinics but not is a big way as the services fees are generally low. However, UMCs provide subsidies to ultra poor to ensure their access, which are paid out of clinic income. Thus provision of subsidy has an impact on UMCs sustainability. MS can set up a separate subsidy fund in the long run to keep to the UMC's financials unfettered.

2.11 Progress of major activities against targets

- Eight existing mini-clinics of MSCS have been upgraded with right based approach; and subsidized treatment fund created.
- About 63,825 services were provided from the eight UMCs against total project target of 180,000 services. It appeared most unlikely that the target will be achieved in the remaining project period.
- BCC sessions are conducted as per plan. A total of 97,789 people were reached in the 2nd year against target of 182,000. Late start of the project could be a reason. However, the current trend is found satisfactory.

2.12 Recommendation for UMC component

- The community awareness campaign and service marketing require further strengthening
- Each UMC needs at least one full time "Clinic Aide" who can be recruited from among the existing volunteers. Volunteers should spend most of their time in the community for promotion and service marketing
- Each UMC should have one male volunteer to mobilize male clients.
- Clinic timetable and opening days should be flexible and determined based on local context and demand
- Marie Stopes may set up a separate subsidy fund for the poor and marginalized women

One Momtaz Begum (17) *from Kamrangir char UMC area expressed, "Girls of our age are often ignored when we visit a clinic, but here in the MS clinic, the situation is very different. Firstly, the counselor advised me in a friendly manner and then the doctor listened to my problem very attentively. She explained to me the consequences of my problem and gave me detail advice and treatments".*

3 COMPONENT THREE: INCREASING MALE INVOLVEMENT IN SRH ISSUES IN THE TARGET AREAS

The ICPD Programme of Action underscored the importance of men to take more responsibility for their sexual and reproductive behaviour and family life. Despite this the reproductive health needs of men generally have been ignored and men continue to remain the 50% that is overlooked. Component three of the EC Block grant project is particularly designed to increase male involvement in SRH issues in the selected target areas. The male involvement component is implemented at four MSCS clinics - two in Dhaka and the other two in Tongi and Narsingdi. MS has targeted an estimated number of 150,000 to 200,000 male population in these clinic catchments areas. Key questions of the MTR were included:

Findings and Analysis

3.1 Approach and targeting

MS adopted several strategies to increase knowledge and awareness of the catchment population. The strategies include:

- Distribution of printed materials (brochures, posters, stickers, referral slips etc.)
- Radio Listeners Club (RLC)
- ALAPIA – news letter published six-monthly
- Strengthening male involvement forum
- Formation of Community Based Advocacy Group (CBAG)
- Develop networks of community and national level 'goodwill ambassadors'

Overall the BCC activities are not adequate in terms of their frequency and attractiveness such that they attract the attention of the male clients. RLC is one such initiative whose members are comprised of different age group (25–58). About 56 RLC members from the male project sites have been selected/rejuvenated in this project phase. Most of them are new members and have expressed their willingness to work as volunteers. However, discussions with RLC members suggest that the activities of the RLC are quite limited. They usually attend a monthly meeting at the clinic level but very few of them could remember what was discussed in the last meeting. They rarely refer male clients for NSV. Generally young RLC members send STI patients and senior members send MR patients. RLC members lack identity in their locality, although there is a provision cod hanging hoardings in their shops.

Most of the RLC members do not have any radio or record player. Therefore, the main purpose of the radio-listening club and playing SRH messages to the public cannot be achieved. RLC members are committed to their role and urged for Radio or tape recorders/players so that they can play massages.

Location/spot RLC members are very important for information dissemination. Current locations of majority of the RLC members are not very strategic. It therefore should be an important consideration that the shops of RLC members are placed at locations where low-income people go and/or get together. Appropriate locations, as mentioned by the members are: entrance of slums or within slum, tea stalls within slum or clusters.

Another means of information dissemination is ALAPIA – a newsletter. This newsletter is sent to 1500 ALAPIA members through out country. The newsletter also contains interactive materials – questions, quiz etc. MS claims that members often asked questions which were addressed through the subsequent issues of the newsletter. As before, it is questionable whether this relevant for illiterate target groups. It has been observed that even the literate people do not read these materials with interest. Therefore, effectiveness of ALAPIA while targeting a huge audience is seemingly low. In contrast, the effectiveness of posters, stickers and billboards seemed much higher. While male clients were asked about how they came to know about MS services, most of them mentioned that the main

sources of information were signboard at the clinic site, posters, billboards at the roadside, and the clinic areas. A few of them had heard about MS clinics from advertisements on television.

3.2 Services availability and utilization

MS clinics are usually well decorated, systematic and neat. The service section for male clients is relatively less crowded. This part contains a reception, counselors cabin/room, doctors consultation chamber, beautifully decorated waiting space with sufficient and comfortable seating arrangement, OT for NSV, recovery room etc. All these facilities are seemingly under-utilised as client flow is quite low. The present mobilization and/or campaign requires strong attention from the policy makers to improve levels of awareness and campaigns in order to optimally utilise the installed facilities at the clinic level.

MS has also introduced a partnership treatment scheme for STI and other communicable diseases to reach male partners of female clients. As it only started in late 2007, the results have yet to bring any visible impact on the existing male client flow.

Referral linkages with the RH service providers (both private and public) in the catchments area need to be strengthened. The existing initiatives seemed inadequate and primarily limited to NGOs. Private clinics and pharmacies could serve as a strong referral points for NSV clients.

3.3 Media and local level advocacy

The media is a very powerful tool to change attitudes and behaviour of male clients. The mass media campaign, in particular the MS TV shots, were to be found very popular and useful for orienting and motivating male clients. Use of mass media is especially useful and cost-effective for increasing people's attention towards FP methods – in particular men. What is needed is to design an appropriate and realistic media strategy so as to increase the coverage. The MS media, which is primarily RH focused, gives an impression of MS facilities as women's centres.only MS has aired over 100 spots in 2007 through two local television channels, but again the majority of them were female client focused. MS needs to combat such an impression with targeting men in their mass media campaign.

The Community Based Advocacy Group (CBAG) in the catchment areas is expected to act as an advocacy body to promote male involvement in RH activities. Eleven such groups have been formed with representatives from NGOs, Bus and Truck associations, Religious Leaders and Retired Government officials. The frequency of CBAG meeting seems inadequate for developing cohesion and momentum within the group. This group can be made an instrument for organising area-based campaign. CBAG's role is also limited – they occasionally provide support while MS takes initiative for a community based program/JARI song etc. Inclusion of celebrities (goodwill ambassadors) in the male gathering is a good initiative but again the frequency of such initiative has been very low – only twice during the project period.

3.4 Male clients in the Mini clinics

Service provision has been created in the Upgraded mini clinics for the male clients from the neighbouring communities. Qualified doctors from Marie Stopes render services once in a week especially to the male clients. Response from the male clients has not been very encouraging till now. One session, typically last for three hours, receives on an average 4-5 clients. This is in any standard poor.

Mini clinics are generally perceived as a female service facility. BCC activities to attract male client is almost non-existent. There are no male volunteer placed at the UMCs to promote male services. On the other hand male patients don't see the UMCs as feasible service option for them as it is open only once in a week and that are also for a short period. Male clients rather prefer local pharmacies or doctors who they can access on demand. Organizing daily services for male client will definitely have an impact on patient flow but that does seemingly feasible from management and financial point of view. Existing arrangement can still be a feasible option provided adequate BCC and the provision of a male volunteer is created for each UMCs.

3.5 Progress of major activities against targets

- All communication materials (referral slips, stickers, poster/leaflets, Alapia) were printed and distributed as per targets.
- Four clinics with male service facility remained operational.
- 8347 male in year one and 15,494 male in year two (total 23,841 in two years) received services from 4 clinics. Of them 9648 (40%) were NSV clients. The client flow increased in the year two.
- RLC and CBAG members meetings are held regularly.
- Organised five interactive forum theatres at the slum areas. Of them two national celebrities delivered speech on the issue of male involvements in RH.

3.6 Recommendation for Male component

- The RLC needs to be activated and necessary logistical support needs to be ensured.
- The existing referral system needs to be reviewed. Private clinics, pharmacies and local opinion leaders need to be brought into the referral system.
- Campaigns and awareness rising programs need to be periodic but regular. Satisfied male client forum could be piloted to market NSV and other services.

***Moidul Islam (35)**, father of three children, came to the Marie Stopes Clinic with a field worker for NSV. The MS volunteer counseled him for NSV at his Rickshaw garage. Moidul and his wife decided not to take any more children. Moidul's wife used to take contraceptive injection periodically to prevent pregnancy. He feels comfortable after the NSV. He mentioned that one hour waiting time was normal for an operation and was very satisfied with the services of the doctor and the technicians for the painless surgery.*

4 COMPONENT FOUR: IMPROVING THE SRH STATUS OF THE FEMALE FACTORY WORKERS IN THE TARGET AREAS

Marie Stopes are currently providing onsite health services to 25 factories in three major cities in Bangladesh namely Dhaka, Chittagong and Khulna. Of those 25 industrial units, 21 are garment industries based in Dhaka and Chittagong and 5 are fish processing industries based in Khulna. Marie Stopes have organized a service package for the workers of the respective industries through a MoU signed between the management of the concerned industry and Marie Stopes. During the MTR, following questions were looked while reviewing this particular program component:

Findings and Analysis

4.1 Awareness about the risk of SRH issues

Marie Stopes conducted a baseline survey on the factory workers on their awareness of SRH issues and healthcare seeking behaviour. The survey showed that a significant gap exists among the factory workers, most of whom are female, regarding SRH. Hence a targeted awareness campaign becomes an important part of this component's strategy. Slide shows, leaflets and counseling are the main vehicles to improve awareness among them.

During discussions with the factory workers, both male and female, it was evident that most of them have developed a basic understanding about SRH and its associated risk factors. It was felt that the factory workers are not only aware about SRH issues but they also improved their SRH practices and personal hygiene as measures to avoid risk. Since a large part of the factory workers are youth, the SRH awareness campaign has equipped them with the necessary life skills to deal with the challenges related to youth and adolescence.

Having said that, there are limitations of the awareness program as well. The noisy and crowded environment of the factories do not provide adequate scope to disseminate information. Therefore the level of understanding varies significantly from worker to worker. Furthermore, the high turnover of the factory workers requires MS to repeat sessions over and over again. Methods of information dissemination are largely one-way. The physical set up and time limitation determine the current communication method, which can hardly be changed for practical reasons. Marie Stopes might consider adopting its peer education method to accomplish higher penetration and impact.

4.2 Access to quality healthcare and improvement of general health

Marie Stopes has arranged for a qualified doctor with an assistant to attend the factory site to provide health services to the factory workers. The services are available once a week or as agreed with the factory management. Factory workers receive health services as well as medicine from the healthcare facilities. General as well as SRH treatments and counseling services are provided from the facilities. Referral services are also ensured for the workers to both public and Marie Stopes's clinics. First aid facilities have also been established with two trained factory staff to cope with accidental emergencies.

Marie Stopes health services ensure not only quality health care for the factory workers but also reduce the risk of maltreatment by untrained doctors and pharmacies. Health awareness coupled with quality medical care has been able to made a positive contribution towards a better health status for the workers. Factory management strongly endorsed the contribution of the program and its economic impact on their business in terms of reduced sick leave and absenteeism. Factory workers also acknowledged the benefit of the health services and demanded an extended service range to fulfil their health needs. Marie Stopes have successfully incorporated a TT vaccination program for the factory workers, which is an innovative approach in this context. This has helped in mitigating health risks of workers during pregnancy.

4.3 Role of factory management

The success of the factory based health programme is largely dependent on the cooperation of the factory management. There is a growing realization among the entrepreneurs that provision of health services is not only beneficial to the workers but at the same time it is beneficial for them as it increases productivity and thereby profit of the industry. A number of international trade compliance issues have also contributed to the cooperation of the industry owners, for they see that spending for workers' healthcare is imperative to stay in business. As a result more and more garment industries are approaching Marie Stopes for providing factory based health services. Above all Marie Stopes have earned a reputation as a low cost and high quality service provider wtihin the garment industry.

Having said that there is still some reluctance from the factory management to pay required amount to Marie Stopes for the services. There is a tendency to seek subsidies from the service provider. While Marie Stopes planned to charge around Tk .18-20 per worker per month for health care and medicine, it has only succeeded in charging around Tk. 14 as of now. This amounts to less than 0.5% of the payroll cost of respective factories. This indicates that still there is a lack of effective commitment to health service provision from the factory management.

***Rozina (20)**, a garment factory worker in Mohakhali area, is married to Jalal, who also works in a garment factory. Being inspired by her husband, she came to the Marie Stopes Clinic (Dhaka-2, Mohkhali) for Ultrasonogram, as she was pregnant for eight months. She is very satisfied with the MS clinic service. She mentioned that the service providers were very careful, sincere and attentive. Except once, she never had to wait more than half an hour for receiving ANC service.*

4.4 Replication and sustainability of the service model

Marie Stopes has developed a simple but financially sustainable model of healthcare for the factory workers. The factory based outreach approach very much is suited to the needs of the factory worker as well as the management. The economic cost of healthcare remains minimum as the services are provided on site and during working hours with no loss of workers productivity. Direct provision of services with an awareness campaign increases the overall impact on health.

The issue of sustainability is built into the model. The factory management share the cost, which is currently meeting the net marginal cost of the service providers. The gradual increase of service charges will meet the full cost of the program with no requirement for subsidizing from the providers.

4.5 Progress of major activities against targets

- Factory mapping exercises completed in year one and negotiated done with factory management.
- 27,645 workers in year one and 35, 168 workers in year two received services against yearly target of 42,000 (+20% incremental). The project could not reach its intended targets. May be MS could not targeted bigger factories.
- TT immunization for female factory workers conducted in year two. 58% (against target of 60%) of total female served during the year were provided with TT injections.

4.6 Recommendation for Factory component

- Bigger factories should be targeted to reach a higher number of clients. But priority needs to be given to factories where working condition are relatively poor.
- Special initiatives should be taken to mobilize male workers along side women.

5 COMPONENT FIVE: IMPROVING THE SRH STATUS OF ADOLESCENT SLUM DWELLERS

Marie Stopes has designed and delivered a special programme for the youth and adolescents in selected urban areas through its static mini clinics. Special arrangements and service provisions have been created at the selected mini clinics to offer critical SRH services for youth and male and female adolescents.

Besides health services, an innovative approach was adopted to develop awareness among the youth on sexual and reproductive issues, using a peer education model that was introduced to disseminate SRH related information and improved health-seeking behaviour. A group of male and females adolescents were recruited as peer educators, who have gone through a rigorous training process, after which they work as field volunteers to disseminate information among their peers and friends. They also refer young people to take healthcare from the adolescent health service points of Marie Stopes clinics.

In addition to the above, Marie Stopes has initiated a new health service package for adolescents engaged in hazardous work. On site service provision has been created in collaboration with employers to ensure access to healthcare for youth involved in hazardous work.

Finding and Analysis

5.1 Awareness among the youth on SRH

Awareness development among youth and adolescents. This model has proven to be very effective, particularly in the context where open discussion with youth on sexual matters is not socially well accepted. Peers have effectively overcome social barriers and they can provide important messages and life skills to their friends and associates. The exemplary skills and awareness of the peer educators itself is a big achievement of this initiative. These little champions have developed considerable acceptability in their respective communities as well as schools. Each of them was seen to be very active and have successfully passed on critical SRH related information to their friends and peers.

The present model allows peer educators to work for only six months under direct supervision and guidance from Marie Stopes. After that period, it is expected that peer educators will continue their job voluntarily. However, the evidence shows that although the peer educators do continue their work, the level of enthusiasm and interest gradually fade out. There are no mechanisms to maintain linkages with these peer educators as Marie Stopes gets busy working with another set of new peer educators. While new peer educators are necessary to reach out new groups of youth, it is equally important to remain involved in the services of the old peer educators for longer period of time. Marie Stopes should either extend their engagement with its peer educators or should develop an informal network of peer educators to keep them engaged well beyond the stipulated six month of extension work. A small allocation of resources should be made to keep this network functioning.

Rashida (17), *an adolescent from Chittagong-1 clinic expressed," I heard about this clinic from a friend of mine, who later on became my peer. Our parents knew what we discussed and encouraged us to discuss RH issue with other friends as well. We had passed on RH information to many of our friends and convinced a good number of friends to come to MS clinics for their RH issues".*

5.2 Demand as well as access to SRH services

A special evening clinic for the adolescent girls and boys generates an enthusiastic response from the catchment areas. A good number of adolescents and youth come to Mare Stopes clinics to receive services. Some of them are referred by the peer educators and some come on the basis of personal initiative. This shows that a degree of demand for healthcare services has been created in the community.

5.3 Health service to the youths in hazardous occupation

Although the health service needs of people engaged in hazardous work are much more demanding than most other occupational groups, yet there is very little service provision existing for their needs, in particular for youth and adolescents. In that Marie Stopes' experimental initiative to provide health services to the youth involved in hazardous work deserve great appreciation. For the first time, the youth have got access to quality health care at work place. The demand for such health needs has been huge. Within six month of introduction of this services, increasing flow of clients were evident. It is expected that the client flow will increase further as more people will become aware of this services.

Currently services are rendered fortnightly. This frequency seems adequate but it may fall short with any growth in client flow. Client flow may increase further with some level of BCC activity. Currently BCC activity is almost non-existent in the areas targeted for hazardous occupations. BCC along with factory level advocacy will help to create an enabling environment for the factory workers to access health services.

The main challenge of this program is to secure adequate support from the factory management. Factory owners are not very aware of the health issues pertaining to young people. It requires much persuasion and motivational work to secure their support and commitment towards this program. The formation of project support group involving the factory owner and management staff may provide a framework facilitating their support, and additionally a sustained level of advocacy work will be necessary.

5.4 Progress of major activities against targets

- A mapping exercise was completed to locate 1800 adolescents in year one and since then twelve YP clinics have been made functional.
- 144 peer educators selected in each year and they were provided with peer education training. Half of them are female. They are disseminating RH information to a large number of youth and adolescents in their respective locality.
- 16,345 services were provided in year one and 20,431 services in year two provided as against a yearly target of 37,440. This indicates that the targets was set at higher level given than the capacity of service providers.
- Support committee meetings (30 meetings) held as originally foreseen.

5.5 Recommendation for YP Component

- Peer educators should be involved in extension work for one year instead of six months under the direct supervision and guidance of Marie Stopes.
- An informal network of peer educators could be formed based at the YP centre and some resources could be allocated to nurture the network.
- Marie Stopes should undertake some BCC and advocacy activities on Hazardous occupations and form a project support group around the SDP involving motivated factory owners, managers and local elites.

6 COMPONENT SIX: PROMOTING QUALITY OF CARE AMONGST SERVICE PROVIDERS IN THE TARGET AREAS

Quality of Care (QoC) is a major concern in the health sector in general and the public sector in particular. Service providers are rather reluctant to adhere to the minimum standard of care. Government had recognized it and adopted a strategy to adopt and implement Client's Charter of Rights (CCR) to enhance service quality. Marie Stopes as part of the EC block grant has taken a series of activities to assist the government to implement the Client's Charter of Rights (CCR) as the latter has adopted it to augment quality of care.

Findings and Analysis

6.1 Awareness development among the policy planners

In 1998 the Government of Bangladesh under the HSPS program developed the Citizen Charter of Rights (CCR) to ensure quality of care for clients. However, the CCR remained a policy document with limited awareness of it among health system functionaries. A study showed that only 7% health functionaries were aware of CCR and more surprisingly less than 3% were actually informed about some articles of CCR. In this context there was a huge challenge to operationalize the CCR at service delivery points.

Marie Stopes has been working closely with the MoHFW, DGHS and DGFP to operationalize the CCR within health service delivery systems. This effort has resulted in the formation of high-powered committees at MoHFW, DGHS and DGFP on CCR. The government has recognized Marie Stopes as a supporting agency in relation to its endeavour of operationalizing the CCR in the health and family planning sector. Marie Stopes has actively supported government initiatives through technical and logistical support for mobilization and awareness building within the health and family planning service delivery system, In addition Marie Stopes is working with the DG health and NIPORT to design a training curriculum on CCR that will be incorporated within the in-service training package of DGFP.

Very recently the government has adopted a Citizen Charter for the Health sector institutions like it has done for many other public institutions. Many issues regarding CCR has been integrated into the Citizen Charter. Thus a policy framework has been in place that supports QoC and clients rights. However, these need much more effort and advocacy to operationalize the policy in real terms.

The recent development (Citizen Charter) has on the one hand raised new challenges but also created enormous opportunities for advocacy. To take advantage of this, Marie Stopes will need to reorganize the existing advocacy strategy and concomitant activities where mobilization and awareness development will take the precedence. While the Ministry agencies DGHS and DGFP should continue to be the main anchor point for advocacy, much needs to be done at the service delivery point in terms of awareness raising and compliance monitoring.

6.2 BCC for public awareness

Marie Stopes is working with the DGFP for public awareness on CCR. IEC materials including posters and leaflets have been produced and distributed through DGFP across the country. Besides IEC materials, a range of interactive events such as round table discussionsand public rallies were held in selected divisional cities to raise public awareness. Although the impact of these awareness events could not be ascertained during the MTR. a further study on communication effectiveness could be planned to assess the impact of the mass awareness campaign. Having said that, Marie Stopes' effort to involve DGFP in the public campaign cannot and should not be over emphasized.

6.3 Strengthening HCRF

HCRF is a network of institutions and individuals committed to realizing the rights of health consumers. As of now more than 55 organizations and individuals have become members of this network. The network works to mobilize public awareness on clients' rights and to promote quality of care. It organizes meetings, workshops and discussion forums on health issues. Marie Stopes is hosting the secretariat of HCRF.

HCRF has evolved as a formal institution. Secretarial support from Marie Stopes has enabled it to mobilize support and undertake events on strategically important issues such as medical waste. Important government institutions in the health sector such as DGHS and DGFP participate in the HCRF forum. Thus it has gained recognition not only from the health professionals and NGOs but also from government institutions. HCRF has, therefore, become an important forum for health sector advocacy as a network provides a much better forum and stronger platform for policy advocacy.

HCRF has developed the capability to take on health sector issues on a collective basis as major health service providers including the government have demonstrated their support towards this network. To capitalize on its role as a network, the Secretariat should be further strengthened with dedicated staff and resources to realize its full potential. Indeed Marie Stopes may pass on part of its advocacy related activities to the network secretariat based at its main office. Thus Marie Stopes can acquire higher leverage from the wider acceptance and linkages of the network.

6.4 Progress of major activities against targets

- Meetings held with DGHS, MOHFW and DGFP on quality issues of health care and modalities developed to operationalise CCR.
- Training Curriculum for training government services providers on quality of care issues developed in collaboration with NIPORT.
- Awareness of health consumers quality issue improved through a media campaign and dissemination of IEC materials with active involvement of DGFP. Rallies and round table conferences in three divisional cities organized.
- Health Consumers Rights Forum has emerged as a strong advocacy body and it is persuading policy issues at appropriate levels. The issues included strategy on medical waste management, CCR etc.
- Meetings held with DGHS, MOHFW and DGFP on quality issues of health care and modalities developed to operationalise CCR.
- Training Curriculum for training government service providers on quality of care issues/ developed in collaboration with NIPORT.
- Awareness of health consumers quality issues improved through a media campaign and dissemination of IEC materials with active involvement of DGFP. Rallies and round table conferences in three divisional cities organized.
- Health Consumers Rights Forum has emerged as a strong advocacy body and it is persuading policy issues at appropriate levels. The issues included strategy on medical waste management, CCR etc.

6.5 Recommendation for Advocacy component

- The HCRF secretariat needs to be further strengthened with fulltime staff and resources. Advocacy initiatives should be implemented through this secretariat.
- There is a need to look at the existing advocacy strategy as the government has adopted the Citizen Charter for the health sector. Future strategy should focus on how the citizen charter can be used to improve quality of care at the service delivery point.

7 COMPONENT SEVEN: PROMOTING A RIGHT BASED APPROACH AMONGST CLIENTS AND SERVICE PROVIDERS

Marie Stopes is experimenting to integrate RBA framework within its program and service delivery mechanism. RBA traditionally attach a strong string with the legal aspects that includes entitlement and the way of enforcement. This approach is more relevant with the public sector institution. In the private sector, RBA have not been very actively researched. Marie Stopes being a private institution strived to devise RBA from its own institution perspective. As a service providers its has developed a range of unique systems and processes that not only raise public awareness but also enforce a set of self-disciplinary measures on its operating system. The MTR has reviewed those systems and looked at the following issues in some length.

Finding and Analysis

7.1 Understanding and application of RBA

Marie Stopes understanding of and approach to RBA is quite pragmatic and significantly different from the traditional understanding and application of RBA. The traditional RBA approach emphasises public rights and entitlements and focuses on as to how public entitlement can be enforced. Therefore the legal aspects of rights or violation thereof come into play very strongly. Public institutions thus become the main target of RBA. Unlike this general understanding of RBA, Marie Stopes has embarked upon on whole new approach to RBA that calls for institutional self-discipline, accountability and public empowerment – all initiated by the service provider per se.

The biggest advantage of this approach is that the provider (herein MS) facilitates to ensure rights of the people rather than creating demand for realization of rights. Sensitivity and a pro-client attitude from the provider underpins the success of the RBA, which is accompanied by public education and awareness building. Furthermore, a range of innovative procedures have been put in place to operationalize RBA: these include mood meters (for non-literates), client satisfaction surveys through periodic FGD exercises and a complaint line. An effective grievance redressal mechanism has been established at the SDP as well as headquarters level.

Marie Stopes' commitment to RBA is demonstrated by the formation of a high profile RBA learning group at the HQs level.To support the complaint line, an independent, accountable and transparent grievance redressal system has been installed at the headquarters level. Recording and disposal of clients complaints have been adequately separated administratively. A Director (second in the organizational hierarchy) is ultimately responsible for handling the clients' grievance redressal process that itself is an example of high institutional commitment to RBA. Having said that, the approach is still evolving and needs further consolidation. Oversight and monitoring of service providers behaviour, compliance to the grievance redressal mechanism and above all clients' empowerment needs to be the cornerstone of RBA as far as its understanding and application is concerned. Progress made so far to this end is commendable and can be a model for replication.

7.2 RBA to empower the customer

Marie Stopes' approach to RBA has requisite elements to empower their clients, as the mechanisms established for RBA are transparent and easily accessible to the clients. At every SDP, processes are in place such as mood meters (to provider clients immediate reaction to service quality) and a complaint system is available to the clients. Community level awareness and training of programme Support Groups provides special emphasis to clients' rights aspects and encourages stakeholders to use the RBA procedures while receiving services from any MS facilities. In particular, community support groups work as the voice of community in the context of RBA. The awareness and training programme deliberately passes on information about the clients' rights to receive quality services from Marie Stopes health facilities and educates them as to how RBA is operationalized at the SDPs.

Clients' direct access to the senior management of MS through the complaint line has effectively empowered the clients. There were examples, though not in many numbers, that unsatisfied clients had called MS program director directly and lodged complains against the clinic doctors and service staffs.

In addition, service providers' behaviour encourages the clients to engage in dialogue and empowers them to ask for clarification. Unsatisfied customers can express their reactions and complaints freely and independently. Thus public education and institutional mechanisms put in place at the SDPs contribute effectively to clients' empowerment.

7.3 Integration of RBA

The RBA mechanism has been effectively mainstreamed throughout the Marie Stopes system through introducing some systems, processes and awareness development training. In all static clinics (RCs and UMCs), identical mechanisms have been put in places that are equally accessible to the clients. At the satellite level, such mechanisms have not been established, as they are not fully feasible, but Marie Stopes has ensured adequate community awareness on people's rights to quality health care accompanied by institutional oversights and monitoring of service providers compliance to clients rights.

Besides the SDP level, RBA has been mainstreamed in service protocols, technical quality standards, staff training and monitoring mechanisms. Besides a full-fledged RBA training program, all other technical and non-technical training programs have a module on RBA. Thus the reinforcement of training on the staff has made a significant impact on the '**MIND SET**" and has caused significant shifts in their approach to clients. An "RBA study group" comprised of the most senior members of the organization is not only instrumental in mainstreaming the RBA concept in programming and service delivery but also serves as a signal of organizational ethos towards the client.

7.4 Progress of major activities against targets

- Desk research conducted by 6 senior staff of MS and as a result, RBA Strategy and training materials designed and contextualized.
- 79 staff in year one and 68 staff in year two were provided with RBA training against target of 175 staff. However, a total of 237 MS staff received refreshers training under the project.
- RBA implementation developed and put in place.
- Community led participatory monitoring system developed and put in place in UMC, YP and health card components.
- 317 project support committee members in year one were provided with training on Clients Charted and 213 staff members in year two were provided with refreshers training on the same topics.

7.5 Recommendation for RBA component

- As the right based approach at Marie Stopes is in formation; there is a need for documentation of the experiences of rolling this out within the organization.

8 REVIEW OF PROJECT MONITORING AND SERVICE STATISTICS

8.1 Monitoring system

Marie Stopes maintains a multi-tier monitoring and reporting system to follow up whether its project interventions are on track and to ensure service quality. Services provided by the EC block grant components are delivered through 6 referral clinics, of which 5 clinics are ISO certified. Therefore, a strong compliance monitoring system is built into the delivery mechanism. MS has a comprehensive and computerized MIS system that generates information to facilitate monitoring and informed decision-making.

The monitoring tools consists of several checklists and formats that cover both technical and physical/general aspects of service delivery based at SDPs. These tools are implemented at regular intervals. Information is collected against indicators derived from the project log frame and used during monthly and quarterly reviews and reporting. The primary responsibility for monitoring lies with the referral centres.

The project combines service delivery as well as mobilization and awareness development. The existing monitoring system, though very stringent and functional, is unevenly tilted towards service

delivery and technical aspects of health management. Monitoring of the results of awareness and mobilization activities remains weak. Further success of service delivery is heavily dependent on the creation of effective demand for services, which in turn is contingent upon the quality of mobilization and awareness work. Therefore MS will need to monitor not only the awareness related activities but more on the results of events and processes planned for awareness rising.

The MTR team is under the impression that corrective measures due monitoring are largely followed up, in particular for technical aspects and compliance monitoring at the service delivery points.

Yasmin (34), *a loyal client of MS expressed her satisfaction on the overall quality of this MS clinic. The main features of quality according to her have been: good behavior of the healthcare provider, less waiting time (only 30 minute this time), short distance from home (10-12) minutes walking distance.*

9 OVERALL ASSESSMENT OF THE EC BLOCK GRANT PROJECT

This section attempts to synthesis the findings of the various components under the review and analyse them in a number of broad thematic terms. They include the design of the EC block grant, relevance of the various components; Effectiveness in term of results of the project components; efficiency of the implementation; sustainability and replication of the components in the present and future context. Following provides the details:

9.1 Project Design

The EC block grant project design was based on Marie Stopes' ongoing project components that were implemented in various locations and with different target groups. As many as seven components make up the EC block grant project as a whole – of them five component are related to direct service delivery and the remaining two components are strategic in nature and deal with macro level policy, advocacy and the integration of the right-based approach in Marie Stopes service delivery approach. Given the size of the project and resources allocated, number of components seemed to be relatively high. Thus the project components are spread out rather thinly in three program districts. That is to say, the project components are being implemented partially within the coverage area. Thus the integration between the project components has serious shortcomings. However, as the project components are managed and implemented through its referral centres where other complementary services are available, Marie Stopes have been able to implement the project without too much difficultly.

The OVIs and targets set in the original project document seemed to be rather high. One could consider them ambitious. The results achieved in the last two years are good but fall short of the original targets. Setting unrealistically high targets without concomitant resource planning has led to under-performance. Marie Stopes should reflect on its capability, resources and set more realistic targets for the EC block grant components.

The advocacy component has been planned to contribute to the larger program goal of Marie Stopes, though the advocacy component strategy has very little relationship with the five service delivery r components of the project. However, advocacy does contribute to CCR and RBA strategy of the EC block grant project.

In the project design two community level structures namely MSV and PSG have been created, which work as the interface between Marie Stopes and the community. Though these groups are working as volunteers, they have been very instrumental in creating demand for health services and contributing towards improved health seeking behaviour of the community people, particularly the poor and the marginalized, including the homeless population.

9.2 Relevance of the project components

The need for SRH services will remain high for many more years. Existing service providers both from the public and the private sector fail to meet SRH health needs as access to these services are limited for the poor and marginalized groups in particular. Through the EC block grant Marie Stopes have extended a range of SRH health services to marginalized people of different backgrounds. An explicit demand for these services exists and the demand is still rising as more clients are coming to MS service centres to receive SRH services. Service needs are particularly high for the vulnerable groups such as youth and adolescents, poor women and the homeless as most of these existing service agencies are not sensitive to their particular needs. The wholesale approach of the public sector service providers effectively excludes the marginalized from the state health facilities. On the other hand, they can't buy health services in general and SRH services in particular from private faculties due to their high cost. Lack of awareness and social values held also hinder proactive health seeking behaviour.

Given the social context and the framework condition, the health service sector is not responsive to the huge demand for the SRH services. Thus the need for donor support in this area will remain for sometime to improve the sexual and reproductive of the people.

9.3 Effectiveness of the project component

The project has made a significant contribution to enhance access to health services in general and SRH services for poor and marginalized groups in particular. The project components have enabled some of most vulnerable groups such as homeless people, adolescents and people working in hazardous occupations to access quality health care with minimum cost at their convenience. The outreach approach to heath services was found particularly suitable for these groups. Upgraded mini clinic (UMCs) have evolved as an appropriate community level service delivery model for women and children. These mini clinics have created enormous opportunities for the low-income groups to access quality SRH services at an affordable price. Besides SRH services, upgraded mini clinic also ensures general health care solutions to the community people.

There has been an improvement in health seeking behaviour observed in the catchment area where Marie Stopes SRH services are made available. Adolescents and youth are increasingly seeking healthcare and they are overcoming social sigma associated with SRH issues. An enabling environment has been created for the young boys and girls to come to the YP centres and learn about reproductive health and the related life skills.

Men are important target for SRH issues and some of them are coming to take healthcare from the Marie Stopes centre but their number is far less than what the project aimed to accomplish. Existing mechanisms to involve male are not functioning as anticipated. Marie Stopes has created excellent facilities and structures at the referral clinics to serve male clients but without much success. Mobilization and awareness among male clients remain low. There are process deficiencies noticed in mobilization of men.

The integration of RBA within the framework of service delivery in effect increased the impact of the programme both for accessing quality services as well as health seeking behaviour. Marie Stopes's health services are perceived as friendly, client focused and respectful. Clients felt empowered here to obtain quality services.

9.4 Efficiency of the project component

The project components were implemented through the existing network of Marie Stopes' referral clinics. In all three project districts Marie Stopes has establishments with referral clinics and management structures. The project components are being effectively implemented as outreach of the respective referral clinics. This implementation strategy enables Marie Stopes to organize and operate the project on the basis of a streamlined management structure.

However, the progress of various components remains below target. There have been delays encountered initially that caused lack of performance in the first year, which has implications for the second year as well. The progress in the second year is relatively better but still below the target. Given the current reality, there will be further improvement of implementation rate in the third year but not as much as planned in the project document. It is now widely accepted within Marie Stopes that the project target was set rather ambitiously. It needs to be adjusted to a realistic level.

The staff members working in the EC block grant project are skilled and well trained. All staff members have the necessary training to provide quality services. A combination of both technical and non-technical training has developed a cadre of high quality and responsible health professionals who are taking the daunting task of reaching out to the most disadvantaged and marginal group day and night. Under the guidance and supervision of Marie Stopes' senior management team, a group of ordinary people is doing an extraordinary job in the SRH sector in Bangladesh.

Marie Stopes has developed a systematic and integrated monitoring and supervision mechanism placed within the referral centres as well as headquarters. Quality issues remain the central part of monitoring and supervision. Project progress is also monitored through the system. The monitoring system allows the RC as well as the central management to review periodic progress and take measures as and when needed. Furthermore, Marie Stopes' management is quite decentralized and

decision-making authority is vested even at the mini clinic level. This ensures access to services even by those who cannot afford to pay fees.

Cost is a major indicator of efficiency and unit costs of services at the SDP level are reasonably low compared to similar services of private and public sector. Low overheads and good service utilization rate have enabled Marie Stopes to keep service cost low. The service costs will reduce further with an increase in the utilization rate in view of the fact that utilisation is yet to reach the optimum level, particularly in male clinic, UMCs and YP centres. More marketing and mobilization are expected to bring more clients and thereby bring costs further down.

9.5 Sustainability of SRH services

SRH services are heavily subsidized both in public and NGO clinics. It will be unrealistic to assume the financial sustainability of the whole package of components under the EC block grant. However, some of the components have better prospects to become sustainable health service mechanism. The upgraded mini clinic is an innovative service delivery mechanism that has the best prospect of sustainable community level SRH service delivery. Some of the UMCs have already achieved a high degree of sustainability. Other UMCs will improve overtime, as the gestation period in the health sector is generally long. Likewise, health services for the factory workers are a sustainable approach as Marie Stopes has been able to realise the marginal cost of services. Some improvement in revenue collection will enable full cost recovery for factory level health services.

Besides the two components mentioned above, there are some other innovative models of SRH services such as the YP centres, homeless program, hazardous occupational healthcare etc. which can be replicated but there are few prospects for financial sustainability. These components have created enormous benefits for the most vulnerable sections of society but these groups can hardly pay for health services. They need incentives to ensure access to healthcare and improve their health-seeking behaviour. Therefore these components required continued external support for at least in the short to medium term.

***Khodeja Akther (18)**, a high school student from Kamrangirchar area, had been suffering from menstruation problems from the age of fifteen and gradually losing weight. But she never went to doctor for shyness. She came to know about adolescents' SH services of Marie Stopes from a friend who happened to be a peer educator. On her friend's advice, Khodeja went to the clinic and found the doctors and the counselors very friendly and approachable. Their friendly behaviour enabled her to overcome shyness and helped her problems get solved.*

10 CONCLUSION AND RECOMMENDATION

The MTR team finds that Marie Stopes is a quality-focused organization and that it strives to innovate sustainable health service delivery mechanisms for the poor and marginalized people. It has successfully developed and implemented sustainable a SRH service delivery model from community to factory level. Furthermore, a number of unique SRH service delivery methods have been developed for high-risk groups such as homeless people, adolescents and people in hazardous occupations. The good work of Marie Stopes should not only continue but also be scaled up to provide much more people with access to quality health services especially SRH services.

RBA at Marie Stopes is a very innovative as well as pragmatic way of conceptualization and application in the context of service delivery. Any and every service delivery organization, be it in the private sector or in the public sector, can learn and apply this approach. This is indeed a governance improvement initiative from the providers end. This experimentation and learning should continue.

While the MTR team appreciates the quality and good work of Marie Stopes and vouch for its continuation and scale up, it does not want to miss out some opportunities where Marie Stopes can work on and improve its quality and impact. The following section provides a number of overall and component specific recommendations.

10.1 Overall Recommendations

- Marie Stopes needs to accelerate program implementation during the remaining project period to accomplish the target and set the project target more realistically after review the service demand and Marie Stopes' service dispensing capability. The start up process needs to be fine-tuned and further accelerated in new projects.
- Project components need to be further integrated and focused to targeted geographical areas or stakeholders groups. This will reduce management complexity and improve implementation and impact.
- Awareness building and mobilization activities need to be planned and designed based on a clear and well-thought out communication strategy. Monitoring of mobilization events and their results need further improvement and thrust.

10.2 Component Specific recommendations

The following section delineates component wise recommendations.

Homeless Component

- A study should be planned to assess clients' willingness and ability to pay to determine a pricing strategy for health services
- Considering the demand for services and capacity of mobile vans, several more homeless spots could be covered in Chittagong.
- Seating and reception for male patients could be improved a bit to match with similar facilities provided for the female clients.

Upgraded Mini Clinic

- The community awareness campaign and service marketing require further strengthening
- Each UMC needs at least one full time "Clinic Aide" who can be recruited from among the existing volunteers. Volunteers should spend most of their time in the community for promotion and service marketing
- Each UMC should have one male volunteer to mobilize male clients.
- Clinic timetable and opening days should be flexible and determined based on local context and demand.

Male component

- The RLC needs to be activated and necessary logistical support needs to be ensured.
- The existing referral system needs to be reviewed. Private clinics, pharmacies and local opinion leaders need to be brought into the referral system.
- Campaigns and awareness rising programs need to be periodic but regular. Satisfied male client forum could be piloted to market NSV and other services.

Health card

- Bigger factories should be targeted to reach a higher number of clients. But priority needs to be given to factories where working condition are relatively poor.
- Special initiatives should be taken to mobilize male workers along side women.

Youth Adolescent and Hazardous Occupation

- Peer educators should be involved in extension work for one year instead of six months under the direct supervision and guidance of Marie Stopes.
- An informal network of peer educators could be formed based at the YP centre and some resources could be allocated to nurture the network.
- Marie Stopes should undertake some BCC and advocacy activities on Hazardous occupations and form a project support group around the SDP involving motivated factory owners, managers and local elites.

Advocacy

- The HCRF secretariat needs to be further strengthened with fulltime staff and resources. Advocacy initiatives should be implemented through this secretariat.
- There is a need to look at the existing advocacy strategy as the government has adopted the Citizen Charter for the health sector. Future strategy should focus on how the citizen charter can be used to improve quality of care at the service delivery point.

Right-based approach

- As the right-based approach at Marie Stopes is in formation, there is a need for documentation of the experiences of rolling this out within the organization.

Annex-1

Terms of Reference for Mid-term Review

1. BACKGROUND:

Marie Stopes Clinic Society (MSCS) was established as an NGO in 1988, registered with the Social Welfare Directorate and the NGO Affairs Bureau to provide family planning and reproductive health service to women, men and adolescents with special emphasis on the poor and vulnerable.

In February 2006, MSCS was granted funding from the European Commission through Marie Stopes International (UK) to "increase access to quality reproductive health service and provide continuous support of quality SRH services among the poor and vulnerable people in selected urban and pre-urban areas".

The project includes 7 components and focuses on increasing access to quality SRH & primary health care services, providing information and promoting rights of the homeless or floating population, female & adolescent slum dwellers (including those working in hazardous occupation) and female workers in garment and fish processing factories. The project also endeavors to increase male involvement in SRH. The last two components of the project focus on promoting Quality of Care amongst service providers and recipients and promoting a Rights-based Approach amongst clients and service providers in the target areas.

1.1 Project Components:

1. Enabling the homeless poor/floating population in the target areas to access quality SRH services and information
2. Enabling female slum-dwellers in the target areas to realize their SRH and rights
3. Increasing male involvement in SRH issues in the target areas
4. Improving the SRH status of female workers in factories in the target areas
5. Improving the SRH status of adolescent slum-dwellers, including those working in hazardous occupations, in the target areas
6. Promoting Quality of Care amongst Service Providers and recipients in the target areas
7. Promoting a Rights-based Approach amongst clients and service providers in the target areas

2. DESCRIPTION OF THE ASSIGNEMENT:

The contractee will assess the progress of EC Block grant project activities in relation to:

- the overall and immediate objectives stated tin the original project document
- the indicators mentioned in the documents,
- the inputs described in project documents,
- the adequacy of the programme management arrangements
- the extent to which the activities for the remaining period are evvectively responding to current needs
- the potential for sustainability when the project period ends.

Based on this assessment, the contractee will advise Marie Stopes to what extent the project is being successfully implemented according to the current plan, to suggest alternatives to the current work plan as required and to support the beneficiary in planning any revised activities.

2.1 Specific objective(s)

- Review project progress in relation to stated objectives and indicators.
- If progresses are not satisfactory, suggest ways and means to achieve purpose and outputs.
- Identify any lesson learnt during this period
- Analyze whether and how project may replicate

3. SCOPE OF WORK:

The Scope of Work is as follows:

- Review EC Block Grant project related documents and any other background documents,
- Discuss/meet Senior Management Team and MS staff responsible for implementing EC Block Grant project to get an understanding of the EC Block grant project
- Field visit,
- Report writing
- Arrange a workshop with the beneficiary for presenting and discussing the results.

4. SUGGESTED METHODOLOGY

For mid-term review, suggested methodology will be:

- Document review (including project documents)
- Focus Group Discussions with field staff and beneficiaries
- In-depth interviews
- Exit Interviews

5. MAJOR DELIVERABLES

- Contractee will conduct a debriefing session after the mid-term Review
- Based on the out come of debriefing discussion a draft report will be submitted to Marie StopesThe review report will include fingings, assessments and recommendations to MS so as to contribute to decision-making regarding the future development of the project.
- Hard and electronics copies of the report