MIDTERM PERFORMANCE EVALUATION OF THE MAYER HASHI FAMILY PLANNING PROJECT (MH-II)

September 2016

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Pinar Senlet, Katya Burns, Soliman Guirgis, M.E. Khan, and Nasima Kamal.
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MIDTERM PERFORMANCE EVALUATION
OF THE MAYER HASHI FAMILY
PLANNING PROJECT (MH-II)

September 2016
USAID Contract No. AID-OAA-C-14-00067

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This document was submitted by GH Pro to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.
ACKNOWLEDGMENTS

The evaluation team would like to thank the more than 200 individuals who generously offered their time and provided insights for this report. During this mid-term evaluation, the team benefited from the contributions of numerous Ministry of Health directors at both central and districts levels, program managers, medical professionals at public, private and NGO facilities, NGO partners, community leaders, health care service providers, volunteers, and the project’s beneficiaries in different districts of Bangladesh. This report therefore represents a collective effort and incorporates experiences, opinions, and observations from a wide community of individuals.

The team would especially like to thank Dr. Samina Choudhury and Dr. Ferdousi Begum, Project Management Specialists at USAID/PHNE, and Brenda Doe, Family Planning Advisor at the USAID/PHNE, for their guidance and support throughout the evaluation process. The team is very grateful to Dr. Abu Jamil Faisel, Mayer Hashi II Project Chief of Party and his team for their unflagging assistance and support.

We offer these observations, analysis, and recommendations in the firm belief that further progress will be achieved through collective efforts.
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>BCC</td>
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<tr>
<td>BGMEA</td>
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</tr>
<tr>
<td>BRAC</td>
<td>Bangladesh Rural Advancement Committee</td>
</tr>
<tr>
<td>BTL</td>
<td>Bilateral tubal ligation</td>
</tr>
<tr>
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<td>Caesarian section</td>
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<tr>
<td>CC</td>
<td>Community center</td>
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<td>CDCS</td>
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<td>CHCP</td>
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<td>CPR</td>
<td>Contraceptive prevalence rate</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple years of protection</td>
</tr>
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<td>DGFP</td>
<td>Directorate General of Family Planning</td>
</tr>
<tr>
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<td>Directorate General of Health Services</td>
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<td>DHS</td>
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</tr>
<tr>
<td>DO</td>
<td>Development Objective</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>FP</td>
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<td>FWA</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<tr>
<td>GOB</td>
<td>Government of Bangladesh</td>
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<td>HPN</td>
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<td>ICT</td>
<td>Information communication technologies</td>
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<td>ICV</td>
<td>Informed choice and volunteerism</td>
</tr>
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<td>IPC/C</td>
<td>Interpersonal communication and counseling</td>
</tr>
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<td>IPPP</td>
<td>Immediate postpartum period</td>
</tr>
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<td>IR</td>
<td>Intermediate Result</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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</table>
KII  Key informant interview
LAPM  Long-acting and permanent methods
MCH  Maternal and child health
MCWC  Maternal and Child Welfare Centers
MDGs  Millennium Development Goals
MH  Mayer Hashi
MH-II  Mayer Hashi II
MIS  Management Information System
MOH&FW  Ministry of Health and Family Welfare
MOs  Medical officers
MSDT  Mobile Service Delivery Team
MSF  Médecins Sans Frontières
MSI  Marie Stopes International
NHSDP  NGO Health Service Delivery Project
NSV  Non-scalpel vasectomy
NTC  National Technical Committee
OB/GYN  Obstetrician and gynecologist
OGSB  Obstetricians and Gynecologists Society of Bangladesh
PAFP  Post-abortion family planning
PMP  Performance Management Plan
PMs  Permanent methods
PNC  Postnatal care
POPs  Progestin-only pills
PPBTL  Postpartum bilateral tubal ligation
PPFP  Postpartum family planning
PPIUD  Postpartum IUD
PSI  Population Services International
PSTC  Population Services and Training Center
PY  Program Year
Q1  Quarter 1
QA  Quality assurance
RH  Reproductive health
RTMI  Research Training and Management International
SACMO  Subassistant Community Medical Officer
SOW  Scope of Work
<table>
<thead>
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<tr>
<td>STI</td>
<td>Sexually transmitted diseases</td>
</tr>
<tr>
<td>TFR</td>
<td>Total fertility rate</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of trainers</td>
</tr>
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<td>UHC</td>
<td>Union Health Centers</td>
</tr>
<tr>
<td>USG</td>
<td>United States Government</td>
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<tr>
<td>VPKA</td>
<td>Voluntary Paribar Kalyan Association</td>
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<tr>
<td>YPSA</td>
<td>Young Power for Social Action</td>
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EXECUTIVE SUMMARY

The purpose of the Mayer Hashi II (MH-II) Project Mid-Term Performance Evaluation is to assess the effectiveness of the project’s approach to increasing the utilization of family planning (FP) services with a focus on long-acting and permanent methods (LAPMs). The evaluation assesses the achievements and results against expectations and the relevance of project activities to date. The findings and recommendations from this evaluation will inform USAID/Bangladesh, the Government of Bangladesh (GOB), and other stakeholders about the best ways to use project technical assistance in order to maximize results over the remaining life of the project, and the design of future FP projects that support the national FP program.

The evaluation was conducted by a team of six consultants between March 27, 2016, and May 3, 2016. It covered the period from the project’s inception in September 2013 to December 2015. The methodology combined a review and analysis of quantitative data and application of qualitative techniques. Analysis of complementary quantitative and qualitative data led to findings that are based on facts and evidence and to reliable and valid conclusions. Data sources included (1) document and data review; (2) key informant interviews (KIIs); (3) secondary data analysis of routine service statistics and the project’s Monitoring and Evaluation Plan; (4) focus group discussions (FGDs) with service providers, community members, users and non-users of LAPMs and NGO volunteers; and (5) facility observations. The team visited four of the 38 MH-II-assisted districts to gather qualitative data. Among the limitations: (1) non-probability sampling methods were used for selecting districts, facilities, communities, and KII and FGD participants, and for this reason, the evaluation findings are not statistically representative of the larger population from which they are drawn; and (2) because the key informants constituted one of the primary sources of data, the information provided is subject to personal biases.

FINDINGS, LESSONS LEARNED, AND CONCLUSIONS

The body of this report responds to six questions specified in the Evaluation Scope of Work. The findings, lessons learned, and conclusions for each question are summarized below.

Evaluation Question 1. How effectively has Mayer Hashi contributed to increasing the utilization of long-acting and permanent method (LAPM) services in GOB/NGO/private facilities?

To assess MH-II’s contribution to the utilization of LAPMs and injectables, the evaluation team compared the couple years of protection (CYPs) of LAPM and injectable acceptors for the 27 months before the program began with the CYPs achieved over 27 months of intervention in the 38 MH-II-assisted districts. The data show that CYPs dropped slightly during MH-II project implementation. An analysis of CYP of LAPM acceptors by method shows a shift during the 27 months of the project away from permanent methods toward implants and injectables. These trends mirror changes in FP method choices in the country as a whole. The evaluation team used qualitative data to identify the reasons for these results. Analysis suggests the following interconnected causes: (1) In the context of a mature FP program, FP appears to be less of a priority for the GOB than it was in the past. The waning interest and commitment of the government is reflected in high vacancy rates of FP workers, inadequate numbers of trained staff, and a high percentage of Ministry of Health and Family Welfare (MOH&FW) facilities not...
equipped to provide LAPM options. (2) The project design spread its resources thinly across the country. Promising new approaches have been implemented on a pilot basis and have not yet had sufficient time to show impact. (3) Widespread service provider bias against permanent methods (PMs) and intrauterine device (IUDs) and method-specific knowledge gaps continue to hamper utilization of these methods. (4) Resurgent challenges regarding religious concerns, fear of side effects, misperceptions, myths, and gender norms against PMs and IUDs are not adequately addressed. (5) Inadequate emphasis on male involvement hampers men’s acceptance of non-scalpel vasectomy (NSV) as well as their support for women to accept sterilization or an IUD.

**Evaluation Question 2.** The predecessor project included training of service providers as an activity to improve access to quality FP services to result in increased FP use, especially of LAPMs. The project evaluation determined that not only did training not improve access to quality FP service delivery, it did not result in increased FP use. This project proposed using a more comprehensive combined approach to training that included following up with the trained staff. Did the new approach improve the delivery of quality FP services, and if so, was it consistent for all cadres (managers, physicians, family welfare visitors [FWVs], family welfare assistants [FWAs]) and also for all facilities (government and private institutions)?

MH-II enhanced the capacity of partner local organizations to improve the quality of, access to, and use of LAPM services. The project’s interventions in capacity building are appreciated by all sectors. In particular, the skills and knowledge transfer for training of trainers (TOTs) have potential to contribute to institutional capabilities and the future sustainability of local organizations. Overall, 28,214 individuals have benefitted from capacity-building efforts since the inception of the project, including clinical and non-clinical training and orientation sessions about the services. To address persistent capacity gaps, MH-II began implementing a new and broader approach to capacity building that had the following elements: 1) expanded involvement of NGO, private sector, and Directorate General Health Services (DGHS) staff in capacity-building efforts; and 2) follow-up visits to trained providers initiated to ensure that trainees are practicing the skills gained. The team’s KIs and FGDs with service providers and trainees during the field visits provided valuable insights into the project’s capacity building efforts: (1) While trainees welcome follow-up and quality assurance (QA) visits at their workplaces, these visits do not seem to be geared toward supporting the staff with mentoring and problem-solving support. (2) Training in interpersonal communication and counseling (IPC/C) is minimal slim and not well integrated into clinical trainings. (3) Many trained providers are not practicing the skills learned through trainings for a variety of reasons explained in detail in this report. (4) Because clinical trainings (in particular for IUDs) do not include adequate practical experience, these providers should not be counted as “trained.” (5) Because supply and demand factors do not appear to be taken into account when planning training sessions, the trainings are not strategically planned to increase service utilization.

**Evaluation Question 3.** To minimize the service gaps, the MH-II Project introduced mobile teams to offer LAPMs in areas where either the MOH&FW service providers were not available or where FP service provision presented difficult challenges. To what extent

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1 The 2014 Bangladesh Health Facility Survey provides ample data on this subject.
To increase the accessibility of LAPMs, MH-II began implementing the mobile service delivery team (MSDT) model in 2014 and sub-granted Research Training and Management Int. (RTMI) to form MSDTs to serve hard-to-reach areas and facilities with no trained providers. The schedule and sites for MSDT’s "special days" are appropriately targeted to the needs of facilities and clients and based on requests from Upazila Family Planning Officers. Family Welfare Assistants (FWAs) and volunteers from partner NGOs conduct effective community mobilization and refer prospective clients to special-day clinics. Key informants and community leaders indicated that MSDTs are filling an important gap by providing LAPM services where trained providers are not available. RTMI managers reported that demand for MSDT services has already exceeded their capacity to deliver, given available resources and staff. RTMI is having difficulty recruiting qualified surgeons because of working conditions and compensation levels. The evaluation team concludes that the approach has helped to increase the utilization of LAPMs. The intervention is well coordinated with the GOB and NGOs, such as the NGO Service Delivery Project (NSDP) and Shushilan, although it is not coordinated with the mobile teams organized by Marie Stopes International (MSI).

Evaluation Question 4. The MH-II Project engaged local national NGOs to improve LAPM information dissemination to clients and to improve their referral network to local facilities which provided the LAPMs. To what extent was this intervention successful in informing and engaging community people on LAPM and also establishing community facility linkage?

MH-II subcontracted six NGOs in rural areas and urban slums to engage existing NGO volunteer networks in community-based information dissemination activities in order to generate demand for LAPMs and refer clients to accessible health facilities. Since the beginning of the project, over 4,000 volunteers from Bangladesh Rural Advancement Committee (BRAC), Young Power in Social Action (YPSA), Shushilan, the Population Services and Training Center (PSTC), Mukti, and the Voluntary Paribar Kalyan Association (VPKA) have been engaged in these efforts. MH-II conducted TOTs for NGO staff, who then offered orientation workshops for their own volunteers on IPC/C, which focused on how to disseminate FP information and effective ways to use behavior change and communication (BCC) materials with various client segments. The team found that NGO demand generation and referral activities are appreciated by government officers and service providers, who reported that gaps in community outreach efforts are associated with an increased workload for FWAs and vacant positions. Information dissemination and referrals by NGOs have been effective: More than 90% of clients referred by NGOs accepted and received an LAPM or injectable.

In addition to the NGO model, MH-II undertook an innovative intervention with the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) in Dhaka and YPSA in Chittagong to reach out to garment factory workers. The team noted that interventions in garment factories are well-positioned to effectively target large numbers of young people in need of FP
services. Both interventions are promising in terms of their potential for scale-up and replication in other locations.

**Evaluation Question 5. To what extent has MH-II Project support been successful in working with public (DGHS, DGFP), private, and NGO facilities to strengthen post-partum family planning (PPFP) services?**

MH-II support for PPFP has focused on orienting health workers on PPFP and clinical training of service providers to develop skills in postpartum IUD (PPIUD) insertions and postpartum bilateral tubal ligation (PPBTL). The number of acceptors of both methods has increased significantly in MH-II-assisted districts. However, the absolute number of PPFP acceptors in those districts is still very low, especially the number of women who accepted a PPIUD. The evaluation team identified a number of programmatic issues that adversely impact uptake of PPIUD at facilities supported by MH-II. These findings are explained in detail in the report. The team also identified a number of missed opportunities that limited the uptake of all forms of post-partum LAPMs: (1) late or lack of information on PPFP during all antenatal care (ANC) visits; and (2) training in PPFP primarily focused on the public sector, though the majority of women who deliver at facilities rather than at home, chose private facilities. Further, most deliveries in the public sector occur in DGHS facilities, where most staff believe that FP is not their responsibility; nor do they have reliable access to MOH&FW imprest funds, which pay the physician fees for providing LAPMs, which are routinely available to DGFP physicians. LAPM supplies are not easily available in DGHS facilities. MH-II has taken the lead in working with the MOH&FW to make imprest funds available to DGHS physicians, though the problem has not yet been resolved. Additionally, MH-II has taken the lead of the PPFP Action Group to work with the Ministry to draft the MOH&FW National PPFP Action Plan, now close to final approval.

**Evaluation Question 6. The MH-II Project was to help in identifying and adapting policies, strategies, regulations, and/or guidelines of the MOH&FW to improve access to and use of quality LAPM services. What kind of impact did these policy changes produce in the service environment in terms of LAPM utilization? Did these policy changes bring any visible pushes among public, private, and NGO providers?**

MH-II has successfully advocated to change a number of key policies affecting the utilization of LAPMs and injectables. The project’s efforts at policy change were welcomed and appreciated by the majority of key informants. However, translation of these policies into action on the ground has been sporadic: Most health officials and service providers interviewed were not able to name policy changes over the past two years. However, the team found that some policy changes have had an impact on service provision, notably the provision of second and subsequent doses of injectables by Community Health Care Providers (CHCPs) and provision of first and subsequent doses of injectables by FWAs, at least in some districts. The team did not find evidence that other important policy changes have had a practical impact on service delivery, notably provision of counseling on LAPMs during all ANC and postnatal care (PNC) visits, which remains weak. Some policy changes have limited potential for impact on service delivery, such as the policy to allow female Sub-assistant Community Medical Officers (SACMOs) to provide IUDs. This cannot have high impact as long as the majority of SACMOs are male.
RECOMMENDATIONS

The following are the evaluation team’s recommendations for MH-II for the remaining life of the project:

• Focus on the 38 districts where it is already working and not expand beyond those districts. MH-II should not aim for national coverage over the remaining life of the project.

• Capitalize on opportunities to promote LAPMs, especially PMs, by continuing and expanding the new approaches adopted by MH-II to date: NGO-supported mobile teams (RTMI), NGO service provision, workplace interventions and community outreach, private facility service delivery, and support to DGHS for PPFP.

• Expand support and scale up effective demand-generation activities via NGO community volunteers and successful NGO-supported interventions – BRAC, YPSA, Shushilan, and PSTC.

• Continue to scale up workplace interventions in current locations and replicate the model in other garment factories.

• Strategically focus trainings to maximize impact by reducing the total number of trainings and improving quality, and institutionalize routine follow-up for all trainees. Plan training activities to address the capacity needs of individual providers and select trainees for both gaps in clinical skills and readiness to provide LAPM services, especially IUDs and PMs. Coordinate with the mobile teams to provide services with facilities that have a newly trained provider to offer high client traffic to ensure sufficient supervised clinical experience, enforce learning, and help inform the community of newly trained staff at the facility.

• Revisit and update the project communication plan to directly combat myths and misperceptions about PMs and IUDs and address provider biases. Develop information, education, and communication (IEC)/BCC materials appropriate for low-literacy beneficiaries and consider using interpersonal communication technologies to disseminate information for policy and decision makers.

• Support NGOs to train male volunteers and organize community meetings for men.

• Mainstream gender into all aspects of training, IEC/BCC, and service delivery, by strengthening training of counselors to include gender-sensitive interpersonal communication focused on respectful interaction and empowering clients; engaging men in FP decisions; and screening for gender-based violence and building an appropriate referral network.

• Expand the focus of PPFP activities beyond immediate PPFP to encompass at least the six weeks after delivery and strengthen capacity to provide counseling on LAPMs during all ANC, PNC, and immunization visits.

• Ensure that managers and staff in all MH-II supported districts and sites are informed about policy changes that impact their work and support the MOH&FW in tracking implementation of new policies.

• Align policy advocacy with international guidelines.
I. INTRODUCTION

Bangladesh is one of the most densely populated countries in the world. According to the latest United Nations estimates, the current population of Bangladesh is about 162 million. Despite its scarcity of resources and high population density, in recent decades Bangladesh has done extremely well in terms of social and health improvements, including the family planning (FP) program and appreciably well in economic improvement.

Although the legal age of marriage is 18 years, many women marry at a much younger age, which correlates with early childbearing and high fertility at early ages. Bangladesh’s demographic composition, structure, and regional variations underline the need for strong FP programs. In addition, rapid urbanization and migration to cities have intensified population density, especially in urban slum areas. About 27% of the population lives in urban areas and 33% lives in Dhaka district.

FP programs have received a great deal of government and donor attention and support since Bangladesh’s independence, but much work remains to be done. The Bangladesh FP program has been a success story in the developing world for its rapid contraceptive increase and resultant fertility decline. However, 26% of births are still unintended and 12% of women report an unmet FP need. Nationally, the fertility goal is 1.6 children; the actual total fertility rate (TFR) is 2.3 children—a reflection of unwanted fertility. Although about 66% of couples do not want any more children, only 8% use a long-acting or permanent method (LAPM) such as an intrauterine device (IUD), implant, or female or male sterilization, and this percentage has remained stagnant for the last five years. Women in Bangladesh typically complete their families between the ages of 25 and 30. The advantage of adopting LAPMs is that they avoid the risks of the failure and discontinuation of short-term methods during their remaining 15-20 years of reproductive life. Thus, the strategic emphasis of Bangladesh’s FP program is to expand access to and use of LAPMs. Table 1 shows the TFR, the total Contraceptive Prevalence Rate (CPR), and the prevalence of LAPMs by division, based on the past two Demographic and Health Surveys (DHSs).

Table 1. Bangladesh Demographic Health Survey Data, 2011 and 2014

<table>
<thead>
<tr>
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<th>TFR</th>
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<tr>
<td><strong>Sylhet</strong></td>
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<td>DHS 2011</td>
<td>3.1</td>
<td>44.8%</td>
<td>6.7%</td>
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<td>DHS 2014</td>
<td>2.9</td>
<td>47.8%</td>
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*Source: BDHS 2011 and BDHS 2014.*
2. THE DEVELOPMENT PROBLEM AND THE USAID RESPONSE

Bangladesh is on the verge of a quantum leap in its development process. The country is almost on track to achieve most of the United Nations Millennium Development Goals (MDGs). Literacy, especially among women, has improved remarkably; there are signs of a steady and consistent decline of poverty; and infant, child, and maternal mortality have declined significantly.

As described in the Bangladesh Country Development Cooperation Strategy (CDCS) 2011–2016, USAID Development Objective (DO) 3 is a flagship DO for the “whole-of-government strategy approach” under the Global Health Initiative (GHI) and brings together each of the United States Government (USG) agency’s exceptional core competencies for strategic programming in health. DO3 stresses improved efficiencies and innovative approaches through building on past and current successful population, health, and nutrition programs while incorporating GHI principles. DO3 states that the goals for Bangladesh are to reduce the fertility rate to two children per woman by 2016, revitalize the FP program, and adopt a multi-sectoral approach to addressing population issues. Gender, youth, and innovation are the cross-cutting themes in achieving these objectives.

Along with the U.S. President’s Global Health Initiative, USAID/Bangladesh developed Bangladesh’s Interagency Program Strategy 2011–2015. This initiative expressly states that “over the next five years, the USG will help Bangladesh to adopt and scale up proven interventions to increase long-term family planning methods and reduce maternal mortality.” The Intermediate Result (IR) (Objective) of the MH-II Results Framework directly corresponds to DO3, IR 3.1 within the Bangladesh CDCS. All MH-II activities are designed to contribute to achieving IR3.1: Increased use of effective family planning and reproductive health services.
Brief Overview of MH-II

The USAID-funded Mayer Hashi Project (MH) was implemented between 2009 and 2013 to increase LAPM use in 21 low-performing districts. MH was implemented by EngenderHealth through the global Respond Project. MH-II (October 2013–September 2017) is a follow-on to MH and is again led by EngenderHealth in collaboration with two Directorates of the Ministry of Health and Family Welfare (MOH&FW) – Directorate General of Family Planning (DGFP) and Directorate General of Health Services (DGHS), local nongovernmental organizations (NGOs), the Population Council, the Meridian Group International Inc., and the Futures Institute. The project's overall objective is to increase use of effective FP and reproductive health (RH) services, with a focus on informed and voluntary use of LAPM. MH-II’s strategic approach recognizes that Bangladesh has a mature FP program that aims to broaden its method mix to meet the unmet needs and reproductive intentions of special populations.

MH-II builds on the experience of the MH Project and has added new approaches to achieve project goals. The project works to achieve the three closely related sub-IRs focused on three major pillars: (1) strengthening FP service supply; (2) creating demand for FP services, especially LAPM; and (3) strengthening the enabling environment. The project's general strategy as stated in the program description is to

- Enhance country ownership and leadership for sustainability in the public, NGO, and private sectors. This includes advocating with the DGFP and DGHS to execute activities through their operational plans; incorporating LAPMs into education curricula; assisting large NGOs to strengthen systems for LAPMs and PPFP service delivery and training; expanding the involvement of the private sector; and collaborating with other ministries.

- Enhance strategic coordination and integration through participation in national networks and coordination committees, such as the National Technical Committee (NTC), to improve the policy environment. MH-II also works to obtain commitments from NGOs and the private sector to provide more LAPM services and coordinates with them to avoid duplication and to leverage resources.

- In addition to promoting FP/RH as a multisectoral issue, enhance linkages with partners in other sectors, including USAID partners and other Bangladesh ministries.

- Ensure that gender is mainstreamed in project design and implementation.

- Emphasize informed choice and voluntarism (ICV). MH-II continues working with DGFP/DGHS, NGOs, and the private sector to strengthen ICV. The project has hired seven Quality Assurance (QA) and FP Compliance Officers to monitor quality and ICV at project-supported sites.

MH-II was designed to cover the entire country—all seven divisions and 64 districts—in a phased approach. Implementation has been rolled out by districts and at the end of the second program year (PY) 2, the project has expanded to 38 districts. In each district interventions are implemented down to the Upazila level but not beyond. In some cases, at the request of the MOH&FW MH-II works in additional districts and at the Union level.
3. EVALUATION PURPOSE AND KEY QUESTIONS

The purpose of the MH-II Project Mid-Term Performance Evaluation is to assess the effectiveness of the MH-II approach to increasing the utilization of FP and RH services, with a focus on LAPMs. The evaluation assesses the extent to which MH-II has achieved its three sub-intermediate results (sub-IRs): (1) delivery of effective and high-quality FP services nationwide via capacity building and actual delivery of services (Sub-IR 1); (2) increased demand for FP services, especially LAPM, using behavior change communications (BCC), and community strategies, i.e., demand generation and community interventions (Sub-IR 2); and (3) expanding a supportive enabling environment to improve access to LAPMs, and other FP/RH services, using policy advocacy efforts (Sub-IR 3).

The performance evaluation assesses the achievements and results compared to expectations and relevance of the project activities to date. The findings and recommendations from the performance evaluation will inform (1) USAID, the Government of Bangladesh (GOB), and other stakeholders on the best ways to use project technical assistance to maximize FP results over the remaining life of the project, and (2) the design and implementation of future FP projects that support the national FP program. The target audience for this mid-term performance evaluation includes USAID/Bangladesh, the Global Health Bureau, the Asia Bureau, the GOB, implementing partners and sub-grantees, local NGOs, and other bilateral and multilateral donors working for health and HP, and the MH-II management and technical teams.

Evaluation Questions

The following questions guided the performance evaluation, as outlined in the Scope of Work (Annex A):

1. How effectively has Mayer Hashi-II Project contributed to increasing the utilization of long-acting and permanent method (LAPM) services in GOB/NGO/private facilities?

2. The predecessor project included training of service providers as an activity to improve access to quality FP services to result in increased FP use, especially of LAPMs. The project evaluation determined that not only training did not improve access to quality FP service delivery, it did not result in increased FP use. This project proposed using a more comprehensive combined approach to training that included following up with the trained staff. Did the new approach improve the delivery of quality FP services, and if so, was it consistent for all cadres (managers, physicians, family welfare visitors [FWVs], family welfare assistants [FWAs]) and also for all facilities (government and private institutions)?

3. To minimize the service gaps, the MH-II Project introduced mobile teams to offer LAPMs in areas where either MOH&FW service providers were not available or where FP service provision presented difficult challenges. To what extent did this intervention of mobile teams help increase the utilization of quality LAPM services, including how it was coordinated with GOB, the private sector, and other NGO service providers, such as the Bangladesh Rural Advancement Committee (BRAC), and Marie Stopes International (MSI)?
4. The MH-II Project engaged local national NGOs to improve LAPM information dissemination to clients and to improve their referral network to local facilities which provided the LAPMs. To what extent was this intervention successful in informing and engaging community people on LAPM and also establishing community facility linkage?

5. To what extent has MH-II Project support been successful in working with public (DGHS, DGFP), private, and NGO facilities to strengthen postpartum family planning (PPFP) services?

6. The MH-II Project was to help in identifying and adapting policies, strategies, regulations and/or guidelines of the MOH&FW to improve access to and use of quality LAPM services. What kind of impact did these policy changes produce in the service environment in terms of LAPM utilization? Have these policy changes brought any visible pushes among public, private, and NGO providers?
4. EVALUATION METHODOLOGY

OVERALL APPROACH

The evaluation was conducted by a team comprised of a Team Leader (Pinar Senlet), a Family Planning Specialist (M. E. Khan), a Marketing, Communications and Demand Creation Specialist (Soliman Guirgis), and an Evaluation Specialist (Katya Burns). In addition, two local evaluators (Nurul Bagmer and Nasima Kamal) supported the team in data collection and logistical/administrative tasks.

The evaluation methodology combined review and analysis of quantitative data, and application of qualitative techniques, to collect data from project implementers, partners, beneficiaries, and other stakeholders. By using a mixed-method approach to analyze variables corresponding with project outputs and outcomes, the team gleaned objective insights into the performance of MH-II interventions. Analysis of complementary quantitative and qualitative data led to findings that are based on facts and evidence and to reliable and valid conclusions.

The evaluation methodology included different data collection techniques, such as structured key informant interviews (KII s), facility observations, review of documents and data, and focus group discussions (FGDs). In short, the evaluation involved the systematic integration of different kinds of data, drawn from the same project using different methods. By approaching the same question from more than one perspective, the evaluation team was able to compare and contrast the results from these different methods through the process known as triangulation. In sum, the evaluation reviewed process, output, and outcome indicators to capture the value of USAID’s investments since the inception of MH-II and inform the design and implementation of future activities. The evaluation model follows USAID Evaluation Policy and performance evaluation best practices.

Selection of Districts and Health Facilities

The evaluation selected four of the 38 MH intervention districts across seven divisions. The selection criteria included (1) implementation of key MH-II interventions; (2) representation of high-, medium-, and low-performing districts based on the CPR; and (3) logistical and security considerations. These criteria helped the team to identify both factors that contributed most significantly to improved outcomes and factors inhibiting positive performance. Using these criteria, the following districts were selected in consultation with USAID/Bangladesh: Chittagong, Cox’s Bazaar, Khulna, and Gazipur. Chittagong and Cox’s Bazaar are among medium-performing districts, Khulna is a high-performance district, and Gazipur is one of the low-performing districts. Project implementation began in the first program year in Gazipur and Khulna and in the second project year in Chittagong and Cox’s Bazaar. The map shows MH-II target districts reached in the first two years and the four districts visited by the evaluation team.
Mayer Hashi PY1 and PY2 Districts and Districts Visited by the Evaluation Team
In the districts, the team visited several types of public, private, and NGO facilities where MH-II has provided substantial assistance and implemented key interventions. Public facilities included district hospitals, Maternal and Child Welfare Centers (MCWC), Union Health centers (UHC), and Family Welfare Centers (FWCs). Private and NGO facilities in which interventions are being implemented were also included. Facilities were selected in consultation with and guided by USAID/Bangladesh and the MH-II Project. The evaluation covered a total of 14 facilities in the four districts.

**DATA SOURCES**

**Document and Data Review:** Before arriving in the country, the evaluation team conducted a detailed desk review of project documents indicated in the Scope of Work (SOW) and data from sources provided by USAID/Bangladesh. The team also reviewed additional documents identified by USAID and MH-II while in the country in order to perform proposed analyses. The list of documents reviewed is in Annex B.

**Key Informant Interviews:** KIIs provided insights into the effectiveness of MH-II technical approaches, contributions, and gaps, with related interventions. Semi-structured interviews with a wide range of stakeholders were conducted in both Dhaka and the districts. In total, the team conducted 72 KIIs. Annex C lists persons contacted, including key informants.

**Secondary data analysis:** The objective of the secondary data analysis was to determine the trends and progress achieved in coverage, access, and utilization of LAPM services and outcomes in selected districts. The evaluation analyzed routine service data from DGFP and data collected by the MH-II Performance Management Plan (PMP) on selected indicators from the inception of the project to the last quarter available at the time of the evaluation (Year 3 1st Quarter, September 1 – December 31, 2015). The team also analyzed the DHS findings as well as data from the MH Impact Evaluation (2014) and preliminary findings from the MH Baseline Survey (2016) conducted by Measure Evaluation.

**Focus Group Discussions:** The team conducted FGDs with various cadres of MH-II stakeholders at the facility and community levels to gain an in-depth understanding of their experiences with project interventions. Information on perceptions of current and past services and changes in availability, access, and use of LAPM were collected and analyzed through FGDs. At the facility level, FGDs were conducted with service providers who have benefitted from MH-II assistance. The purpose of the FGDs with service providers was to understand how the MH-II capacity-building efforts helped them to improve their performance.

In the communities, three groups of FGDs were conducted, with (1) community support groups and local representatives of unions of parishads, to determine the extent to which they find community involvement, information dissemination, and the referral process at the community level to be effective; (2) users and non-users of LAPMs (women and men), to understand their unmet needs and how these could be addressed by appropriate interventions; and (3) volunteers, to identify the main motivational and hindering factors that affect the utilization of the LAPMs. The FGD results complemented the information gained from KIIs. Altogether, the evaluation team conducted 15 FGDs, with 138 participants. A summary of the findings is in Annex D.
FACILITY OBSERVATIONS

During site visits, the team conducted structured observations at 14 facilities assisted by MH-II using a comprehensive observation checklist. The purpose was to determine how ready the facilities were to provide quality counseling services for LAPM. Annex E summarizes the findings from the facility observations.

Data Collection Tools and Instruments

The team developed data collection tools and instruments for all data sources, including semi-structured KII guides, FGD guides for specific groups, and the facility observation checklist. The FGD guides were translated into Bangla. All data collection tools are focused on relevant evaluation questions and were pre-tested, revised, and approved by USAID prior to data collection. Data collection tools are found in Annex F.

Data Analysis Methods

Since this is a mixed-method evaluation integrating both quantitative and qualitative data, the team triangulated the results from the different data sets and sources. For the process of triangulation, the team used the approach known as parallel combination: Each data collection method was carried out in its entirety and analyzed separately over the same period of time. Then the results were triangulated. The results from the different methods were compared, contrasted, and validated. Overall, the findings from different methods were similar and reinforced one another, giving the team greater confidence in its findings.

Limitations of Evaluation Methods

The evaluation team acknowledges some limitations to the evaluation design outlined here. First, because non-probability sampling methods were used for selecting districts, facilities, communities, and KII and FGD participants, the evaluation cannot generate findings that statistically represent the larger population from which they are drawn. Second, because the key informants constituted one of the primary sources of data, it is subject to personal biases.

Gender Considerations

The approach incorporated a gender analysis throughout all levels of evaluation and also analyzed other variables that might place certain individuals or populations at a disadvantage. Specific attention was given to gender considerations while collecting and analyzing data. Where possible, sex-disaggregated data were evaluated for outputs and outcomes in order to determine the degree to which the project affected both women and men. Specifically, the team ensured that gender was incorporated into (1) evaluation design – both women and men would be interviewed and participated in KII and FGDs; (2) the data collection tools, which include specific questions on equal access to both sexes; and (3) data tabulation, analysis of results, and the conclusions and recommendations.

Ethical Considerations and Confidentiality

The team obtained oral consent from all KII and FGD participants according to USAID Evaluation Policy guidelines. Interviewees and group participants were given the option to opt out of particular questions or the whole interview and the information provided would remain completely confidential. USAID Non-Disclosure and Conflicts Agreement signed by each evaluation team member are in Annex G.
5. FINDINGS, LESSONS LEARNED, AND CONCLUSIONS

EVALUATION QUESTION 1: How effectively has the Mayer Hashi-II Project contributed to increasing the utilization of long-acting and permanent method (LAPM) services in GOB/NGO/private facilities?

To assess Mayer Hashi's contribution to the utilization of LAPMs and injectables, the evaluation team compared the CYP of LAPM and injectable acceptors for the 27 months before the program began with the CYPs achieved over 27 months of intervention in the 38MH-II districts (figure 1).

Figure 1. Comparison of CYP of LAPM and Injectables during the 27 Months before the Project Began (July 2011 – Sept. 2013) and the 27 Months of Project Implementation (Oct. 2013 – Dec. 2015) in the 38 MH–II Districts

Figure 1 shows that CYPs dropped slightly during MH-II Project implementation. The evaluation team compared these findings with preliminary findings from a baseline survey of MH-II conducted by MEASURE Evaluation. The MEASURE Evaluation baseline survey used data on the percentage of women with two or more children who accepted LAPM between January 2014 and June 2015 and compared MH-II districts in which implementation started in PY1 Quarter 1 (Q1) (October 2013) with MH-II districts where implementation was scheduled to begin in PY3 (October 2015), i.e., those in which implementation had not yet begun at the time the data were collected in June 2015. The data showed slightly higher acceptance of LAPM in the districts where MH-II had not yet started implementation.

The evaluation team also compared the CYP of LAPM and injectable acceptors by method before and after MH-II implementation (figure 2). (A breakdown by district visited for the evaluation of CYP of LAPM and injectable acceptors by method, before and after MH-II implementation, is provided in Annex G.)
Figure 2 shows a shift over the course of the project away from permanent methods and toward implants and injectables. CYP for bilateral tubal ligation (BTL) in Mayer Hashi districts dropped by 11.7% and CYP non-scalpel vasectomy (NSV) dropped by 32.3%, while CYP implants rose by 34.9% and CYP injectables rose by 83%. CYP IUDs remained virtually unchanged between pre-project and implementation periods, experiencing a modest drop of 4.5%. These shifts mirror changes in FP choices in the country as a whole.

The evaluation team used qualitative data collected from KIIIs, FGDs with community representatives, service providers, and LAPM users and non-users at MH-II-supported sites, to identify reasons for (1) the drop-in utilization of permanent methods, (2) stagnant / falling
utilization of IUDs, and (3) increased utilization of implant and injectable methods. Qualitative analysis suggests the following interconnected causes for these results:

**Shifting National Focus in the Context of a Mature FP Program**

Shifting FP choices in MH-II districts reflect a national trend: If in the past DGFP employees numbered in the millions and penetrated down to the ward level, today, vacancy rates hover around the 40% mark. Staff well-trained in PM and IUD insertions are retiring or have been assigned additional responsibilities. New staff lack the training required to effectively promote LAPM, and as a result they tend to promote the newer, more recently available methods that are easiest for providers to administer – injectables and implants. According to the Bangladesh Health Facility Survey 2014, only 57% of all health facilities that offer modern FP methods report having at least one staff member who has received in-service training in FP, and that percentage drops drastically when assessing for providers with recent in-service FP training. For example, 93% of MCWCs have at least one staff member who has received in-service FP training, but only 46% have a provider who has received training in the past 24 months. Facilities that offer long-term methods also experience stock-outs: According to the Bangladesh Health Facility Survey 2014, 13% of facilities that provide IUDs did not have them in stock, and 22% of facilities that provide implants did not have them in stock. These developments are reflecting the inadequate focus of a mature FP program in which fertility rates reached 2.3 in 2011 but have since stagnated, and the CPR has hovered around the 62% mark since 2011. The waning interest and commitment of the government is seen in the high vacancies and inadequate numbers of trained staff and the weaknesses in facility readiness to provide quality services.

**Challenges in Project Design**

MH-II aims for national coverage. At the time of the assessment, it directly covered 38 districts in seven divisions spread across the country and also provided technical assistance to the DGFP outside the focus districts. With its resources spread thin, it is challenging for the project to achieve visible impact. The project implemented promising new approaches, which are discussed in detail in this report. However, these have only been implemented for a short time and therefore have not yet had sufficient time to show impact.

**Widespread Service Provider Bias and Knowledge Gaps**

Across the health system, the evaluation team found widespread bias against PMs and IUDs. Key FP officials reported that they are not supportive of PMs for either women or men, and in the districts some MH-II-trained service providers refused to provide PMs to women. Service providers at some government FP facilities reported that they instruct women who have two children to wait two years before accepting LAPM, because one of the children could die. In many cases, lack of basic medical knowledge foiled the uptake of IUD, with service providers attributing high levels of sexually transmitted infections (STIs) to lack of female hygiene – suggesting that service providers lack the training needed to diagnose and treat STIs – and they advise women they have diagnosed with STIs to avoid IUDs. Service providers blamed women for low levels of PM and IUD uptake, reporting that low acceptance rates and frequent drop-out for IUD clients were discouraging and that they therefore had stopped offering these services. Still others reported that poor uptake of LAPM was due to general physical weakness caused by these methods and that women needed vitamin supplements.
Resurgent Challenges Not Adequately Addressed

Awareness: The evaluation team found variable levels of awareness of LAPM among target populations at MH-II-supported sites, especially for PMs and IUDs. Most community members and clients reported increased awareness of all LAPM compared to their awareness before they had contact with the project — they were able to name most of the FP methods, including LAPM, but lacked specific and accurate information on LAPM.

Religious concerns: MH-II has worked to mitigate religious barriers to LAPM uptake, including producing a brochure for religious leaders. The assessment team found, however, that religious barriers to the use of PMs and IUDs persist. A woman in Khulna, for example, explained that: “… My husband is a local religious leader, and he believes that modern FP, especially permanent methods, are haram…” Another common concern, as voiced by a woman in Khulna, was that: “… if I die with the IUD or Norplant in my body, who is going to remove them and this is a big sin to Allah…”

Fear of side effects: Women interviewed by the team complained of a range of side effects from IUDs (and injectables) and reported that they were unprepared and afraid when they experienced side effects. Women reported that medical staff and FWVs did not proactively follow up with clients after acceptance, prompting drop-out, especially for IUD accepters.

Persistent and resurging myths: The team noted that MH-II’s approach does not adequately address widespread community beliefs — such as the belief that tubal ligation causes female physical weakness and NSV adversely impacts male sexual abilities, or the pervasive social prejudice against women and men who accept PMs, some of whom reported that they hide their choice in the face of stigmatizing attitudes in their communities.

Gender norms, female roles, and family pressure: The evaluation team noted that the MH-II approach does not effectively address gender norms that impact women’s and men’s FP choices — particularly PMs and IUDs; interventions are not aligned with USAID’s Gender Equality and Female Empowerment Policy (2012); and gender-sensitive or gender-transformative FP programming, such as the approaches recommended by WHO’s Gender Mainstreaming in Health (2011), has not been undertaken. Key gender-specific barriers noted during the evaluation assessment are

- The commonly held view that a woman’s value is based on her fertility: As one doctor in Khulna explained: "After sterilization, a woman loses her capacity to produce a child. It reduces her value."

- Lack of female decision-making power: Although some women interviewed by the team expressed a personal preference for PMs, pressure from husbands, and in some cases mothers-in-law, made it impossible for women to accept PM. A One 40-year old mother of two who used traditional FP reported: “If my husband is convinced, I would use a long-term FP method in the future and would go for tubal ligation…”

- Male preference for a male child: KIIIs conducted by the assessment team found that in some cases, women who have daughters refuse PM because they fear that the husband would leave her and marry another woman in the hopes of having a son.

- Desertion in case of child death: A woman in Gazipur explained her decision not to accept PM: "If one of my children dies, my husband can marry somebody else."
Male aversion to NSV and stigmatization of NSV accepters: Although a number of women interviewed by the assessment team expressed a preference for NSV, most reported that their husband would never agree. A service provider explained: "Because the society is male-dominated, so no NSV." The team found that NSV accepters can experience ridicule and stigmatization in their communities. MH-II’s approach does not include systematic outreach to men; meetings with men are rarely held and men are not welcome in courtyard meetings. The project is perceived to focus on women, not men. As one community member reported: "The project is called Mother’s Smile, not Father’s Smile."

In sum, the assessment team found that LAPM utilization in Mayer Hashi districts has been lower during the 27 months of project implementation than in the 27 months before the project began. A comparison by method showed that the decline is associated with a drop-in PM and IUD utilization, though utilization of implants and injectables has increased. Qualitative analysis identified a number of interconnected causes for these outcomes: a shifting national focus away from FP associated with a mature FP program in which the CPR has hovered around the 62% mark since 2011; a project design that seeks to cover the entire country and has therefore experienced challenges in showing impact; widespread service provider bias against permanent methods and IUDs; knowledge gaps among service providers; and resurgent challenges that have not been adequately addressed – such as religious concerns, fear of side effects, persistent and resurging myths, and gender issues.

EVALUATION QUESTION 2:

The predecessor project included training of service providers as an activity to improve access to quality FP services to result in increased family planning use, especially of LAPMs. The project evaluation determined that not only training did not improve access to quality FP service delivery, it did not result in increased family planning use. This project proposed using a more comprehensive combined approach to training that included following up with the trained staff. Did the new approach improve the delivery of quality FP services, and if so, was it consistent for all cadres (managers, physicians, family welfare visitors [FWVs], family welfare assistants [FWAs]) and also for all facilities (government and private institutions)?

MH-II enhances the capacity of partner local organizations to improve the quality, access, and use of LAPM services. The project focuses on providing technical assistance in training and orientation of managers, service providers, field workers, and volunteers. Training activities include vast numbers of individuals to be engaged in demand creation for, and provision of, LAPM information and services. The efforts include several cadres of health providers in clinical training on LAPMs and government and NGO grassroots workers and volunteers on outreach and demand generation, covering all three sectors (government, NGO, and the private sector). MH-II interventions in capacity building are appreciated by all sectors. In particular, the skills and knowledge transfer for training of trainers (TOTs) have potential to contribute to institutional capabilities and the future sustainability of local organizations.

Overall, 28,214 individuals have received clinical or nonclinical training or participated in orientation sessions to LAPM services since inception of the project (see Table 3).
Most of the interventions of MH, the predecessor project, also involved training, refresher training, and orientation to LAPM service provision. An impact evaluation of MH conducted in 2014\(^2\) found that although the vast majority of service providers in project districts received training, knowledge and practice of service provision were similar in project and non-project districts. The impact evaluation concluded that the training provided had not translated into improved knowledge or practice among providers. The evaluation also determined that the vacancy rate among LAPM providers and program managers, a key supply-side factor directly associated with LAPM service delivery, was higher in project than non-project districts. A baseline survey of MH-II covering the first 18 months of project implementation also determined that although provider training – especially for obstetricians and gynecologists (OB/GYNs) and medical officers (MOs) – was provided in program districts, provider practices in project districts were the same as in districts where the project had not yet begun providing training.

Based on these lessons learned, MH-II introduced new modalities to address the gaps identified in the previous MH Project. To address vacancy rates, MH-II adopted a mobile service delivery team (MSDT) approach to offer LAPM services in areas where service providers were not available. The mobile team approach is discussed in detail in the next section of this report. To address persistent capacity gaps, MH-II began implementing a new and broader approach to capacity building. The new approach included the following elements:

The project began to involve NGOs and the private for-profit sector in capacity building efforts. A reproductive health/family planning (RH-FP) training center in the private sector under the leadership of the Obstetricians and Gynecologists Society of Bangladesh (OGSB) was established. The training center provides courses to NGO and private providers. For the first time, MH-II worked outside the government sector; it trained trainers, managers, and providers at various NGOs (7,868 individuals from NGOs were trained or oriented as illustrated in Table 3); and facilitated private sector and NGO affiliation with the DGFP. NGO and private organizations that have benefited from MH-II capacity-building efforts are discussed in detail later in this report. MH-II also expanded its assistance to build the capacity of DGHS staff to provide LAPM services. In total, 1,923 DGHS staff were oriented to LAPM services, 538 received clinical training, and 127 received nonclinical training on LAPMs.

MH-II initiated follow-up visits to trained providers to ensure that trainees are practicing the skills gained and to provide supportive supervision. Trainers are tasked to do follow-up visits using a simple checklist. According to MH-II workplans, all trainees are supposed to be followed

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up through visits two months and six months after their training. Overall, the evaluation team found that across the sectors 15% of the clinical trainees received a follow-up visit or phone call. MH-II informed the evaluation team that the workplans have been revised: 10-15% of clinical trainees are to be followed up within three to six months following training. Trainees are followed up purposively when they are not performing or providing services and also when they seek assistance from MH-II to help them in providing the services.

MH-II emphasized QA approaches that include informed choice and consent to LAPM services. According to the MH-II SOW, among the components of quality are facility preparedness and the safety of services, including infection prevention and counseling. To support QA, the project deployed seven QA and FP Compliance Officers, six of them outside Dhaka. Compliance officers provide support to all sectors to provide LAPM and injectable services as well as conducting compliance monitoring visits and distributing job-aids and information, education, and communication/ behavior change and communication (IEC/BCC) materials. The Compliance Officers are also required to support the skills of service providers through hands-on coaching when required.

In addition to their supervisory responsibilities, MH-II QA and FP Compliance Officers also support the public and NGO sectors to organize mobile teams to conduct special service delivery days for provision of LAPM and injectable services. MH-II hires skilled surgeons to provide LAPM services during the special days. (This is in addition to and separate from the mobile teams approach.) This intervention is discussed in detail later in this report.

Another new initiative implemented by MH-II is the focus on building the capacity of postpartum family planning (PPFP) providers. MH-II built on the lessons learned from the previous MH Project to expand PPFP services. PPFP interventions are discussed in detail in Section 5, Question 5.

The team’s interviews with KII and FGDs with service providers and trainees during the field visits provided valuable insights regarding MH’s capacity-building efforts:

- Trainees welcomed MH-II or affiliated MOHFW staff visits to their workplaces; however, the team did not observe routine/planned follow-up or QA visits. The facility staff could not differentiate between QA visits and follow-up supportive visits. In many cases the follow-up for trainees (in particular PPFP trainees) is conducted by phone. Service providers report that the purposes of visits are to monitor their work to determine whether or not they are providing services and to collect and verify service data and records maintained by the providers. The follow-up and QA visits do not seem to be geared to supporting facility staff in mentoring, problem solving, hands-on coaching, etc.

- Training in IPC/C seems slim and is not well-integrated into clinical trainings. The IPC/C component in provider training is only 1-½ hours of the three-day training.

- The team also observed that for a variety of reasons many trained providers are not practicing the skills they learned through training. Some providers from DGHS facilities who were trained do not practice the skills because they believe FP service provision is not their responsibility and they are very busy with curative services: "FP is the responsibility of the DGFP." The lack of imprest funds to pay provider fees for DGHS employees and of easy access to FP commodities is probably the main cause of the reluctance.
• Many providers are biased against LAPM. Some trained providers were not providing PMs for religious reasons and others were biased against IUDs and reluctant to provide them. The team observed that in a few facilities, the doctors were strongly in favor of IUD and not in favor of implants/injectables because they believed hormonal FP methods were harmful to women. Overall, the team observed widespread provider biases.

• Clinical trainings, in particular for IUDs, do not include adequate practical experience. The majority of trainees interviewed reported that they did not have practical experience inserting IUDs during trainings; they practiced on dummies (models) or had theoretical instructions on the procedure. Providers trained in IUD insertions had few opportunities to practice their skills due to low IUD caseloads. As a result, the trained providers do not have confidence in their ability to insert IUDs and they request "refresher trainings." The OGSB report on findings from follow-up visits recommends refresher training for trainees every six months. This was a common finding across facilities and among IUD trainees, and MH-II has been supporting refresher trainings for some time. International guidelines recommend refresher trainings for contraceptives every five years, usually to catch up on new developments and technologies. Requests for frequent refresher training reflect the need to retrain providers because they lack the skills and confidence to perform the necessary procedures.

• Supply and demand factors do not appear to be taken into account when developing training schedules, and as a result training courses are not strategically planned to increase service utilization. For example, the team observed that five providers were trained from one facility where the current demand for IUDs is less than five cases a month, and none of the providers were trained in counseling skills.

• The capacity-building efforts for demand creation and provision of information and services seem to be well-coordinated with the NGO and private sectors and special initiatives implemented by MH-II (mobile teams, garment factories, etc.). Within the structure and routine functions of the MOFWH, however, these three pillars – demand creation, information provision, and service delivery – are not well-coordinated.

In conclusion, MH-II enhanced the capacity of partner local organizations to improve the quality, access, and use of LAPM services. The skills and knowledge transfer have potential to contribute to institutional capabilities and the sustainability of local organizations. The project’s new and broader approach to capacity building are appreciated by all sectors. However, there are challenges that need to be addressed to improve project outcomes. The areas of improvement include increased involvement of non-DGFP staff in capacity-building efforts, improved follow-up visits to trained providers, strengthened IPC/C, and improving the quality of clinical trainings by including adequate practical experience. The evaluation team also concludes that many trained providers are not practicing the skills learned through trainings and supply/demand factors do not seem to be taken into account when planning training sessions.

EVALUATION QUESTION 3:
To minimize the service gaps, the MH-II Project introduced mobile teams to offer LAPMs in areas where either MOH&FW service providers were not available or where FP service provision presented difficult challenges. To what extent did this intervention of mobile teams help increase the utilization of quality LAPM services, including how was it
coordinated with GOB, private sector, and other NGO service providers, such as Bangladesh Rural Advancement Committee (BRAC) and Marie Stopes International (MSI)?

The MSDT approach is a tested service delivery model that provides health and FP services in remote areas and in facilities where such services are not available. Globally, this approach is used in many developing countries and has been successfully implemented by a variety of organizations, such as EngenderHealth, MSI, Family Planning Association of Bangladesh (FPAB), and Population Services International (PSI). In Bangladesh, MSI and FPAB have been using this model for over a decade. MSI currently deploys 30 teams to cover 30 districts and 194 Upazilas in the country. FPAB works in 32 districts and uses the mobile approach by organizing 55 outreach satellite clinics to reach out to the underserved and marginalized people in rural areas.

To increase the accessibility of LAPM, MH-II began implementing this model in August 2014 and sub-granted Research, Training and Management Int. (RTMI) to form MSDTs and serve hard-to-reach areas and facilities with no trained providers. At the time of the assessment, RTMI MSDTs employed 5 part-time surgeons, 8 full-time doctors trained in LAPM, 12 paramedics, and 12 field officers.

RTMI carefully plans the schedule of the MSDTs at monthly meetings with district and Upazila Family Planning Officers. The schedule and sites for "special days" to provide services are appropriately targeted to the needs of facilities and clients and based on requests from Upazila FP Officers. FWAs, Family Planning Inspectors (FPIs), and volunteers from partner NGOs such as those in the NGO Health Services Delivery Project (NHSDP) and Shushilan conduct effective community mobilization and refer or accompany prospective clients to the special-day clinic. The Upazila FP Officers also coordinate the activities of MH-II with MSI to ensure that coverage does not overlap. To avoid duplication of efforts, districts and Upazilas are demarcated between the two organizations.

Key informants and community leaders with whom the assessment team met during field visits indicated that MSDTs are filling a major gap by providing LAPM services where trained providers are not available.

"Indeed, mobile teams of RTMI are filling a big service gap because of the non-availability of trained providers. Our NGO partners have greatly benefited from this service." –Senior NSDP Manager

The team’s observations in Cox’s Bazaar during an RTMI MSDT special day confirm that the MSDT approach is well-received by communities. Similarly, key informants in Khulna reported that MSDTs were fulfilling an unmet need for FP services, particularly in rural areas where there are no trained providers or where provider positions are vacant. In Gazipur, the team was informed that MSI is operating MSDTs to reach FP clients with unmet needs.

RTMI managers interviewed by the evaluation team reported that demand for MSDT services from Upazila health officials has already exceeded RTMI’s capacity to deliver, given their available resources and staff.

In addition to RTMI, MH-II has also introduced its own mobile teams. MH-II uses the same approach and organizes special days to provide LAPM services using its Senior QA and FP compliance officers and has temporarily hired surgeons retired from the MOH&FW. Table 4
shows the performance of MSDTs implemented by RTMI and MH-II over the last 18 months. During this period, the average number of special days organized was around 380 per month. The average number of clients served per special day (number of LAPM acceptors) was around 16. The number of districts reached by MSDTs increased from 25 in 2014 to 53 by December 2015. Overall, the MSDT approach achieved 13% of the project’s total LAPM acceptors to date.

Table 4. LAPM Acceptors who Received Services from MSDTs Organized by RTMI and MH-II, July 2014 – December 2015

<table>
<thead>
<tr>
<th>Organizer of Special Days</th>
<th>Number of Special Days</th>
<th>BTL</th>
<th>NSV</th>
<th>IUD</th>
<th>Implant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTMI</td>
<td>5,388</td>
<td>9,311</td>
<td>12,370</td>
<td>3,838</td>
<td>53,950</td>
<td>79,469</td>
</tr>
<tr>
<td>MH-II</td>
<td>1,483</td>
<td>3,769</td>
<td>5,600</td>
<td>1,168</td>
<td>19,701</td>
<td>30,238</td>
</tr>
<tr>
<td>Total</td>
<td>6,871</td>
<td>13,080</td>
<td>17,970</td>
<td>5,006</td>
<td>73,651</td>
<td>109,707</td>
</tr>
<tr>
<td>Percent of acceptors served by MSDT in total project performance</td>
<td>12</td>
<td>19</td>
<td>2</td>
<td>18</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Source: MH-II database.

Team discussions with RTMI staff in both Dhaka and the field indicated that the MSDTs work under several constraints. Among the challenges in implementing the MSDT approach:

- There are difficulties in recruiting and retaining surgeons. In general, there is a lack of surgeons and most of them are not interested in working for an FP program. In addition, they need to travel long distances by public transportation to attend special days.

- Working conditions and compensation provided to RTMI teams are lower than those of other organizations implementing the same approach. For example, MSI provides vehicles for transportation and performance-based incentives for its staff.

- Uncertainty about whether or not the sub-grant will be extended beyond September 2016 makes it difficult to plan and expand to meet growing demand.

In summary, the team concluded that the intervention of mobile teams has helped to increase access to and utilization of LAPM in remote and underserved areas. The intervention is well-coordinated with the GOB and NGOs such as those in the NHSDP and Shushilan. Even with the limited number of mobile teams, the approach was able to contribute 13% of the total achievement of the project. If the number of teams is increased and the issues cited above are addressed, there could be significant increases in the utilization of LAPMs.

**EVALUATION QUESTION 4:**

The MH-II Project engaged local national NGOs to improve LAPM information dissemination to clients and to improve their referral network to local facilities which provided the LAPMs. To what extent was this intervention successful in informing and engaging community people on LAPM and also establishing community facility linkages?

The project designed a communication plan (October 2013 – September 2017) to promote use of FP services by increasing knowledge and awareness of the benefits of LAPMs for spacing and limiting births among target populations. MH-II strategies are aligned with the National
Framework for Effective Health, Population and Nutrition (HPN) Social and Behavior Change Communication, developed by the Bangladesh BCC Working Group. The vision of BCC in the project focuses on information dissemination activities, such as community outreach, direct materials distribution, and interpersonal communication and counseling (IPC/C). MH-II has emphasized the distribution of educational, promotional, and giveaway materials and ensured the availability of job aids for service providers and volunteers.\(^3\) The evaluation team visited 14 health facilities, covering all sectors, to assess their readiness to disseminate information and provide quality counseling. A summary of findings is found in annex E.

Review of MH-II documents and interviews with project staff at headquarters and in the field indicates that there is modest appreciation of the importance of BCC activities as a cross-cutting approach that strengthens the impact of other project components. However, demand creation activities and building the capacity of service providers were not always synchronized to ensure the availability and accessibility of quality services. Such availability and accessibility are major driving forces for demand creation. Also, the role of information communication technology (ICT) in information dissemination is minimal in the project communication plan and its implementation activities. The evaluation team did not find any information dissemination activities that utilize this technology. However, FGDs and interviews with volunteers in the field found that using audio messages on various MCH issues including those related to FP through cell phones to women and couples can be an effective approach.

According to interviews the team conducted with the MH-II BCC team and based on project reports, it is not clear how or if formative and operational research has been used to inform the design of the BCC strategy. Most of the studies conducted are limited to field testing BCC materials before finalization and production. Several relevant studies were fielded by the previous MH Project and their results could be useful in informing the design of MH-II BCC activities and materials.

MH-II has subcontracted six NGOs in rural areas and urban slums to engage their existing volunteer networks in community-based information dissemination activities in order to generate demand for LAPMs and to refer clients to accessible health facilities. Since the beginning of the project, over 4,000 volunteers from BRAC, Young Power in Social Action (YPSA), Shushilan, the Population Services and Training Center (PSTC), Mukti, and the Voluntary Paribar Kalyan Association (VPKA) have been engaged in these efforts. MH-II signed agreements with BRAC, YPSA, and Shushilan in December 2014 and with the other organizations in December 2015. In addition to the community outreach activities, MH-II assisted YPSA in utilizing community radio stations to disseminate messages on FP and LAPMs.

MH-II conducted a three-day TOT for NGO mid-level staff, who then offered a one-day orientation workshop for their own volunteers on IPC/C, focused on how to disseminate FP information and effective ways to use FP BCC materials with various client segments. MH-II equipped the volunteers with BCC materials. Most volunteers are women of reproductive age,

\(^3\) In 2015, USAID requested that the SIAPS, MH-II, and BKMI Projects work together to develop a system to help the DGFP – and later the DGHS – to enable all facilities to order and receive a standard set of BCC materials for use in facilities and by FWAs in the community through the DGFP logistics system, just as other commodities can be ordered using the eLMIS.
who conduct home visits and courtyard meetings. Volunteers referred eligible clients to FWAs, who follow up with them and/or accompany clients to health facilities.

KII and FGDs in the field found that NGO demand generation and referral activities are highly appreciated by government managers and service providers, who reported that gaps in community outreach efforts are associated with an increased FWA workload and expansion of their responsibilities to include annual updating of the eligible couples register and attending weekly meetings at the union clinics. Thus, NGO volunteers are making a valuable contribution by helping fill in the community outreach gap. In Gazipur, for example, key informants reported that “NGO volunteer networks are supporting the FWAs, as the worker/client ratio for FWA has increased from 1:5,000 to 1:10,000.”

The evaluation team found that information dissemination and referrals by NGOs have been effective. More than 90% of the clients referred accepted and received an LAPM or injectable (see Figure 3).

**Figure 3. Clients Referred by YPSA, BRAC, and Shushilan and Received LAPMs or Injectables, October 2014 – December 2015**

Further analysis of the data indicates that more than 90% of referred cases were in rural areas and about 93% of women who received LAPM and injectable services are from rural communities. NGO referrals have been particularly successful at increasing the utilization of implants and injectables. More than 70% and 23% of referred women who received LAPM and injectable services accepted injectables and implants respectively. The injectable and implant utilization trends are similar in both urban and rural settings (see Table 5).
Table 5. Clients Referred who Accepted LAPMs or Injectables by Location and Method, October 2014 – December 2015

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Clients Referred</th>
<th>Number of Referred Clients Received Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BTL</td>
<td>NSV</td>
</tr>
<tr>
<td>Urban</td>
<td>3,624</td>
<td>72</td>
</tr>
<tr>
<td>Rural</td>
<td>35,834</td>
<td>522</td>
</tr>
<tr>
<td>Total</td>
<td>39,458</td>
<td>594</td>
</tr>
</tbody>
</table>

Source: MH-II database.

KIIIs and FGDs with different groups in the four districts visited revealed that community-based activities are an effective strategy for information dissemination, creating positive social norms, behavior change, and referrals to health facilities.

In addition to the NGOs model, MH-II undertook an innovative intervention with the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) in Dhaka and YPSA in Chittagong. The intervention has been piloted in 16 factories in Dhaka and 15 factories in Chittagong. MH-II trained YPSA and BGMEA mid-level staff as peer educators to disseminate FP information through motivational group sessions and one-on-one counseling, using a flexible schedule tailored to factory production schedules and worker availability. MH-II is also training health personnel in BGMEA and factory clinics to provide temporary methods. Trained staff and volunteers refer clients to conveniently located health facilities in nearby communities for LAPMs. MH-II also provides educational and promotional materials.

This garment factory-based referral system has been very successful: 79% of women referred have accepted and received FP services. Further analysis showed that 86% of women who accepted FP methods preferred injectables and 13% preferred implants—a trend similar to that of women referred by NGO community outreach work. This finding supports the popularity of injectables and implants compared to IUDs and PMs, cited elsewhere in the report.

The team noted that interventions in garment factories are well-positioned to effectively target large numbers of young people in need of FP services. About four million people work in the garment industry, accounting for 85% of the total industrial work force in Bangladesh, and about 95% of garment factory workers come from rural areas where access to FP services is limited. About 80% of garment factory workers are women and most are married and between the ages of 18 and 30. Based on direct observation of an educational session at a garment factory in Chittagong, led by a YPSA-trained factory welfare officer, the evaluation team found that the educational sessions are of high quality and the interest of women in FP interventions is high.
The team also found that MH-II has successfully collaborated with the BGMEA and that support for the FP interventions at the BGMEA is high. MH-II helped BGMEA to establish linkages with the DGFP, which now provides condoms, pills, injectables, and implants to the association. The BGMEA plans to scale up the MH-II piloted interventions to another 80 to 100 factories, including factories in Chittagong. Since this represents only a small percentage of BGMEA’s total 3,500 functional factories, that leaves huge potential for the intervention to expand. Both interventions have promising potential for scaling up and replication in other locations.

MH-II has established an effective network to refer potential clients for services, with a high acceptance rate, and created venues for satisfied NSV acceptors to advocate for NSV in their communities. DGFP and MH-II data show a 16% increase in the three months pre- and post-
NSV performance analysis where the Satisfied NSV Acceptors Intervention was conducted. More attention is required to consider utilization of ICT in information dissemination, ensure the availability of BCC materials in different facilities, and revisit their content to address common misconceptions about LAPMs, with emphasis on the health and social benefits of these methods.

In summary, the evaluation concludes that MH-II has achieved considerable success in establishing effective networks of NGO trained volunteers to disseminate information and refer potential clients for services. MH-II has also successfully collaborated with the BGMEA and support at the BGMEA for the FP interventions is high. However, project BCC materials lack versions appropriate for low literacy and illiterate clients that address common misconceptions about LAPMs. Also, ICT is not utilized in supporting the BCC materials/dissemination efforts for different project audiences. Finally, the evaluation team concludes that BCC integration as a cross-cutting intervention in other project components is limited.

**EVALUATION QUESTION 5:**
To what extent has MH-II Project support been successful in working with public (DGHS, DGFP), private, and NGO facilities to strengthen postpartum family planning (PPFP) services?

One of the objectives of MH-II is to improve acceptance of LAPM in the postpartum period by providing postpartum FP services. PPFP is an effective approach to increase the intervals between births (spacing) and address the FP needs of couples who have completed their family and do not want more children. PPFP contributes to improved maternal health, reduces demand for abortions, and reduces cases of unwanted pregnancies shortly after delivery – which are high risk for both mother and child. MH-II focuses specifically on increasing the number of clients who adopt LAPM during the immediate postpartum period (IPPP), i.e., within 48 hours of delivery. Hence the findings and conclusions of the evaluation pertain to the success of providing LAPM during the IPPP.

MH-II support for PPFP has focused on orientation of health workers and clinical training of service providers to build skills in postpartum IUD (PPIUD) insertion and postpartum bilateral tubal ligation (PPBTL). Table 6 shows the numbers of doctors and paramedics MH-II trained in these skills by sector. Of the 568 individuals trained in PPFP clinical skills, 52% were DGHS staff and 26% were DGFP staff. Altogether, 78% of the trainees were employed by the public sector. About 149 of those trained in clinical skills (26% of the total trained) received follow-up visits in their workplaces. MH-II provided PPFP training in 41 districts covering 98 Upazilas and 299 clinic sites; 71% of the training sites were in the public sector, 24% at NGOs, and 5% in the private sector. In addition to the PPFP clinical trainings, MH-II also conducted orientations on PPFP for 1,161 doctors and 1,030 paramedics.

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4 Although MH-II interventions had been implemented in 38 districts at the time of the evaluation, PPFP activities had expanded to 41 districts.
Table 6. Providers Trained in PPFP Clinical Skills by Sector

<table>
<thead>
<tr>
<th>Providers</th>
<th>DGFP</th>
<th>DGHS</th>
<th>NGOs</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>28 (13.7)</td>
<td>138 (67.6)</td>
<td>35 (17.2)</td>
<td>3 (1.5)</td>
<td>204 (100.0)</td>
</tr>
<tr>
<td>Paramedics</td>
<td>121 (33.3)</td>
<td>157 (43.1)</td>
<td>51 (14.0)</td>
<td>35 (9.6)</td>
<td>364 (100.0)</td>
</tr>
<tr>
<td>Total</td>
<td>149 (26.2)</td>
<td>295 (52.0)</td>
<td>86 (15.1)</td>
<td>38 (6.7)</td>
<td>568 (100.0)</td>
</tr>
</tbody>
</table>

Source: MH-II database.

The trends for the number of postpartum acceptors are presented in Figure 5, which shows that acceptance of PPBTL and PPIUD has increased significantly since MH-II began work. PPBTL acceptors increased from 2,997 to 5,088 and PPIUD acceptors from 352 to 1,251 between the quarters of October – December 2013 and October – December 2015. Although this is a significant increase and demonstrates the effectiveness of the MH-II approach, the absolute number of PPFP acceptors in 41 districts is still very low, especially the number of women who accepted a PPIUD.

Figure 6. PPFP Acceptors During IPPP in Project Districts

Source: MH-II database.

Further analysis of PPBTL acceptance shows that in MH-supported districts, the share of PPBTL in total tubectomy acceptors has been increasing rapidly: from December 2014 to December 2015 the share of PPBTL in the total number of bilateral tubal ligations (BTLs) has increased from 40% to 58%. This finding is probably a result of (1) increasing numbers of Caesarian sections (C/S) in the country, and (2) the preference of doctors to perform PPBTL during a C/S compared to providing interval BTLs. Similarly, the share of PPIUDs among all IUD acceptors went up from 2% to 6% during the same time period. Although the increase is significant, the finding indicates that the majority of health workers prefer providing interval IUD services rather than inserting PPIUDs.

The evaluation team identified a number of programmatic issues that adversely impact uptake of PPIUD at facilities supported by MH-II:
• Despite training, many providers remain reluctant to provide PPIUD, citing high levels of expulsion. Some providers reported that they recommended IUDs six weeks after delivery to minimize chances of expulsion.

• Some doctors who were willing to provide PPIUDs reported that they lacked adequate experience and confidence in PPIUD insertion. These doctors reported that the PPIUD training they received did not include hands-on practical experience. Instead, most of the trainees reported that training included instruction on using a flipchart and a demonstration of IUD insertion techniques by the instructor.

• Even providers who felt both confident and willing to provide PPIUD reported that lack of clients, and therefore prolonged lack of clinical practice in PPIUD insertion, eroded their skills. This issue was further compounded by the planning of trainings, which, at some facilities, included providing PPIUD training to all FWV and nursing staff at a facility despite low demand for the services.

• In some cases, the evaluation team noted that PPIUD training was provided to nurses in OB/GYN facilities where IUDs are not available. Similarly, doctors at DGHS maternity facilities, who were trained in PPIUD, reported that they did not provide PPIUD, because it is not among their responsibilities – and that providing PPIUD is the mandate of DGFP facilities and staff.

The team also identified a number of missed opportunities that limited the uptake of all forms of postpartum LAPM at MH-II-supported facilities:

• Late information on PPFP or lack of it at antenatal care (ANC) visits have adversely impacted demand. KII and FDGs conducted by the team found that FP information is mainly provided during the third or fourth ANC visit. Many providers wait until women return for postnatal care before discussing PPFP. This limits the number of pregnant women who are offered PPFP as many women only receive ANC once during pregnancy. Preliminary data from the MH-II baseline survey reinforces these findings. The baseline study shows that only 26% of pregnant women with two or more children were offered PPIUD or PPBTL at the time of delivery and 34% of those to whom it was offered accepted a LAPM.

• Training in PPFP has primarily focused on the public sector, but the majority of women (60%) who deliver at facilities rather than at home chose private facilities. This trend can be expected to continue. Between 2004 and 2014, the percentage increase of institutional deliveries was 175% at private facilities and 62% at public facilities. Between 2011 and 2014, the trend accelerated; institutional deliveries at public facilities increased by just 1% while deliveries at private facilities increased by 7 percentage points. In conclusion, capacity building for providers across the sectors does not match the trends in clients' preferred place of delivery.

In sum, the evaluation team concludes that MH-II interventions to strengthen PPFP services by addressing both service delivery and policy barriers has resulted in increased utilization of PPIUD and BTL in MH-II-assisted districts. However, the absolute number of PPFP acceptances is still very low, especially the number of women who accepted a PPIUD. The evaluation team identified a number of programmatic issues that adversely impact uptake of PPIUD that are explained above. The team also identified a number of missed opportunities and impediments that limited the uptake of all forms of post-partum LAPMs: (1) late information on PPFP or a
total lack of it during all ANC visits; and (2) training in PPFP primarily focused on the public sector, though the majority of women who deliver at facilities rather than at home chose private facilities. Further, most of the deliveries in the public sector occur in DGHS facilities, which do not have reliable access to MOH&FW imprest funds to pay the physicians for providing LAPMs. MH-II has taken the lead in working with the MOH&FW to make imprest funds available to DGHS physicians; though not yet resolved, this is close to final approval.

**EVALUATION QUESTION 6:**
*The MH-II Project was to help in identifying and adapting policies, strategies, regulations and/or guidelines of the MOH&FW to improve access to and use of quality LAPM services. What kind of impact did these policy changes produce in the service environment in terms of LAPM utilization? Did these policy changes bring any visible pushes among public, private, and NGO providers?*

The MH-II Project aimed to help in identifying and adapting policies, strategies, regulations, and/or guidelines of the MOH&FW to improve access to and use of quality LAPMs and injectable services. This section reviews the impact of policy changes (Table 7) on the service environment in terms of method utilization.

**Table 7. Summary of Policy Changes and Findings**

<table>
<thead>
<tr>
<th>Policy Change</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of second and subsequent doses of injectables by Community Health Care Providers (CHCPs) in Community Centers (CCs) after receiving training.</td>
<td>CHCPs interviewed by the evaluation team reported receiving training and providing second and subsequent doses of injectables.</td>
</tr>
<tr>
<td>Provision of IUD services by female Sub-Assistant Community Medical Officers (SACMOs) working at Family Welfare Centers after receiving training.</td>
<td>SACMOs at the sites visited by the team were all male.</td>
</tr>
<tr>
<td>Provision of supplementation of calcium fortified with Vitamin D to injectable users.</td>
<td>Service providers were not aware of this policy, and there was no calcium fortified with Vitamin D at sites visited by the team. Moreover, this policy is not in line with international guidelines.</td>
</tr>
<tr>
<td>Revision of the policy guideline on the management of excessive bleeding following implant use.</td>
<td>Service providers at sites visited by the team were not aware of this policy guideline.</td>
</tr>
<tr>
<td>Provision of first and subsequent doses of injectable contraceptive by Family Welfare Assistants after receiving training.</td>
<td>Findings varied across the regions visited. Some of the FWAs interviewed had been trained to provide first doses and were doing so. Others had not been trained to provide the first dose and provided only second and subsequent doses.</td>
</tr>
<tr>
<td>PPFP counseling provided during ANC, postnatal care (PNC), and immunization visits jointly by DGHS and DGFPP.</td>
<td>Few women reported receiving counseling on LAPM during ANC. Most reported receiving information after delivery. Few women reported receiving counseling on LAPM during PNC or immunization visits.</td>
</tr>
<tr>
<td>FP services for short-acting methods such as pills, condoms, and the injectable now available at immunization sites.</td>
<td>The team did not visit immunization sites. Service providers reported providing both immunization and FP counseling, including provision of pills, condoms, and injectables, at special days/camps. Some FWAs reported</td>
</tr>
</tbody>
</table>
Policy Change | Findings
--- | ---
Implants and progestin-only pills (POPs) allowed as an immediate PPFP can be provided to clients immediately postpartum, irrespective of her parity (approved in March 2016). | Sites visited were providing POPs as PPFP — six weeks after delivery, clinics in Chittagong provide implants as immediate PPFP.

The assessment team found that MH-II has successfully advocated to change a number of policies affecting utilization of LAPMs and injectables. The project's efforts at policy changes are welcomed and appreciated by the majority of key informants in Dhaka. However, translation of these policies into action on the ground has been sporadic: Most health officials and service providers interviewed in the districts were not able to name policy changes in the past two years. However, the team found that some policy changes have had an impact on service provision, notably the provision of second and subsequent doses of injectables by CHCPs in CCs and provision of first and subsequent doses of injectables by FWAs, at least in some districts. The team did not find evidence that other important policy changes have had a practical impact on service delivery; provision of counseling on LAPMs during ANC and PNC is still particularly weak. Some policy changes have limited potential for impact on service delivery: The policy to allow female SACMOs to provide IUDs cannot have much impact because the majority of SACMOs are male. Other policy changes are ill-conceived, such as the policy to provide calcium fortified with Vitamin D to injectable users, which is not in line with international guidance.

In summary, the evaluation concludes that MH has a strong record of successfully advocating for important policy changes that can impact service provision on the ground, notably provision of second and subsequent doses of injectable contraceptives by CHCPs in CCs and provision of first and subsequent doses of injectable contraceptive by FWAs. The important policy change to provide PPFP counseling during ANC, postnatal care (PNC), and immunization visits has rarely been implemented. Some policy changes, such as allowing female SACMOs to provide IUD and providing calcium fortified with Vitamin D to injectable users, are not impactful or are not in line with international guidance.
6. RECOMMENDATIONS

The following are the evaluation team’s recommendations for MH-II for the remaining life of the project. The recommendations are linked to evaluation questions and are based on the findings and conclusions discussed in this report.

1. Do not aim for national coverage, as MH-II has been doing. At the time of the assessment, the project was working in 38 districts in seven divisions spread across the country. MH-II was also providing technical assistance to the DGFP beyond these focus districts. The evaluation team believes that the project’s resources are already spread too thin and recommends that the project focus on the current districts for the remaining life of the project.

2. Capitalize on opportunities to promote LAPMs – especially PMs – by continuing and expanding the new approaches adopted so far by MH-II: NGO-supported mobile teams (RTMI), NGO service provision, workplace interventions and community outreach, private facility service delivery, and support to DGHS for PPFP.
   - The lack of imprest funds and FP commodities for DGHS facilities and staff continues to be a barrier to LAPM services, especially expansion of PPFP services. MH-II should increase advocacy efforts with MOHFW to approve the final steps and follow up on implementation.
   - Increase support to RTMI to enable NGOs to (1) increase the number of teams and expand coverage of their services, and (2) attract and retain more qualified staff by improving working conditions. These may include resolving transportation challenges and offering competitive compensation to mobile team professionals to retain qualified staff.
   - Focus resources for mobile teams on qualified NGO service providers (RTMI) rather than organizing the same approach through MH-II QA teams. The focus of QA teams should be on supervising quality assurance.
   - Focus technical assistance for service delivery on the facilities that attract the greatest numbers of clients, i.e., NGO and private, and DGHS facilities for PPFP.

3. Expand support and scale up effective demand-generation activities via NGO community volunteers and successful NGO-supported interventions – BRAC, YPSA, Shushilan, and PSTC.
   - Continue to scale up workplace interventions in current locations and replicate the model in other garment factories.
   - Strengthen training for grassroots community workers and volunteers to capacitate these frontline workers to identify and address myths and misconceptions about LAPMs, gender-specific barriers to LAPM utilization, and basic clinical questions.
   - Continue to work to simplify NGO affiliation processes with DGFP to facilitate provision of contraceptives to NGO facilities to ensure there are no stock-outs. Simplifying the NGO affiliation process was listed as a goal in the MH-II agreement.
and the evaluation team believes that is particularly important for future work with BGMEA and the garment factories.

4. Strategically focus trainings to maximize impact by
   • Reducing the total number of trainings and improving quality – notably by incorporating adequate clinical experience and by follow-up. Institutionalize routine follow-up for all trainees, consisting of on-the-job, hands-on training, and supportive supervision.
   • Plan training activities to address the capacity needs of individual providers and facilities and meet unmet demand at the community level. Strategically select trainees for both gaps in clinical skills and readiness to provide PM and IUD.
   • Improve the quality of clinical trainings by incorporating practical experience during training – by, for example, coordinating trainings with "camps," "special days," or mobile team visits to allow trainees to practice their skills.
   • Integrate a substantial high quality IPC/C training component into the clinical training curricula and strengthen IPC/C training for dedicated counselors.

5. Revisit and update the project communication plan to directly combat myths and misperceptions about PMs and IUDs and address provider biases.

6. Develop IEC/BCC materials appropriate for low-literacy beneficiaries with an emphasis on specific messages that address myths and misconceptions. The project should also consider using ICT to disseminate messages to beneficiaries and community leaders.

7. Support NGOs to train male volunteers and organize community meetings for men with the participation of religious leaders (imams) and service providers to respond to their religious or health concerns regarding LAPMs. Analyze the results of the Satisfied NSV Users intervention and consider scaling it up.

8. Mainstream gender into all aspects of training and BCC/IEC by (1) including training on gender-specific barriers to LAPM utilization, and practical strategies to address those barriers, in IPC/C training for counselors, medical practitioners, and frontline grassroots workers and volunteers; (2) integrating gender-specific messaging into IEC and BCC materials and activities; and (3) ensuring that gender-specific services are available either on-site or via referral. Critical skill-sets to develop include: gender-sensitive interpersonal communication for service providers focused on empowering clients and strengthening women’s negotiating skills and decision-making power on FP methods; providing couples counseling and engaging men in FP decisions; and screening for gender-based and intimate-partner violence, and incorporating referrals for survivors of GBV into current referral networks.5

9. Continue work on the PPFP National Action Plan and advocate to expand the focus of its activities beyond immediate PPFP to encompass at least the six weeks after delivery.

Provide information and counseling on PPFP starting from the first ANC visit and build up capacity to provide counseling on LAPMs during ANC, PNC, and immunization visits.

10. Ensure that MOH&FW and NGO managers and staff at all MH-II supported districts and sites are informed about policy changes that impact their work.

11. Ensure that policy advocacy is aligned with international guidance and avoid support for policies that contravene international guidelines, such as the provision of calcium-fortified vitamin D to injectable accepters.
ANNEX A: SCOPE OF WORK

Assignment #: 187 [assigned by GH Pro]

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 12-01-15
Last update: 2-16-16

I. TITLE:Mayer Hashi Family Planning Project (MH-II)

II. Requester / Client
☐ USAID Country or Regional Mission
Mission/Division: Bangladesh / OPHNE

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☐ 3.1.1 HIV  ☐ 3.1.6 MCH
☐ 3.1.2 TB  ☐ 3.1.7 FP/RH
☐ 3.1.3 Malaria  ☐ 3.1.8 WSSH
☐ 3.1.4 PIOET  ☐ 3.1.9 Nutrition
☐ 3.1.5 Other public health threats  ☐ 3.2.0 Other (specify):

IV. Cost Estimate: (Note: GH Pro will provide a final budget based on this SOW)

V. Performance Period
Expected Start Date (on or about): 02/29/2016
Anticipated End Date (on or about): 07/29/2016

VI. Location(s) of Assignment: (Indicate where work will be performed)
Sample of districts where MHII has interventions

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)
EVALUATION:
☐ Performance Evaluation (Check timing of data collection)
☐ Midterm ☐ Endline ☐ Other (specify):
Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)
- Baseline
- Midterm
- Endline
- Other (specify):
  Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

Other Analytic Activities
- Assessment
  Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.
- Costing and/or Economic Analysis
  Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.
- Other Analytic Activity (specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)
Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)
- Midterm
- Endline
- Other (specify):
  Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation
Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)
- Baseline
- Midterm
- Endline
- Other (specify):
  Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.
Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

If an evaluation, Project being evaluated:

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Myer Hashi Associate Award under RESPOND LWA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Number:</td>
<td>Associate Cooperative Agreement No. AID-388-LA-13-00002 under Leader Award No. GPO-A-00-08-00007-00</td>
</tr>
<tr>
<td>Award Dates:</td>
<td>October 2013 to September 2017</td>
</tr>
<tr>
<td>Project Funding:</td>
<td>$20,000,000</td>
</tr>
<tr>
<td>Implementing Organization(s):</td>
<td>EngenderHealth</td>
</tr>
<tr>
<td>Project AOR:</td>
<td>Samina Choudhury</td>
</tr>
</tbody>
</table>

Background of project/program/intervention:
A.1. Country Context

Bangladesh has shown remarkable achievements in reducing child and maternal mortality in the last two decades. In 2011, Bangladesh had surpassed the MDG 4 target (reducing the under-five mortality rate by two-thirds) and is on track to achieve MDG 5a (reduce the maternal mortality ratio by three quarters). Progress on key indicators is listed in the table below.

Progress on Key Indicators in Bangladesh

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2007</th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality rate (per 1000 live births)</td>
<td>37</td>
<td>32</td>
<td>28</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>52</td>
<td>43</td>
<td>38</td>
</tr>
<tr>
<td>Under-five mortality rate (per 1000 live births)</td>
<td>65</td>
<td>53</td>
<td>46</td>
</tr>
<tr>
<td>Total fertility rate (TFR)</td>
<td>2.7</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (CPR)</td>
<td>56</td>
<td>61</td>
<td>62</td>
</tr>
<tr>
<td>Low height for age (stunted)</td>
<td>43</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>Low weight for height (wasted)</td>
<td>17</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Percent of children &lt; 6 mos exclusively breastfed</td>
<td>43</td>
<td>64</td>
<td>55</td>
</tr>
</tbody>
</table>

Bangladesh greatly reduced the maternal mortality ratio, from 322 per 100,000 live births in 2001 to 194 in 2010. The country is on track to reach the MGD target of 143. Some 79 percent of women receive at least one antenatal care (ANC) visit, the majority from a medically trained provider (64 percent). However, only 31 percent received the recommended four or more ANC visits. Although still low, some 42 percent of deliveries are assisted by skilled provider, 37 percent of those in a facility. Most, 63 percent births still occur at home, attended by untrained providers. The majority of those who deliver in a facility are delivering in private sector facilities (22 percent), and there is cause for concern with the alarming rate of cesarean section deliveries in private facilities (80 percent). Increasing skilled birth attendance is a priority area of action for the national program. Post-natal care (PNC) is increasing, but yet only 34 percent of mothers and 32 percent of infants receive care from a medically trained provider within 48 hours of birth, and only six percent of newborns receive all the elements of essential newborn care.

While Bangladesh has had strong success in fertility reduction and contraceptive use, both the CPR and TFR stagnated since 2011 as shown in the 2014 BDHS. There are regional variations in TFR with Sylhet Division having the highest TFR (2.9) and Khulna and Rangpur Divisions the lowest (1.9). Results from BDHS 2014 show that TFR in Dhaka Division increased since 2011 which is a concern since Dhaka comprises one third of the country’s population and the TFR of this division has a large impact on the national TFR. Some 12 percent of the population still has an unmet need for contraceptives. Although 62 percent of couples want no more children, long acting reversible contraceptives and permanent method (LARC/PM) use remains low at 8 percent. The discontinuation rate is high (30 percent) which indicates that there is scope for improving quality of services.

During the past decade, the CPR increased by only 4 percentage points, from 58 percent in 2004 to 62 percent in 2014, although the mCPR increased by 7 percentage points, from 47 percent to 54 percent. Between 2011 and 2014, CPR increased by only 1 percentage point and mCPR by only 2 percentage points. Under the Health Population and Nutrition Sector...
Development Program (HPNSDP) 2011-2016, the Government of Bangladesh set a goal to increase the CPR to 72 percent by 2016 (MOHFW, 2011). To achieve this goal, an increase of 10 percentage points would need to occur in the next two years, or an average of 5 percentage points of an increase per year which is highly unlikely to happen. The HPNSDP 2011-2016 also focuses on reducing regional differences in CPR, in particular in the low-performing divisions of Chittagong and Sylhet, and to increase the mCPR in Chittagong and Sylhet to 50 percent by 2016. Based on the 2014 BDHS data, to reach this level in the next two years, mCPR in Chittagong and Sylhet must increase by 3 and 9 percentage points, respectively. Between 2011 and 2014, mCPR in Chittagong increased by 2 percentage points and in Sylhet by 6 percentage points.

Male involvement in family planning is below the desired levels, but male sterilizations are increasing in some areas where quality services are offered. There is an opportunity to increase provider knowledge and skills, strengthen LARC/PM referral networks, and improve facility readiness to provide LARC/PM services by providing needed equipment, supplies and BCC materials.

The burden of poverty and cultural constraints falls disproportionately on women, with women representing only 26 percent of the workforce. The average age of marriage is very young (15.3 years\(^8\)). Just over half of women contribute to household decision making, and these women are more likely to use family planning and receive antenatal or delivery care from a trained provider. Because unmarried adolescents are not included in national level surveys, little is known about their reproductive health needs.

A.2. Mayer Hashi Family Planning Project (MH-II) History
MHII is USAID/Bangladesh’s flagship family planning project. The project evolved from the precursor project, Mayer Hashi, also funded by USAID. Mayer Hashi was a bilateral cooperative agreement with Engender Health Bangladesh.

A.3. MH-II Project Overview
Mayer Hashi Family Planning Project (MH-II), October 2013 to September 2017, is an Associate Award under the global RESPOND Project led by EngenderHealth. MH-II aims to support the national family planning (FP) and maternal health (MH) programs for “Increased Use of Effective Family Planning and Reproductive Health (RH) Services in Bangladesh” with a focus on the informed and voluntary use of long-acting reversible contraceptives (LARCs), and permanent methods (PMs). The objectives of MH-II are as follows:

- Delay first birth
- Space between the first and second birth
- Limit births through high-quality services delivered to better-informed clients in an enhanced policy environment

\(^6\) Unless otherwise noted, all references from the Bangladesh Demographic and Health Survey 2014: National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International.2015. *Bangladesh Demographic and Health Survey 2014: Key Indicators.* Dhaka, Bangladesh and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.


MH-II is designed to support the national family planning program of Bangladesh through capacity building, demand generation and creating an enabling environment by removing key policy barriers.

In phases four years, the project will cover all 64 districts using a cluster based approach. This project is designed to support both the public and private health sectors. MH-II engages local and international partners to ensure wider coverage of its interventions. The international partners are:

- Meridian International: To support BCC and private sector activities
- Future Institute: To support identification of policy barriers
- Population Council: To support monitoring, evaluation and research activities

Expanded access to and use of family planning services resulting from MH-II Project efforts should measurably contribute to increasing the CPR and mCPR with an increased share of LAPM methods. Project implementation contributes to: the Global Health Initiative/Bangladesh (GHI/B) Country Strategy and the principles of women, girls, and gender equality; USAID’s Country Development Cooperation Strategy (CDCS); and GOB’s Health, Population, and Nutrition Sector Development Program (HPNSDP) 2011-2016. Specifically, MHII Project activities will contribute to the GHI/B Results Framework and CDCS Development Objective 3 (DO3): Health Status Improved and its sub-result: “increased use of effective family planning (FP) and reproductive health (RH) services”. This project is also responsible to oversee informed choice and voluntarism (ICV) and family planning compliance with USG law and policies regarding family planning and abortion, and to build the MoHFW capacity to ensure ICV and compliance with USG law and policies.

A.4. MH-II Project Approach

The MH-II Project has the following strategic approaches:

- A phased district based approach for national coverage. By the third year of the project, interventions in all 64 Districts will be completed so that in the last year comprehensive follow-up will be conducted.
- Facilitate all-inclusive programming to expand access and coverage (GO, NGO and Private);
- Support critical gaps in service delivery and capacity building;
- Ensure continued engagement with facilities on service organization and quality assurance including compliance monitoring;
- Engagement with National Technical Committee and MOHFW to advance innovations and policy reforms;
- The ultimate aim of the project would be sustainability of all efforts particularly that of capacity development which would enable continued availability of LARC and PM services throughout the country. All activities have been designed in such a way that after third year of the project MH – II staffs will gradually withdraw and public Director General for Family Planning (DGFP) and Director General of Health Services (DGHS) and private sector organizations (NGOs and private facilities) will gradually assume responsibilities of performing the activities that used to be done by MH – II staffs.

Short description on other approaches are given below:

Phased Cluster/District Based Approach

During the four years of project interventions, MH-II will work in all 64 districts of the country. MH-II’s approach will be targeted, phased, and evidence-based. Through a Cluster/District based approach, MHII will harness the experience of high-performing areas of the country, and foster cross-learning among managers in high-, low-, and mid-performing areas. To ensure that
regional differences are taken into account, it uses a regional approach and continues prioritizing **hard-to-reach and underserved areas and marginalized populations**. Through provider support and targeted messaging to address provider biases, MH-II will work to motivate trained service providers to provide client-centered counseling and to increase delivery of services. MHII includes an appropriate package of interventions, tailored to regional and district needs. As interventions will be customized to regional priorities, the Project approach will ensure efficient use of resources and relevance to the needs of the districts and communities. It will use experiences from the field to identify and prioritize policy and health-systems gaps and address these at the policy level in coordination with USAID partners, national task forces and committees and development partners.

As a part of phase-wise expansion of project interventions, by the end of third year MH-II will cover all the 64 districts while undertaking comprehensive follow-up in the last year of the Project. One project staff will be assigned for each cluster/division to ensure follow-up of the implemented activities. Within each district MH-II will work in all Upazilas in public, NGO and private sector facilities. At the beginning of each project year, district information will be collected about the estimated population, eligible couples (ELCOs) and if possible age-parity distribution of the ELCOs, number of potential public, NGO and private sector facilities for initiation/strengthening of LARCs and PMs, including PPFP and injectable services.

To complement the district approach, MH-II will also undertake significant national level work to support the special initiatives initiated in the first Mayer Hashi Project such as training and developing a pool of trainers for clinical and non-clinical activities; piloting and documenting models and approaches to support scale-up; support national RH commodity security initiatives; advocate for increasing the visibility of LARC/PMs in the FP program; work for HR and medical eligibility policy reforms; and continue communication efforts to enhance the acceptability of LARC and PMs, including PPFP and Injectables.

**Lessons learned will be gleaned and shared nationally and internationally.**

Priority population groups in the geographic focus areas include women and men with unmet need for LARC/PMs, in addition to urban slums and rural poor, young married couples, and high parity women. Secondary population groups include middle class women and men who can be reached relatively easily by the public and private sectors. In addition to focusing on the priority population, the project will also complement demand generation activities. MH-II will also target FP service providers with training and support to address provider biases that limit LARC/PM service provision and develop skills in client centered counseling to promote method uptake among clients.

**Facilitate inclusive programming to expand access and coverage (government, NGO and Private):** The LARC and PM, including PPFP, activities to be undertaken during the PY I period and subsequently will be through using the Supply-Demand and Enabling Environment programming model. MH-II will facilitate an inclusive programming process to expand access and coverage involving government, NGO and private sectors. Service delivery of LARCs and PMs including PPFPs will be expanded through using mobile service delivery teams and rapidly scaling up of the state of the art activities, like integrating PPFP with maternity services in all three sectors.

**Support critical gaps in service delivery and capacity building:** Mobile service delivery teams will be engaged to fill the service delivery gaps in the public sector sites. Capacity building
of government, NGO and private sectors will be supported through training, sub-grants and working with public sector training centers.

**Ensure continued engagement with facilities on service organization and quality assurance including compliance monitoring:** MH-II will provide continuous follow-up of the implemented activities through project staff, trainers of the training sub-grant, and will engage regional QA and FP Compliance Officers for quality assurance including compliance monitoring of government, NGO and private sector services.

**Engagement with National Technical Committee (NTC) and MOHFW to advance innovations and policy reforms:** MH-II Policy and Advocacy Team will support service delivery and training, and BCC activities to be undertaken by the demand generation team. The Policy and Advocacy Team will continuously engage with the National Technical Committee (NTC) and MOHFW to advance innovative activities undertaken by other teams and will also continue to work for policy reforms to support easy access to LARCs, PMs and PPFP. The Policy and Advocacy Team will also work to implement planned policies, guidelines, standards and protocols formulated and approved by the NTC.

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Describe the theory of change of the project/program/intervention.

As stated above, USAID/Bangladesh DO3 strives to stabilize population and improve health and nutrition. DO3’s Development Hypothesis is: if all Bangladeshis have access to quality health services at an affordable cost and are aware of the benefits of using these services, they will use these services, leading to improved health outcomes. Strengthened health systems are integral to ensuring access to quality and sustainable service provision.

MH-II efforts will contribute to Intermediate Result number 1, Increased use of effective family planning (FP) and reproductive health (RH) services under DO3. Expanded access to and use of family planning services resulting from MHII efforts should measurably contribute to increasing CPR and mCPR with an increased share of LAPM methods.
As illustrated in the Results Framework (Figure 1), the MHII Project is implemented through three sub intermediate results (IR).

- **Sub-IR 1**: Effective and high quality FP services delivered nationwide includes capacity building and actual service delivery,
- **Sub-IR 2**: Behavior change, communications, and community strategies increase the demand for FP services, especially LARCs and PMs. This refers to demand generation and community interventions.
- **Sub-IR 3**: Supportive enabling environment advances access to LARCs, PMs, and other FP/RH services and includes policy advocacy efforts.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

The project has been implemented in phase’s manner. So, at the end of the project will have has national coverage of all 64 districts. By the end of PY2, MH-II will cover 48 districts.

**IX. SCOPE OF WORK**

**A. Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)?

Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.
The purpose of the MH-II Project performance evaluation is to assess the performance status of the project and provide suggestions to the USAID/Bangladesh Mission for its improved implementation and for the design and implementation of future family planning projects.

The performance evaluation will assess the achievements, results compared to expectations, relevance and sustainability of the project activities to date. The evaluation results will inform USAID, the GoB and other relevant stakeholders how the project technical assistance can best be used to maximize family planning results in this project.

The evaluation should include recommendations on possible options for USAID in adopting the MH-II Project model of capacity building, demand generation, policy advocacy and service delivery to support the national family planning program.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The audience for this mid-term performance evaluation includes USAID/Bangladesh, the Global Health Bureau, the Asia Bureau, the GOB, relevant implementing partners and sub-grantees, local NGOs, and other bi-lateral and multi-lateral donors working for health and family planning. Other stakeholders include the MH-II Project management team and technical teams.

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

USAID intends to use the assessment findings as part of the evidence base for the design of a follow on project. Any procurement sensitive recommendations should, therefore, not be made public. However, the findings and programmatic aspects of the assessment recommendations will be shared with EngenderHealth and its partners to improve its activities and performance for the rest of the project period. Therefore, the assessment team should prepare both public and Sensitive But Unclassified (SBU) versions of the report (or the SBU section may be a separate, clearly marked, section in the report). USAID intends to arrange broader dissemination of the evaluation through a presentation to stakeholders via seminars and public websites. Such dissemination will help a broader range of stakeholders, including the GOB and donor partners, to collaborate on needed family planning support, including strategy development and project design and implementation.

D. **Evaluation questions:** Evaluation questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. USAID policy suggests 3 to 5 evaluation questions.

**Evaluation Questions**

For each question below, as appropriate, include:
- Best practices and successes
- Challenges, barriers and lessons learned
1. How effectively has Mayer Hashi contributed to increasing the utilization of long acting and permanent method (LAPM) services in GOB/NGO/Private facilities?

2. The predecessor project included training of service providers as an activity to improve access to quality of FP services to result in increased family planning use, especially of LARCs and PMs. The project evaluation determined that only training did not improve access to quality FP service delivery, and did not result in increased family planning use. This project proposed using a more comprehensive combined approach to training that included following up with the trained staff.

   Did the new approach improve the delivery of quality FP services, and if so, was consistent for all cadres (managers, physicians, FWVs, FWAs) and also for all facilities (government and private institutions)?

3. To minimize the service gaps, the MH-II Project introduced mobile teams to offer LAPMs in areas where either the MoHFW service providers were not available or where family planning service provision presented difficult challenges.

   To what extent did this intervention of mobile teams help increase the utilization of quality LAPM services, including how was it coordinated with GOB, private sector, and other NGO service providers, such as BRAC, and Marie Stopes?

4. The MH-II project engaged local national NGOs to improve LAPM information dissemination to clients and to improve their referral network to local facilities which provided the LAPMs.

   To what extent was this intervention successful in informing and engaging community people on LAPM and also establishing community facility linkage?

5. To what extent has the MHII project support been successful in working with public (DGHS, DGFP), private and NGO facilities to strengthen Post-Partum Family Planning (PPFP) services.

6. The MH-II project was to help in identifying and adapting policies, strategies, regulations and/or guidelines of the MoHFW to improve access to and use of quality LAPM services.

   What kind of impact did these policy change produce in the service environment in terms of LAPM utilization? Whether these policy changes brought any visible pushes among public, private and NGO providers?

Other Questions[OPTIONAL]
(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

E. Methods: Check and describe the recommended methods for this analytic activity.

   Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

   To get the better result this assessment will use either qualitative, quantitative method or adopts mixed method (combination methods). Moreover, KIIs GIs, RAMs and FGDs would be conducted to get more information about the assessment on key success, challenges, new interventions and areas of improvement etc. from key/selected stakeholders. Following methods will be used to collect data mentioned below

   It is assumed that the Team will split into two sub-teams for data collections.
**Document and Data Review** *(list of documents recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- Mayer Hashi II (MH-II) proposal Statement of Work(s)
- MH-II Project M&E Plan
- MH-II Quarterly and Annual Progress Reports
- MH-II BCC Strategy
- MH-II Indicator Performance Tracking Table (IPTT)
- BCC materials produced by the Project
- MH-II Training manuals
- MH-II Training follow-up plan
- MH-II Facility Assessment (Audit) data/reports
- CDCS
- PAD
- Bangladesh Multiple Indicator Cluster Surveys 2012-13, 2006 ([http://mics.unicef.org/surveys](http://mics.unicef.org/surveys))
- HPNSDP Mid-Term Assessment (2013)
- Current Five Year Plan of UNFPA
- National PPFP strategy and plan of action, road map
- Current Five Year Plan of DFID

**Secondary analysis of existing data** *(list the data source and recommended analyses)*

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGFP</td>
<td>Service data from DGFP</td>
<td>Trend analysis</td>
</tr>
</tbody>
</table>

**Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

KIIs will be conducted with key stakeholders. Purpose is to assess the effectiveness of MH-II support, the extent of collaborative and cooperative efforts pursued by MH-II. Key informants will be selected from among the following. The final list if informants to be interviewed will be finalized in consultation with the USAID/Bangladesh Health Office.

- MH II staff and implementing partners: SMC, OGSB, RTM, BRAC, YPSA, and Shushilon
- MaMoni-HSS, BKMI, and NHSDP staff (COP, Technical Advisors, BCC advisor)
- Government of Bangladesh, Ministry of Health and Family Welfare counterparts, Directorate General of Health Services (DGHS) and Directorate General of Family Planning, (DGFP), Directorate General of Management Information Systems (DGMIS),
**Focus Group Discussions** *(list categories of groups and purpose of inquiry)*

a) The assessment team may elect to conduct FGDs with service providers of GOB, NGOs and private sectors, to know how the capacity building efforts of MH-II helped them, what were the gaps, did the policy changes helped them. The service provider groups can be in several groups such as service providers at district and Upazila level and service providers at union level.

b) FGD will be conducted among community support groups, local representatives of union parishad to determine how they find community involvement and information dissemination at the community to be effective.

**Group Interviews** *(list categories of groups and purpose of inquiry)*

The assessment team may elect to conduct few group interviews with government policy makers to know whether they agree that the policy changes advocated by this project helped them or not and also to know how did this project helped in Quality Improvement as well as improving access to FP services.

Other of the key informant interviews can also be clustered in a group, as long as there are no power differentials, and all respondents feel comfortable in voicing their opinions within the group. (See list and description above under KII.)

**Client/Participant Satisfaction or Exit Interviews** *(list who is to be interviewed, and purpose of inquiry)*

Using a semi-structured questionnaire, exit interviews may be conducted with FP clients during site visits LAPM clients to determine if they were they counselled properly, if the counseling included comprehensive and correct FP information, including LAPMs, and if the provider obtained their consent.

**Observations** *(list types of sites or activities to be observed, and purpose of inquiry)*

The assessment team will observe selected clinics under MH-II interventions during site visits, to observe FP counseling, to observe FP counseling that includes LAPMS and actual service provision at GOB (Family welfare centers, Upazila Health Complexes, and District hospitals), NGOs and Private sectors. During these visits the Team can also observe the accuracy of the Facility Audits (assessments) from MH-II.

**Rapid Appraisal Methods** *(ethnographic / participatory)* *(list and describe methods, target participants, and purpose of inquiry)*

The assessment team will also use RAMs to obtain quick information from local populations (FP non users, long-term injectable users) to know about their unmet need and how it could be addressed by developing appropriate interventions.
X. HUMAN SUBJECT PROTECTION

The Evaluation Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interviews data, or a descriptive analysis of quantitative survey data.

The evaluation team will analyze the information collected to establish credible answers to the questions and define major trends and issues in the Project. This will require a thematic analysis of qualitative data, validated by trends of project-produced quantitative data and the data produced by the DGFP. The evaluation must collect and include gender disaggregated data in the analysis of findings and conclusions and in making recommendations.

Methodological limitations and challenges for this evaluation are expected to include:
- Ensuring adequate representation of interview and rapid appraisal sources vis-à-vis the full scope of MH II activities and outcomes; and
- Taking systematic actions to counter any biases in (a) reporting by data collection sources and (b) interpretations of collected data by the evaluation team.

The methodology narrative should discuss the merits and limitations of the final evaluation methodology. The evaluation team will design appropriate tools for collecting data from various units of analysis. The tools will be shared with USAID during the evaluation and as part of the evaluation report.

XII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Document and Data Review
Prior to arrival in country, the team will review key documents on Bangladesh for context (DHS, Facility Survey, HPNSDP Mid-term Report, and National Population Policy). The team will also review program documents, including the technical proposal, annual work plans and annual reports, technical and training materials, and the evaluation reports. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation. The Mission will provide all of the documents.

Evaluation Launch Phone Call
After beginning document review, the evaluation team will conduct a planning phone call with the Mission. This launch call between USAID/Bangladesh, GH Pro and the Team Lead is meant to initiate the evaluation activity and review expectations. The Mission will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review travel schedule.

**Team Planning Meeting (TPM)**

The evaluation team will conduct a 4-day team planning meeting (TPM) upon arrival in Bangladesh and before starting the data collection portion of the evaluation. The Team during the TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID’s approval
- Develop a preliminary draft outline of the team’s report
- Assign drafting/writing responsibilities for the final report

The TPM outcomes will be shared with USAID/Bangladesh and various members of the OPHNE team will participate in sections of the TPM. Discussions will also be held with other USAID offices such as OFDHA, DG and EG.

**Briefings:**

- **In-brief with USAID:** The full evaluation team will conduct an in-brief with USAID/Bangladesh as part of the TPM. This briefing will be broken into two meetings: a) at the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations and intended plans; and b) at the end of the TPM when the Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **In-brief with Mayer Hashi** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- **The Team Lead (TL) will brief the USAID weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

- **Out-brief with USAID:** The Evaluation Team meet with USAID/Bangladesh at the end of their in-country evaluation work, before leaving Bangladesh and prior to preparing the draft final report, to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a PowerPoint Presentation that summarizes findings, conclusions and recommendations will be prepared and distributed during the debriefing. USAID will provide feedback during the briefing meeting, and debriefing(s). The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation
Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Stakeholders’ Meeting
The evaluation team will conduct a stakeholders (USAID and MH-II) meeting prior to departing country to share and ground truth top-line results (excluding any that are procurement sensitive).

Evaluation Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:
1. An annotated outline of the Report will be submitted to USAID and GH Pro for review by the end of the TPM
2. Using the outlined reviewed by USAID/Bangladesh and GH Pro, the Team Lead will submit draft evaluation report to GH Pro for review and formatting
3. GH Pro will submit the draft report to USAID
4. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
5. GH Pro will share USAID’s comments and edits with the Team Lead who will work with his/her team to do final edits, as needed. This final draft of the report will address the comments provided by USAID/Bangladesh. The Team Lead will submit the revised report to GH Pro
6. GH Pro will review and reformat the final Evaluation Report, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved by USAD/Bangladesh, GH Pro will copy edit and re-format the report. Once this is approved by USAID, GH Pro will have the report edited for 508 compliance and post it to the DEC.

The Evaluation Report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

### XIII. DELIVERABLES AND PRODUCTS
Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch briefing</td>
<td>February 29, 2016</td>
</tr>
<tr>
<td>In-brief with Mission</td>
<td>March 20 and 24, 2016</td>
</tr>
<tr>
<td>Team Planning Meeting</td>
<td>March 20-24, 2016</td>
</tr>
<tr>
<td>In-brief with Mayer Hashi II</td>
<td>March 27, 2016</td>
</tr>
<tr>
<td>Work plan, Evaluation Protocol and data collection tools due</td>
<td>March 27, 2016</td>
</tr>
<tr>
<td>Annotated Report Outline</td>
<td>March 28, 2016</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
</tbody>
</table>
Debrief with Mission with Power Point presentation | April 24, 2016
---|---
Findings review workshop with stakeholders with Power Point presentation | April 25, 2016
Draft report | Submit to GH Pro: May 11, 2016
GH Pro Submits to Mission: May 16, 2016
Final report | Submit to GH Pro: June 6, 2016
GH Pro Submits to Mission: June 9, 2016
Raw data | June 9, 2016
Report Posted to the DEC | July 15, 2016
Other (specify): |

**Estimated USAID review time**
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

**XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)**

**Evaluation team:** When planning this analytic activity, consider:
- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.
- Team should include at least one national expert.

**Team Qualifications:** Please list technical areas of expertise required for this activities

The Evaluation Team will consist of up to 4 members including a Team Leader and a Logistics/Administrative Assistant. The team members should represent strong knowledge related to family planning service delivery in Bangladesh, capacity building, quality of care, behavior change and demand creation. In addition to technical members, the team will have a host country national to provide administrative and logistics support.

The technical team members must all have significant international health program and evaluation experience. They should have some Bangladesh country or Asian regional experience, along with comparative experience in MCH-FP service delivery in other countries or regions of the world. At least two members of the technical experts must have Bangladesh experience, speak Bangla, and be familiar with the MCH-FP service delivery structure in public and private facilities. Demand creation is one of the key component of this project like for LARC and reaching to unreached, so a BCC expert is needed. The logistic/support person should have basic knowledge about interview techniques and be able to provide translation
services to other team members. All team members must have professional-level English speaking and writing skills.

**Key Staff 1: Team Leader**
This is an international consultant who has significant experience conducting project evaluations. The Team Leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other members of the team. The Team Leader will work with his/her Team on all aspects of the evaluation, but will be responsible for the development tools for the evaluation and a design of the workplan, and communications with USAID/Bangladesh for needed approvals on these deliverables. The Team Leader will develop the outline for the draft report, write the report by synthesizing inputs for other Team member and after USAID/Bangladesh review edit the report, and submit the final report to GH Pro and USAID/Bangladesh within the prescribed timeline.

**Skills/Experience:** The Team Leader should have:
- Advanced degree in health management, public health or related field
- At least 10 years working experience in the field of international health;
- Knowledge of health systems and health issues in Bangladesh;
- A good understanding of USAID project evaluation;
- At least 10 years of experience in conducting/leading evaluations in the health sector; preferably with USAID evaluations
- Program planning, and assessment/evaluation experience;
- Experience leading a team for international health program evaluations or related assignments; and
- Excellent writing, communication, and presentation skills

In addition to the technical responsibilities outlined in the scope of work for the assignment, team leader responsibilities include:

**Preparations**
- Finalize and negotiate with USAID/Bangladesh the evaluation workplan
- Establish assignment roles, responsibilities, and tasks for each team member
- Ensure that the logistics arrangements in the field are complete

**Management**
- Facilitate the Team Planning Meeting to set the agenda and plan the evaluation
- Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report
- Manage the process of report writing
- Manage team coordination meetings in the field
- Coordinate the workflow and tasks and ensure that team members are working to schedule
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.)

**Communications**
- Handle conflict within the team
• Serve as primary interface with the client and serve as the spokesperson for the team, as required.
• Debrief the client as the assignment progresses, and organize a final debriefing
• Keep the GH Pro HQ staff apprised of progress challenges, work changes, team travel plans in the field, and report preparation via phone conversation or email at least once a week
• Serve as primary interface with GH Pro in submission of draft and final reports/deliverables to GH Pro.
• Make decisions about the safety and security of the team in consultation with the client and GH Pro HQ.

Direction
• Assume technical direction lead as required in order to ensure quality and appropriateness of assignment and report content.

Key Staff 2: Family Planning Specialist (national/expat): 1
This consultant will provide expertise in all aspects of family planning (FP) service provision. A major thrust of Mayer Hashi-II is related to improved access to family planning services through GOB, NGO and private sectors. Given the GOB and USG interest in repositioning population as a development issue and revitalizing family planning, this Specialist will look at how this project has met expectations and can boost the stagnating FP performance in the next design. The Specialist will be able to effectively examine referral networks and links to other networks of service providers, including the private sector, BRAC, and GOB systems using project and system data.

Responsibilities: The FP Specialist will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. He/she will participate in presenting the report to USAID and other stakeholders, and be responsible for addressing pertinent FP comments from USAID/Bangladesh and other stakeholders. He/she will communicate with the Team Leader and other consultants to produce written notes to incorporate in the report as required addressing comments and feedbacks from USAID. He/she is required to make his/her contributions to the Team Leader within the timeline.

Qualifications:
• An advanced degree in public health or related field
• At least 10 years managing MCH/FP programs
• Experience in design and implementation of health and FP service delivery programs
• Able to analyze quantitative data, which will be primarily descriptive statistics
• Must have excellent data interpretation and presentation skills
• Good writing skills, with experience producing evaluation and/or technical reports
• Experience working in the region, and experience in Bangladesh is desirable

Key Staff 3: Marketing, Communication and Demand Creation Specialist (national/expat): 1
A consultant will have strong expertise in strategic communication, marketing and demand generation for FP services. This specialist will look at how the project has engaged
communities, and whether or not these activities have stimulated demand and/or resulted in increased service utilization. S/he will identify promising demand generation

Responsibilities: The consultant will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. He/she will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID Bangladesh or other stakeholders. He/she will communicate with the Team Leader and other consultants to produce written notes to incorporate in the report as required addressing comments and feedbacks from USAID. He/she is required to make his contributions to the Team Leader within the timeline.

Qualifications:
- An advanced degree in public health, evaluation or research or related field
- At least 10 years of experience working with marketing, communication and demand creation programs in developing country settings
- Experience in social marketing and demand generation for FP/RH and MCH services
- Experience and knowledgeable on evaluation methodologies related to marketing, communication, and demand creation
- Experience working in private sector health service delivery
- Experience working in the region, and experience in Bangladesh is desirable

Key Staff 4: Evaluation Specialist (national/expat): 1

The consultant will provide quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, and data analysis to report writing.

Responsibilities: The consultant will participate in team meetings, key informant interviews, group meetings, site visits, and contribute in drafting the sections of the report relevant to his/her expertise and role in the team. He/she will also participate in presenting the report to USAID or other stakeholders and be responsible for addressing pertinent comments provided by USAID Bangladesh or other stakeholders. He/she will communicate with the Team Leader and other consultants to produce written notes to incorporate in the report as required addressing comments and feedbacks from USAID. He/she is required to make his contributions to the Team Leader within the timeline.

Qualifications:
- At least 10 years in conducting evaluations as a lead or co evaluator
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in developing qualitative and quantitative evaluation tools
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Able to analyze qualitative data
• Experience using analytic software
• Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
• Must have excellent data interpretation and presentation skills
• An advanced degree in public health, evaluation or research or related field
• Good writing skills, with experience producing evaluation and/or technical reports
• Familiarity with USAID policies and practices
  – Evaluation policy
  – Results frameworks
  – Performance monitoring plans
• Experience working in the region, and experience in Bangladesh is desirable

**Other Staff**

**Logistics/Administrative Coordinator (National): 1**
GH Pro will recruit a local logistics/administrative coordinator to support the team in all aspects of their work for carrying out this assignment. This includes making provision for workspace, copying, internet, local transport, including any travel outside of the capital, and meeting rooms as needed for the teams’ internal consultations. The administrative coordinator will have a good command of English in writing and verbally, as well as Bangla. S/he will have knowledge of key actors in the health sector and locations including GOB, donors and other stakeholders including the private sector partners. S/he will be able to efficiently liaise with hotel staff, arrange car rentals through using approved mission or hotel cars and ensure cell phones, business center support, e.g. copying, internet, and meeting space is available for the team. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings including roundtable meetings, travel outside of Dhaka and ensuring note taking at required meetings. S/he will conduct administrative and support tasks as assigned and ensure the process moves forward smoothly. S/he will be attentive to team requirements and anticipate needs for computers, AV equipment or other last minute requests as required. S/he will report to the Team Lead and liaise directly with GH PRO as required to satisfactorily complete assignments for support the team.

**Local Evaluators: 2**
Local Evaluators will assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with FP and other related health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and Bangla. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:
☐ No

**Staffing Level of Effort (LOE) Matrix:**
This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

### Level of Effort in days for each Evaluation/Analytic Team member

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation Team</th>
<th>Number of persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team Leader</td>
<td>FP/RH Specialist</td>
</tr>
<tr>
<td>Launch Briefing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Desk review</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Preparation for Team convening in-country</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Travel to country</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Team Planning Meeting</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>In-brief with Mission PHNE team members</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>In-brief with Mayer Hashi team</td>
<td>7</td>
<td>0.5</td>
</tr>
<tr>
<td>Data Collection DQA Workshop (protocol orientation for all involved in data collection)</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Prep / Logistics for Site Visits</td>
<td>9</td>
<td>0.5</td>
</tr>
<tr>
<td>Data collection / Site Visits (including travel to sites)</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Data analysis</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Debrief with Mission with prep</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Stakeholder debrief workshop with prep</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Depart country</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Draft report(s)</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>GH Pro Report QC Review &amp; Formatting</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Submission of draft report(s) to Mission</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>USAID Report Review</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Revise report (s) per USAID comments</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Activity / Deliverable</td>
<td>Evaluation Team</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team Leader</td>
<td>FP/RH Specialist</td>
</tr>
<tr>
<td></td>
<td>Number of persons</td>
<td>1 1 1 1 1 1 2</td>
</tr>
<tr>
<td>20 Finalize and submit report to USAID</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>21 508 Compliance Review</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>22 Upload assessment/Evaluation Report(s) to the DEC</td>
<td>1 1 1 1 1 1 2</td>
<td></td>
</tr>
<tr>
<td>Sub-Total LOE</td>
<td>49 46 46 46 31 31</td>
<td></td>
</tr>
<tr>
<td>Total LOE (280 person-days)</td>
<td>49 46 46 46 31 62</td>
<td></td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted? Yes ☐ No ☐

**Travel anticipated:** List international and local travel anticipated by what team members.

All team members will be expected to travel to at least 4 to 5 sites outside Dhaka districts.

**XV. LOGISTICS**

*Note:* Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ **USAID Facility Access**

Specify who will require Facility Access:

☐ **Electronic County Clearance (ECC)** (International travelers only)

☐ **GH Pro workspace**

Specify who will require workspace at GH Pro:

☐ **Travel -other than posting** (specify):

☐ **Other** (specify):

**XVI. GH PRO ROLES AND RESPONSIBILITIES**

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.
XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

**USAID Roles and Responsibilities**

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

### Before Field Work

- **SOW.**
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- **Consultant Conflict of Interest (COI).** To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- **Documents.** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- **Local Consultants.** Assist with identification of potential local consultants, including contact information.
- **Site Visit Preparations.** Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- **Lodgings and Travel.** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

### During Field Work

- **Mission Point of Contact.** Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work.
- **Meeting Space.** Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- **Meeting Arrangements.** Assist the team in arranging and coordinating meetings with stakeholders.
- **Facilitate Contact with Implementing Partners.** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

### After Field Work

- **Timely Reviews.** Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)
**REPORTING REQUIREMENTS/GUIDELINES:** The format of the Evaluation Report should strike a balance between depth and length. The draft report should be a comprehensive analytical evidence-based evaluation report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will include a table of contents, table of figures (as appropriate), acronyms, executive summary, introduction, purpose of the evaluation, research design and methodology, findings, conclusions, lessons learned and recommendations. Where appropriate, the evaluation should utilize tables, graphs and maps, and link with data and other relevant information. The report should include, in the annex, any “Statement of Differences” by any team member or by USAID on any of the findings or recommendations. The report will be in English and **should not exceed 30 pages**, excluding Executive Summary, Table of Contents and Annexes. The Evaluation Report should **exclude any potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report. The report will be submitted electronically. The report format should be restricted to Microsoft products and 12-point type font should be used throughout the body of the report, with page margins one inch top/bottom and left/right. Once approved by USAID, GH Pro will post the Evaluation Report to the Development Experience Clearinghouse (DEC) for dissemination among implementing partners, stakeholders, and the general public. The DEC submission must be within three months of USAID’s approval of the final report. The report will be **edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.**

In addition to the Evaluation Report, any procurement sensitive information will be separated from the final report and be included in an Internal Strategy Recommendation Memo that will be submitted USAID/Bangladesh, and not for public distribution.

Discussions and recommendations related to MH-II performance can be made publicly available, matters related to MH-II management can be shared with USAID and MH-II, but matters related to future directions can be shared with USAID only.

The **Evaluation Final Report** must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report must not exceed 40 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

**Reporting Contents:** The total pages, excluding references and annexes, should not be more than 30 pages. The following content (and suggested length) should be included in the report:

**Report Outline:**
Table of Contents (1 page)
Acknowledgements (1 page)
Acronyms and Abbreviations (2 page)
Glossary of terminologies used in the report (2 page)
Executive Summary - concisely state the project purpose and background, key evaluation questions, methods, most salient findings and recommendations (2-3 pp.);
1. Introduction – country context, including a summary of any relevant history, etc. (1 pp.);
2. The Development Problem and USAID’s Response - brief overview of the development problem and USAID’s strategic response, including design and implementation of the NHSDP program and any previous USAID activities implemented in response to the problem, (2-3 pp.);
3. Purpose of the Evaluation - purpose, audience, and synopsis of task (1 pp.);
4. Evaluation Methodology – detailed describe evaluation methods, including strengths, constraints and gaps (1 pp.);
5. Findings and Conclusions - describe and analyze findings for each evaluation question using graphs, figures and tables, as applicable, and also include data quality and reporting system that should present verification of spot checks, issues, and outcomes Conclusions should be credible and should be supported by the findings (12-15 pp.);
6. Lessons Learned - provide a brief of key technical and/or administrative lessons on what has worked, not worked, and why for future project or relevant program designs (2-3 pp.);
7. Recommendations – prioritized for each evaluation question; should be separate from conclusions and be supported by clearly defined set of findings and conclusions. Include recommendations for future project implementation or relevant program designs and synergies with other USAID projects and other donor interventions as appropriate (3-4 pp.);
8. References -to include bibliographical documentation, meetings, interviews and focus group discussions;
9. Annexes – to include statement of work, documents reviewed, bibliographical documentation, evaluation methods, data generated from the evaluation, tools used, interview lists, meetings, focus group discussions, surveys, and tables. The Evaluation Design Matrix must be presented as an annex to the report. Annexes should be succinct, pertinent and readable. They should also include, if necessary, a statement of differences regarding significant unresolved difference of opinion by funders, implementers, or members of the evaluation team on any of the findings or recommendations. Summary of annexes are given below:
   • Annex I: Evaluation Statement of Work
   • Annex II: Budget
   • Annex III: Evaluation Methods and Limitations
   • Annex IV: Data Collection Instruments
   • Annex V: Sources of Information
     o List of Persons Interviews
     o Bibliography of Documents Reviewed
     o Databases
   • Annex VI: Disclosure of Any Conflicts of Interest
   • Annex VII: Statement of Differences [if applicable]
## XIX. USAID CONTACTS

<table>
<thead>
<tr>
<th></th>
<th>Primary Contact</th>
<th>Alternate Contact</th>
<th>Alternate Contact (POC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td>Samina Choudhury</td>
<td>Brenda Doe</td>
<td>Ferdousi Begum</td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td>Project Management Specialist</td>
<td>Family Planning Advisor</td>
<td>Project Management Specialist</td>
</tr>
<tr>
<td><strong>USAID Office/Mission</strong></td>
<td>Bangladesh/OPHNE</td>
<td>Bangladesh/OPHNE</td>
<td>Bangladesh/OPHNE</td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td><a href="mailto:schoudhury@usaid.gov">schoudhury@usaid.gov</a></td>
<td><a href="mailto:bdoe@usaid.gov">bdoe@usaid.gov</a></td>
<td><a href="mailto:fbegum@usaid.gov">fbegum@usaid.gov</a></td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>+88-02 5566-2560</td>
<td>+880-2-5566-2658</td>
<td></td>
</tr>
<tr>
<td><strong>Cell Phone</strong> (optional)</td>
<td>01711181297</td>
<td></td>
<td>+8801755637029</td>
</tr>
</tbody>
</table>

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

<table>
<thead>
<tr>
<th></th>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Title:</strong></td>
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<td><strong>USAID Office/Mission</strong></td>
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<td><strong>Email:</strong></td>
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<td><strong>Telephone:</strong></td>
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</tr>
<tr>
<td><strong>Cell Phone</strong> (optional)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## XX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

- National Action Plan of Action for Post-preterm family Planning, Bangladesh
ANNEX B: LIST OF DOCUMENTS REVIEWED

**Mayer Hashi Evaluation Reports**
- Mid-term Evaluation of Mayer Hashi Program – June 2012

**Mayer Hashi II Annual Reports**
- Year 1 Annual Report, Oct 2013-Sept 2014
- Project Year1 Quarter 1 Report, 01 Oct-31 Dec 2013
- Project Year1 Quarter 3 Report, 01 April-30 June 2014
- Project Year1 Quarter 4 Report, 01 July-30 Sept 2014
- Project Year2 Quarter 1 Report, 01 Oct-31 Dec 2014
- Project Year2 Quarter 2 Report, 01 Jan-31 March 2015
- Project Year2 Quarter 3 Report, 01 April-30 June 2015
- Project Year2 Quarter 4 Report, 01 July-30 Sept 2015
- Project Year3 Quarter 1 Report, 01 Oct-31 Dec 2015

**Mayer Hashi II Agreement, Strategies, Workplans, and Manuals**
- MH-II Agreement Statement of Work(s)
- MH-II Monitoring and Evaluation Plan, Oct 2013-Sept 2017
- MH-II Strategic Communication Plan, Oct 2013-Sept 2017
- Year2 Workplan, Oct 2014-Sept 2015
- MH-II Organizational Chart
- MH-II Training manuals
- MH-II BCC materials
- MH-II Training follow-up plan
- MH-II Indicator Performance Tracking Table (IPTT)
- BCC materials produced by the Project
- MH-II Facility Assessment (Audit) data/reports

**National Documents**
- Bangladesh Demographic and Health Survey (BDHS) 2014
- Bangladesh Demographic and Health Survey (BDHS) 2014 – Three Qualitative Studies
- Bangladesh Urban Health Survey, 2013
- Bangladesh Health Facility Survey, 2014
- Bangladesh Multiple Indicator Cluster Surveys 2012-13, 2006
- National Postpartum Family Planning Strategy and Plan of Action
- Comprehensive Social and Behavior Change Communication Strategy, Ministry of Health and Family Welfare (DRAFT)
UNFPA
Current Five Year Plan of UNFPA

Department for International Development
Operational Plan 2011-2016 (updated Dec 2014)

Others
WHO Chart – Medical Eligibility Criteria
Bringing Long-Acting Reversible and Permanent Contraceptives and Services Closer to
Client – Innovative Approaches – USAID, PSI, Marie Stopes and Respond Project - 2013
Menstrual Regulation and Induced Abortion in Bangladesh, Fact Sheet, Guttmacher
Institute, September 2012
ANNEX C: LIST OF PERSONS CONTACTED

USAID/BANGLADESH
Brenda Doe, Senior Family Planning Advisor, OPHNE
Kanta Jamil, Results Monitoring and Evaluation Advisor, OPHNE
Samina Choudhury, Project Management Specialist, OPHNE
Ferdousi Begum, Clinical Service Lead, OPHNE
Sukumar Sarker, Senior Technical and Policy Advisor, OPHNE
Umme Salma Jahan Meena, Team Leader, HSS, OPHNE
Farheen L Khurrum, Senior Monitoring & Evaluation Specialist, Program Office
Motasim Billah, Project Management Assistant, M&E- Program Office

DIRECTORATE GENERAL OF FAMILY PLANNING, MOH&FW
Mohamed Sharif, Director MCH & Line Director – MCRAH
Moinuddin Ahmed, Line Director-Clinical Contraception & Service Delivery Program
Zakia Sultana, Deputy Director & PM – IEM
Shamsul Karim, Program Manager, Field Services Unit
Fahmida Sultana, Deputy Director of Services
Delawar Hossain, Divisional Director, Family Planning
Mirza Kamrun Nahar, Deputy Director of FP, Dhaka Division

Directorate General of Health Services, MOH&FW
Habib Abdullah Sohel, Director, Primary Health Care & LD MNC&AH
Azizul Alim, Deputy Program Manager, Emergency Obstetric Care

MAYER HASHI-II
Abu Jamil Faisel, Country Representative, Engender Health, and Project Director, MH-II
A F M Nazmul Alam, Senior Program Officer
Mizanur Rahman, Capacity Building Advisor
S.M Nizamul Haque, Program Manager
Fatema Shabnam, Program Manager
Shahana Rahman, Program Manager
Liaquat Ali, Program Manager, Monitoring and Data Management
Bikash Chandra Barman, Senior Program Officer
Azmal Hossain, Program Manager, Policy Advocacy
Shahid Hossain, BCC Advisor
Mezanur Rahman, IT Officer
Shushanto Shekhar Roy, Program Officer
Khondoker Abu Jafar Saleh, Program Officer
Salah Uddin Masum, Program Officer
Waliul Islam, Program Officer
UNFPA
Loshan N. Moonesinghe, Family Planning Specialist

BGMEA
Zaglul Hayder, Administrator and Head of Human Resources, Dhaka
Sharmina Jahan, Assistant Secretary

BKMI
Zeenat Sultana, Deputy Project Director, BKMI & Deputy Director of BCCP

SMC
Ashfaq Rahman, Managing Director & CEO
Toslim Uddin Khan, General Manager
Salah Uddin Ahmed, Head of Training & Service Delivery
Moshiur Rahman, Program Manager, Research & ME

POPULATIONCOUNCIL
Ubaidur Rob, Country Director
Sharif Mohammed Ismail Hossain, M&E Advisor

MARIESTOPESINTERNATIONAL
Reena Yeasmin, Country Representative

SIAPS
Zahedul Islam, Country Project Director
Mohammed Golam Kibria, Senior Technical Advisor
Abdullah, Senior Technical Advisor, Logistics

RTMI
Ahmed Al Kabir, President, Dhaka
Ashraf Ali, Project Coordinator-MSDCT, Dhaka
Nasrin Akhter Monika, Field Coordinator & Program Officer, Cox's Bazaar

OGSB
Rowshan Ara, President, OGSB, Dhaka
Farhana Dewan, General Secretary, OGSB, Dhaka
Jobayer Faruque, trainer, OGSB RH&FP Training Centre, Dhaka
Sirajul Islam, Admin & Finance, OGSB RH&FP Training Centre, Dhaka

BRAC
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Ariful Alam, Program Coordinator Health, Dhaka

NHSDP
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Sailkul Islam Helal, Policy & Coordination Advisor
Roushon Ara Begam, Maternal Health Advisor

**AD-DIN MEDICAL COLLEGE HOSPITAL**
Tariqul Islam Director, MC Hospital
Nahid Yasmin, Deputy Director Addin

**COX’ S BAZAAR**
Amir Hossen, Deputy Director, Family Planning
Nazmul Hasan, Family Planning Officer, Sadar
Bidhan Kanti Rudra, Pekula Upazila Family Planning Officer
Alamgir Hossain Sarker, Clinical MO
Lucky Akter, Female Medical Attendant
Baby Mallik, Paramedic
Daisy Chakraborty, Paramedic
Romana, Paramedic
Rowshon Ferhana, FWV
Sadir Prava Das, FWV
Jahan Akther, FWV
Fatema Akter Daisy, FWV
Disu Pal, FWV

**NHSDP, COX’ s BAZAAR**
Isha, Clinic Manager
Samir Das, Sr. Medical Officer
Shakera Begum, Paramedic
Musa Chawdhury, Admin Assistant

**COMMUNITY CLINIC, UKHIYA, COX’S BAZAAR**
Mridul Kanti Acharjee, Ukhia Upazila Family Planning Officer
Mohsina Sharmeen, Community Health Care Provider
Miheer Barua, Family Planning Inspector

**PM-KHALI, FWC, COX’ S BAZAAR**
Rahimullah, FP Inspector
Jesmine Sultana, FWV
Shikha Rani, FWV
Humaira Khanum, FWV
Masu Rani Majumder, FWA
Jahan Akther, FWA

**CHITTAGONG**
Sheikh Rakun Uddin Ahmed, Deputy Director, Family Planning

**MAMATA MATERNITY HOSPITAL, CTG**
Ershadul M.M, Administrator
MID-TERM PERFORMANCE EVALUATION OF THE MAYER HASHI FAMILY PLANNING PROJECT (MH-II)

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Mohammad Habibullah, Consultant

SHAKPURAUH&FWC, BOALKHALI, CTG
Bishawjit, SACMO
Amrita Rani Dev, FWV
Hanif Uddin, District FP Coordinator, BRAC
Baby Naznin, Health Worker, BRAC
Kohinoor Akter, Volunteer, BRAC

CHATTAGRAMMAA-SHISHU O GENERAL HOSPITAL, CTG
Nurul Haque, Administrative Director
Sabina Yeasmin, Assistant Professor

YPSA, CTG
Mahbubur Rahman, Director, Social Development Program
Shahidul Islam, Project Coordinator
Fate Maldris, Program Officer
Shaheen Akter, RH Service Promotion Officer

CLIFTON COTTON MILLS, LTD, CTG
Kutubuddin Ahamad Chowdhury, Administrator
Syed Noor Talukder, Human Resources

KHULNA
Guru Proshad Ghosh, Deputy Director, Family Planning
Dilara Islam, UFPO, Rupsha FP Office
Nazma Akhter, Assistant UFPO, Rupsha FP Office
Prova Bairagi, MO-MCH&FP, Rupsha UHC
Uday Baran Mondol, UH&FPO, Rupsha UHC
Meherunnessa FWV, Sreefaltala UFWC
Shamsul Ahsan, DA, MO-MCH &FP, MCWC
Rowshan Ara, MO- Clinic, MCWC
Feroza Begum, FWV, MCWC
Mahmuda Khatun, FWV, MCWC
Dil Rafaza Parvin, FWV UFWC
Setara Begum, Paramedic, Smiling Sun
Nanda Debi, SACMO, UFWC

SHUSHILAN, KHULNA
Mostafa Nuruzzaman, Chief Executive
Shaikh Mostafizur Rahman, Senior Program Officer
Abu Hasnat, Project Coordinator

GAZIPUR
Sanowar Hossain, Asst. Director, Clinical Contraception, District Family Planning Office
Fatema Dolon, Consultant, OBGYN, District Hospital
Syeda Siddiqua, Consultant, OBGYN, District Hospital

**KALIAKOIRUHC, GAZIPUR**
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Rowshan Ara, OB/GYN, MCWC
Mir Sajedur Rahman, UFPO
Hosne Ara Yasmin, FWV
Shebika Rani Das, Nursing Supervisor
Razia Begum, SSN
Bilkis Begum, SSN
Anwara Akter, SSN
Samena Khatun, SSN

**PSTCGAZIPUR**
Munmun Biswas, Medical Officer
Probir Kumar Das, Project Manager
Mahbubul Alam, Team Leader
Rozy Khatun, FWV

**MOUCHAKUH&WFC GAZIPUR**
Nasrin Akhter, FWV
Mokbul Hossain, SACMO & Community Leader of Union
Belal Hossain, Service Provider
Jahera Khatu, Union Member
Shefali Akter, Teacher

**BRACGAZIPUR**
Rezaul Molla, HNPP, Regional Manager
Amal Krishna, Manager, Branch Office
Abdullah Al Mamun, Program Organizer, Branch Office
Selina Akter, Paramedic, BRAC
Mirza Bani, Paramedic, BRAC
ANNEX D: FOCUS GROUP DISCUSSIONS
SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Users/Non-Users female</th>
<th>Users/Non-Users male</th>
<th>Service providers female</th>
<th>Service providers male</th>
<th>Community leaders female</th>
<th>Community leaders male</th>
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<tbody>
<tr>
<td>Khulna</td>
<td>19</td>
<td>1</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Chittagong</td>
<td>22</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>10</td>
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<td>19</td>
<td>1</td>
<td>9</td>
<td>0</td>
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<td>7</td>
</tr>
<tr>
<td>Gazipur</td>
<td>16</td>
<td>0</td>
<td>8</td>
<td>2</td>
<td>not done</td>
<td>not done</td>
</tr>
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<td>76</td>
<td>2</td>
<td>36</td>
<td>2</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>38</td>
<td>22</td>
<td></td>
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<td>22</td>
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</table>

The assessment team conducted FGDs with a total of 78 users and non-users, 38 service providers, and 22 community leaders. FGDs were organized by MH-supported sites in each district. The assessment team attempted to hold separate FGDs for LAPM users and for non-users, however, in several instances it was found that participants in non-user FGDs were in fact users. For this reason, the data for users and non-users has been presented above in consolidated form. FDG composition for users, non-users and service providers was overwhelmingly female, but for community leaders, FGDs were overwhelmingly composed of men, with the exception of Khulna, in which the majority of FGD participants were female. In Gazipur, it was not possible to organize a FGD for community leaders, and in the place of a FGD for service providers, separate interviews were held.

Khulna Findings: Service providers at the FWA level reported reluctance to discuss side effects of LAPM due to lack of information. Self-reported high rates of illiteracy together with service provider reports of low literacy rate among clients meant that written pamphlets were not accessible to many women. FWVs have been trained in IUD insertion but have minimal practice inserting them. Among users and non-users, religion remains a barrier to accepting PM and IUD, and many women prefer traditional methods. Women reported that husband and mother in law opposition, and fear of side effects – especially for IUD – discouraged use of LAPM. Women who are satisfied with their method have not experienced any side effects. Direct person to person contact was found to be the most effective way of conveying information. NGO volunteers follow up 7 days after using the method and if necessary make joint visits with FWAs and provide referral to the HWFC as needed. Fear of disclosure of FP method, especially PM for both men and women, was reported. High acceptance of implant and injection was reported. The one NSV user – who was interviewed together with women users – reported satisfaction with the method and readiness to advocate for NSV in his community.

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9 According to BDHS 2014, 25% of ever married women never attended school and 18% haven’t completed primary school.
**Chittagong Findings:** A religious community leader reported that he started to discuss FP at Friday Prayers after reading a MH booklet for religious leaders. One male community leader expressed support for NSV arguing that it is less invasive than tubectomy. Service providers reported minimal opportunity to practice IUD insertion. There is a demand for refresher trainings, despite TOTs. YPSA has been coordinating well with private and NGO service providers and YPSA-supported interventions in garment factories are well received and have excellent coverage and referral networks. The YPSA-supported intervention in a private hospital is innovative and successful. Religious reasons, fear of side effects, and husbands' complaints were cited as reasons for low IUD uptake. Women had little knowledge about tubectomy and many were using injection – which they viewed as a gateway method to LAPM based on future satisfaction with injection.

**Cox's Bazaar Findings:** Cox's Bazaar was the only district in which there were no female members in the community leaders FGD. All community members were very positive about the RTMI mobile team, but one religious leader made a vigorous call for integrating primary health care services into mobile team activities, due to the absence of a doctor in the community and high unmet demand for primary health care services. Religious barriers to PM and IUD were reported in all FGDs, and fear of adverse health effects were cited as a barrier to IUD uptake. Limited attention to men in FP services was noted by community leaders and users and non-users, and was a source of concern. Lack of knowledge among government FWV about immediate PPFP methods and non-acceptance of any LAPM method as immediate PPFP was noted. FWVs reported that during training, most had no experience inserting IUD and were only trained to use a flipchart. Women users reported that their husbands would never accept NSV, and many complained about side effects of injection and IUD. Women using short-term and injection, who had 2 children or more, reported that they were planning to have more children. Non-users reported using traditional methods and had no desire to change.

**Gazipur Findings:** Service providers reported that they prefer the injectable method, because it is easy to administer. District level service providers under the DGFP structure reported virtually no contact with DGHS structures. Women users reported that they did not receive any information on FP during pregnancy – only after delivery. Women users reported that their husbands would never agree to NSV, although the women thought it is the best FP. Women using LARC reported that they prefer the method because they do not have to visit facilities often. Some women said IUD is best because it does not require an operation – like tubectomy, or any cut in the skin – like implant. Women reported that their preferred source of information is one to one contact with volunteers.
**ANNEX E: FACILITY OBSERVATION CHECK LIST SUMMARY**

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<thead>
<tr>
<th>Q #</th>
<th>ITEM</th>
<th>YES (numbers are referred to the name of the facility)</th>
<th>NO (numbers are referred to the name of the facility)</th>
<th>Comments/Observations – numbers are referred to the name of the clinics</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinic Signage (availability and visibility)</td>
<td>1 2 3 4 5 6 7 9 10 12 13 14</td>
<td>8 11</td>
<td>7: General not for family planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8: the unit receives around 15 clients/day – we arrived at</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11:30 nobody was there (women and men)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12: FP clinic inside private/charity hospital</td>
</tr>
</tbody>
</table>

1 Rubsha Complex – Khulna
2 FDSR Cox’s Bazaar
3 MCWC Cox’s Bazaar
4 PM Khali - FWC Cox’s Bazaar
5 Community Clinic on way to Ukhia
6 Ukhia UHC/RTMI (Camp)
7 PSTC Urban Health Clinic for MCH – Gazipur
8 FP Unit at the District Hospital Gazipur
9 Maternal and Child Health Center – Khulna
10 Srifuttala UNWC– Khulna
11 Kaliakoir Upazila Health Complex – Gazipur
12 Ma-O-Shishu Chittagong (NGO hospital)
13 Mamota – Chittagong (NGO Hospital)
14 Shakpura UH&FWC Boakhali – Chittagong
2. Counseling Room availability (private and assigned for counseling)  
   
<table>
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<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
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</table>
   | 2 7 9 1 0 1 1 1 3 | 1 3 4 5 6 8 1 4 | 7: good and private  
   | 8: counseling room has administration staff  
   | 1 1: no privacy |

3. Counseling Room visible signage and directions  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
</table>
   | 2 6 7 1 1 | 1 3 4 5 8 9 1 0 | 2: marked room  
   | 8: counseling room signage not noticed and in English |

4. LAPM displayed educational materials in the counseling room  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
</table>
   | 6 7 8 9 1 0 1 1 1 3 | 1 2 3 4 5 | 4: no counseling room  
   | 7: Many posters and materials but for EPI-ANC-danger signs displayed on the counseling table |

5. Availability of counseling aids (models-samples of the LAPM)  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
</table>
   | 1 3 6 7 8 9 1 0 1 1 1 3 | 2 5 | 4: not sure  
   | 8: Flip Chart |

6. Availability of giveaway materials on LAPM  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
</table>
   | 6 9 1 0 1 1 1 4 | 1 2 3 5 7 8 1 3 1 4 | 4: not sure  
   | 8: out of stock since a long time  
   | 1 1: only 8 leaflets remaining – last package a year back |

7. Availability of giveaway materials on PPFP  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 9</td>
<td>1 2 3 5 7 8 1 0 1 1 1 3 1 4</td>
<td>4: not sure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Availability of giveaway material on PAFP  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 1 0 1 1 1 3 1 4</td>
<td>4: not sure – don’t think so</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Waiting Area Availability (if No, please go to Q # 14)  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 1 0 1 1 1 3 1 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Availability of TV in the waiting area  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
</table>
   | 7 9 | 1 2 3 4 5 6 8 1 0 1 1 1 3 1 4 | 7: cable TV not for FP  
   | 9: not working |

11. If yes in Q10, is the TV working and displaying FP/RH information materials  
   
<table>
<thead>
<tr>
<th>Value</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Q1</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 4 5 6 7 9 1 0 1 1 1 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Female</td>
<td>Male</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Is there a special space for men in the waiting area (separated by screen from women)?</td>
<td>1 7</td>
<td>2 3 4 5 6 8 9 10 11 13 14</td>
<td>4: definitely not</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Are there men in the waiting area?</td>
<td>6 14</td>
<td>1 2 3 4 5 7 8 9 10 13 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Are there FP (specially for LAPM) materials displayed visible and clear in the health facility</td>
<td>1 3 4 7 8 9 10 11 13 14</td>
<td>25 6</td>
<td>3: Standard Tihart poster – no discussion of misconception</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4: standard poster</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11: only in FP clinic</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>If yes to Q14, what are the main messages on these materials (side effects – advantages/disadvantages – PPFP – PAFP – call to action – how it works – criteria for use – etc…)</td>
<td>1 6 7 8 9 10 11</td>
<td>2 4 5</td>
<td>1: Tihart poster</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2: not sure they read</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4: standard poster</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6: standard poster</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8: different methods – MH-II poster of LARCs/PMs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11: one poster says about advantages</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13: clinical messages</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do the available materials have specific messages that combat misconceptions related to different LAPM?</td>
<td>7 11</td>
<td>1 2 3 4 5 6 8 9 10 11 13</td>
<td>11: two booklets on Islamic issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13: no one has this</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Are there referral forms from community to clinics?</td>
<td>7 9 10 14</td>
<td>13 4 5 8 11 13</td>
<td>2: don’t know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6: n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7: given to the reception</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Sex of service provider (counselor)</td>
<td>Male 6</td>
<td>Female 1 2 3 4 5 6 7 8 10 11 13</td>
<td>5: CHCP and FWA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9: DK</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14: both – FWV – female SAKMO – male</td>
<td></td>
</tr>
</tbody>
</table>
SUMMARY OF THE FACILITIES OBSERVATION CHECKLIST

The evaluation team visited 14 health facilities from different sectors in four districts and used a comprehensive observation checklist to assess the availability of information dissemination activities and materials on the level of health facilities.

Majority of visited facilities have some display and/or giveaway materials on LARCs/PMs. 7 out of the visited facilities have counseling room available (private and assigned for counseling). Majority of the visited places have counseling aids in the counseling materials. Majority of facilities have convenient waiting areas, among which three have TV (not working). Only two facilities have a separate area for men in the waiting area. The evaluation team didn't observe any waiting area educational/promotional activities and none of the visited facilities has materials (displayed nor giveaway) on PPFP or PAFP.

Only one facility has a poster on the answers to some common misconceptions that are related to LARCs/PMs. Eight of the visited places have counseling aids available in the counseling rooms. Two health facilities indicated that they are out of stock of the LA/PMs giveaway materials since than 8 months. 12 facilities have female counselors and two facilities have both male and female counselors.

Summary of the main findings per question:

<table>
<thead>
<tr>
<th>Q #</th>
<th>ITEMS OBSERVED</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinic Signage (availability and visibility)</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Counseling Room availability (private and assigned for counseling)</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Counseling Room visible signage and directions</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>LARM displayed educational materials in the counseling room</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Availability of counseling aids (models-samples of the LARM)</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Availability of giveaway materials on LARM</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>Availability of giveaway materials on PPFP</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>Availability of giveaway material on Post Abortion Family Planning (PAFP)</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>Waiting Area Availability (if No, please go to Q # 14)</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Availability of TV in the waiting area</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>If yes in Q10, is the TV working and displaying FP/RH information materials</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>Is there a special space for men in the waiting area (separated by screen from women)</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>13</td>
<td>Are there men in the waiting area?</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>14</td>
<td>Are there FP (specially for LA/PMs) materials displayed visible and clear in the health facility</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>15</td>
<td>If yes to Q14, What are the main messages on these materials</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>Do the available materials have specific messages that combat misconceptions related to different LARM?</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>17</td>
<td>Are there referral forms from community to clinics?</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>18</td>
<td>Sex of service provider (counselor)</td>
<td>2 male</td>
<td>12 female</td>
</tr>
</tbody>
</table>
ANNEX F: DATA COLLECTION TOOLS

Key Informant Interview Guide

Introduction:
Introduce the evaluation team members, purpose of evaluation, confidentiality, right to refuse to answer questions or participate in the interview, and oral consent.

Instructions:
- This is a semi-structured interview guide. The actual questions will be tailored based on the individual interviewed.
- For each question probe for the best practices, successes, challenges, and lessons learned

1. How effectively has MH-II contributed to increasing the utilization of LAPM services in GOB/NGO/private facilities?

2. MH-II is using a more comprehensive approach to improve access to FP services compared to MHI, such as involvement of private sector, establishment of mobile teams, community linkages, postpartum FP, etc.

   a) Describe the benefits and drawbacks of the new approach, were they consistent for all cadres (managers, physicians, FWVs, FWAs) and also for all facilities?

3. To what extent did the intervention of mobile teams help increase the utilization of quality LAPM services, including how was it coordinated with GOB, private sector, and other NGO service providers, such as BRAC, and Marie Stopes?

4. The MH-II project engaged local national NGOs to improve LAPM information dissemination to clients and to improve their referral network to local facilities which provided the LAPMs. To what extent was this intervention successful in informing and engaging community people on LAPM and also establishing community facility linkage?

5. To what extent has the MH-II project support been successful in working with public (DGHS, DGFP), private and NGO facilities to strengthen Post-Partum Family Planning (PPFP) services.

6. The MH-II project assisted identifying and adapting policies, strategies, regulations and/or guidelines of the MOH&FW to improve access to and use of quality LAPM services.

   a) What kind of impact did these policy change produce in the service environment in terms of LAPM utilization? b) Whether these policy changes brought any visible pushes among public, private and NGO providers?
### Health Facility Observation Check List

**Date:** ____________________  **Name of the visitor:** __________________________________________________________

**Health Facility Name:** __________________________

**Health Facility Type:** District Hospital () - General Hospital () - Upazila Health Complex () - Family Welfare Center – Community Clinics () - Private Clinic () - NGO Clinic () - Maternal and Child Welfare Centre () – Private ()

<table>
<thead>
<tr>
<th>Q #</th>
<th>ITEM</th>
<th>YES</th>
<th>NO</th>
<th>Comments/Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Clinic Signage (availability and visibility)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Counseling Room availability (private and assigned for counseling – visual and sound)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Counseling Room visible signage and directions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>LAPM displayed educational materials in the counseling room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Availability of counseling aids (models-samples of the LAPM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Availability of giveaway materials on LAPM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Availability of giveaway materials on PPFP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Availability of giveaway material on PAFP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Waiting Area Availability (if No, please go to Q # 14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Availability of TV in the waiting area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>If yes in Q10, is the TV working and displaying FP/RH information materials?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Is there a special space for men in the waiting area (separated by screen from women)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Are there men in the waiting area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Are there FP (specially for LAPM) materials displayed visibly and clearly in the health facility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>If yes to Q14, what are the main messages on these materials (side effects – advantages/disadvantages – PPFP – PAFP – call to action – how it works – criteria for use)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Do the available materials have specific messages that combat misconceptions related to different LAPM?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Are there referral forms from community to clinics?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Sex of service provider (counselor)</td>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Focus Group Discussion Guide For Community Support Groups

We are conducting a study to help health clinics improve the Family Planning services and care provided in your community. We are here today to talk about the services provided and to listen to your opinions about those services. This group discussion should not take more than 60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. There is no right or wrong answer, please feel free to say what you think. We hope you will, as your responses will assist in improving these services. May be begin? Start with introducing yourself and the group.

Interviewer/s: __________________ Date: __________________
District: _________________ Community Groups involved in this discussion: ______

1. In your opinion, do the family planning services available in your community meet the needs of your community members? Are they the right services? Prompt: Ensure they list the services and methods available and their opinion about each type of service.

2. Do you know about LAPMs? Do you think that more people in your community use LAPM methods now compared to two years ago? Why, why not?

3. Have you seen or heard information about LAPM from public posters, TV, service providers, community leaders, religious leaders?

4. Where are LAPM services provided in your community?

5. What do you think of the services provided by these facilities? Prompt: quality, informed choice, counseling, accessibility and affordability

6. Have you heard of/seen the Mobile Teams that go to communities to provide LAPM services? What do you think of this approach - is a good way to learn about and get LAPM services? Why or why not?
Focus Group Discussion Guide for Service Providers

We are here to conduct a study to help health clinics improve the family planning services and care they provide. We are here today to talk about your work at the health clinic and the support (training, follow-up etc.) that you and your facility have received over the past two years. This group discussion should not take more than 60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. We hope you will, as your responses will assist the health clinic to improve family planning services provided to you. May be begin? Start with introducing yourself and the group.

Interviewer/s: ___________________ Date: ___________________
District: _____________ Service Providers involved in this discussion: ____

1. Please describe any training you have received, and any support you have received following the training. Did the training improve your ability to do your job? If so, how? Do you have any suggestions for improvement in the training or support? Prompt to discuss any "follow-up" and clarify what exact follow-up was provided.

2. Do you know about LAPMs? In your work, do you introduce women and men to LAPM? If so, in your opinion, what are the main reasons women and men may or may not accept LAPM? Prompt to discuss policy barriers, social, family issues religion, gender of the provider.

3. Have you worked on a mobile team? If so, please describe the team and how you offer services (how many people on the team, hours of service provision, location of service provision). In your opinion, is the mobile team effective at providing services? What challenges have you encountered working in the mobile team and do you have any suggestions for overcoming those challenges?

4. Do you provide referral services or participate in a referral network including information dissemination? Please describe – to whom do you refer (public, private, NGO).

5. Do you think post-partum uptake of LAPM is improving or not? In your opinion why?
Focus Group Discussion Guide For LAPM and Injectable Users

We are here to conduct a study to help health clinics improve the family planning services and care provided to you. We are here today to talk about your health and that of your children. This group discussion should not take more than 60 minutes and all answers will remain confidential. You may choose not to answer any questions if you are not comfortable. We hope you will choose to answer, as your responses will assist the health clinic to improve family planning services provided to you. May be begin? Start with introducing yourself and the group.

Interviewer/s: __________________ Date: ___________________
District: _____________ Users involved in this discussion: ______

Are you using a long-term or permanent family planning method / injectable?

Yes (Users):

1. How did you learn about it (friend, health care worker, etc.)?
2. Injectable, long term or permanent?
3. For how long have you used it? (right after delivery or later?)
4. Where did you get it? Prompt to discuss mobile units, clinics, home care etc. during pregnancy, delivery, and post-partum.
5. What information did you receive about the method you are using?
6. Did you receive checkups for your method? If yes, when?
7. Are you happy with it (LAPM /injectable)? Why or why not?
**Focus Group Discussion Guide For LAPM and Injectable Non-Users**

We are here to conduct a study to help health clinics improve the family planning services and care provided to you. We are here today to talk about your health and that of your children. This group discussion should not take more than 60 minutes and all answers will remain confidential. You may choose not to answer any questions if you are not comfortable. We hope you will choose to answer, as your responses will assist the health clinic to improve family planning services provided to you. May be begin? Start with introducing yourself and the group.

**Interviewer/s: ___________________ Date: ___________________**
**District: ______________ Non-User involved in this discussion: ______**

Are you using a long-term or permanent family planning method?

**No (Non-Users):**

1. Do you want more children? (none – limiter, or later – spacer) If want more children, when?
2. Can you go to the health facility anytime? If not, why not?
3. Are you using any method of family planning? (pill, condom, traditional methods)
4. Why not using LAPM or injectables?
   - Not using any FP, and don’t want to
   - Lack of information
   - Can’t access health workers / facility
   - Misperceptions— *what misperceptions and where did they hear it?*
   - Cannot afford it
   - Husband / other family member does not agree
ANNEX G: COMPARISON OF CYPS BEFORE AND AFTER PROJECT INTERVENTIONS IN FOUR DISTRICTS VISITED BY THE EVALUATION TEAM

Figure G-1: Comparison of CYP of LARC, PM and Injectable services of 27 months before the project began (July 2011 – Sept. 2013) and during the 27 months of project implementation (October 2013 – December 2015) in the four MH – II Districts visited by the evaluation team.

<table>
<thead>
<tr>
<th>Service</th>
<th>Before 27 Months</th>
<th>During Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>TUB</td>
<td>1,984,047</td>
<td>1,752,208</td>
</tr>
<tr>
<td>NSV</td>
<td>2,303,119</td>
<td>1,558,300</td>
</tr>
<tr>
<td>IUD</td>
<td>1,457,197</td>
<td>1,392,416</td>
</tr>
<tr>
<td>Implant</td>
<td>790,320</td>
<td>1,066,026</td>
</tr>
<tr>
<td>Inj.</td>
<td>615,433</td>
<td>1,126,057</td>
</tr>
</tbody>
</table>

Figure G-2a: Comparison of CYP of LARC, PM and injectable service of 27 months before the project began (July 2011 – Sept. 2013) and during the 27 months of project implementation (October 2013 – December 2015) in Khulna District.
Figure 2b: Comparison of CYP of LARC, PM, and injectable service of 27 months before the project began (July 2011 – Sept. 2013) and during the 27 months of project implementation (October 2013 – December 2015) in Chittagong District
Figure 2c: Comparison of CYP of LARC, PM, and injectable service of 27 months before the project began (July 2011 – Sept. 2013) and during the 27 months of project implementation (October 2013 – December 2015) in Gazipur District

<table>
<thead>
<tr>
<th></th>
<th>CYP before 27 months</th>
<th>CYP during intervention</th>
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</thead>
<tbody>
<tr>
<td>TUB</td>
<td>42,718</td>
<td>33,143</td>
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<tr>
<td>NSV</td>
<td>43,745</td>
<td>41,430</td>
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<tr>
<td>IUD</td>
<td>47,661</td>
<td>36,994</td>
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<tr>
<td>Implant</td>
<td>11,955</td>
<td>15,145</td>
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<tr>
<td>Inj.</td>
<td>20,356</td>
<td>26,772</td>
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Figure 2d: Comparison of CYP of LARC, PM, and injectable service of 27 months before the project began (July 2011 – Sept. 2013) and during the 27 months of project implementation (October 2013 – December 2015) in Cox’s Bazaar District

<table>
<thead>
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<tr>
<td>TUB</td>
<td>15,158</td>
<td>8,992</td>
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<tr>
<td>NSV</td>
<td>24,336</td>
<td>8,171</td>
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<tr>
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<tr>
<td>Implant</td>
<td>9,393</td>
<td>9,911</td>
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<td>Inj.</td>
<td>14,695</td>
<td>14,762</td>
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ANNEX H: NON-DISCLOSURE AND CONFLICTS AGREEMENTS SIGNED BY THE EVALUATION TEAM MEMBERS

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID’s mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient’s “need to know” or “need to access” Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government, (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to...
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires
access to Sensitive Data.
9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure
by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii)
is required to be disclosed by law, court order, or other legal process.

ACCEPANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date March 4 2016

Katya Bums

Name

Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature __________________________ Date 1 Jan 2016

Name Soliman Guirgis Title Consultant
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[Signature]

Date 01/14/16

Name  M E. H A N

Title
$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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<table>
<thead>
<tr>
<th>ACCEPTANCE</th>
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<tbody>
<tr>
<td>The undersigned accepts the terms and conditions of this Agreement.</td>
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<th>Signature</th>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Nasima Safa Kamal</td>
<td>Consultant</td>
</tr>
</tbody>
</table>
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Rina Seale

Signature

Date 2/10/2016

Name

Title Consultant
For more information, please visit ghpro.dexisonline.com