The Impact of Quality Monitoring and Supervision on NSDP Services

The NGO Service Delivery Program in Bangladesh

<table>
<thead>
<tr>
<th>Validation Phase 1: Comparison Between QMS Validation Scores and NGO Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Quiz</td>
</tr>
<tr>
<td>QMS</td>
</tr>
<tr>
<td>87</td>
</tr>
<tr>
<td>85</td>
</tr>
</tbody>
</table>

The Impact of Quality Monitoring and Supervision on NSDP Services

The NGO Service Delivery Program in Bangladesh
Acknowledgements

I want to thank Dr. Neeraj Kak, vice president and QA specialist, University Research Corporation (URC). His continued technical support and insight have led to integration of supportive supervision and quality assurance in service delivery at Smiling Sun clinics and institutionalized the Quality Monitoring and Supervision (QMS) system, supported by quality improvement audits and QMS data validation. Special thanks also to Mr. Terrence Whitson, consultant, URC, who helped operationalize the QMS across the NSDP network in the first year of the project. Valuable day-to-day contributions were made by URC’s team at NSDP, which include Dr. Sadia Dilshad Parveen, director, Quality Improvement and team members Dr. Kazi Asadur Rahman, Dr. Fatema Zannat, Dr. Sanaul Bashar, Dr. Ikhtiar Uddin Khandaker, Dr. Dominic Robin Guda and Dr. Rokhsana Reza.

I also thank Ms. Joy Riggs-Perla, consultant, URC, for her assessment of NSDP’s quality improvement work. Special recognition also goes to the NSDP Regional Coordinators who made concerted efforts to ensure the correct and timely implementation of the QMS and its associated functions. Many staff at NSDP and the NGOs in the network assisted in the scaling-up of our QI initiatives. I thank them too. Last, I thank NSDP’s former CTO at USAID, Mr. Mosleuddin Ahmed, current CTO, Mr. Belayet Hossain and Sheri-Nouane Johnson, OPHN Director, who have provided sound advice and support. Any deficiencies in the system are the product of NSDP’s efforts. Ms. Jennifer Wilder, Senior Technical Communications Advisor of Pathfinder International edited the report.

Dr. Robert Timmons
Chief of Party
The Impact of Quality Monitoring and Supervision on NSDP Services

The NGO Service Delivery Program in Bangladesh

Technical Report
Cooperative Agreement No. 388-A-00-02-00060-00

April 2007

NGO Service Delivery Program
House No. NE(N) 5, Road No. 88
Gulshan - 2, Dhaka - 1212
Bangladesh

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
# Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTC</td>
<td>District Technical Committees</td>
</tr>
<tr>
<td>ESD</td>
<td>Essential Service Delivery</td>
</tr>
<tr>
<td>ESP</td>
<td>Essential Service Package</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
</tr>
<tr>
<td>NIPHP</td>
<td>National Integrated Population and Health Program</td>
</tr>
<tr>
<td>NSDP</td>
<td>NGO Service Delivery Program</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality Improvement Partnership</td>
</tr>
<tr>
<td>QMS</td>
<td>Quality Monitoring and Supervision</td>
</tr>
<tr>
<td>RSDP</td>
<td>Rural Service Delivery Program/Partnership</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UFHP</td>
<td>Urban Family Health Partnership</td>
</tr>
</tbody>
</table>
Table of Contents

| Background | 4 |
| The NSDP Quality Monitoring and Supervision System | 5 |
| Planning the QMS Intervention | 5 |
| NGO Manager Training | 5 |
| The QMS Visits | 6 |
| QMS Data Analysis and Utilization | 7 |
| Key Lessons Learned | 7 |
| Training | 7 |
| Providing Feedback | 8 |
| Challenges | 9 |
| Utilization of QMS Information | 10 |
| Validation of QMS Data | 11 |
| Quality Improvement Audits | 13 |
| Sustaining Quality Improvement Culture | 13 |
| Developing Mentors to Transfer QMS Training Skills | 14 |
| Conclusions | 14 |

Figures and Charts
Figure 1: QMS Assessment Modules | 6 |
Figure 2: The Quality Improvement Process | 7 |
Figure 3: QMS Data Flow | 7 |
Chart 1: QMS Scores by Round | 10 |
Chart 2: Composite Scores for QMS vs Data Validation (Phase 1) Scores | 11 |
Chart 3: Composite Scores for QMS vs Data Validation (Phase 2) Scores | 12 |
Background

The NGO Service Delivery Program (NSDP) is generously funded by the USAID. It was launched in 2002 as a follow-on to the Quality Improvement Partnership (QIP), Rural Service Delivery Partnership (RSDP), and Urban Family Health Partnership (UFHP), which together have built an extended network of 318 clinics and 8,200 satellite clinics throughout most of Bangladesh. Located in both urban and rural areas, these clinics are supervised and managed by more than 30 local NGO partners of the NSDP.

Beginning in 1997, a quality assurance program was introduced to the clinic network under the supervision of RSDP and UFHP, as well as QIP. With the introduction of NSDP, the management of this program was moved to the NGOs themselves. The current Quality Monitoring and Supervision (QMS) system was designed during the later part of the first phase of Bangladesh’s National Integrated Population and Health Program (NIPHP) in 2000. The system was pilot tested in two urban and two rural NGOs, reviewed in November 2002, and subsequently modified and revalidated. Community perceptions were also assessed prior to finalizing the current QMS system.

The aim of the QMS system was to institutionalize an NGO- and clinic-level monitoring system using quality assessment data to improve the quality of the Essential Service Delivery (ESD). This involved:

- Establishing service delivery guidelines and standards;
- Formalizing problem-solving techniques, organizing technical and skills updates, and;
- Ensuring proper referrals and reinforcing the follow-up to ensure that problems identified are adequately addressed.

Following the pilot test and adjustments, the QMS system was rolled out to all NSDP partner NGOs and their clinics in mid-2003. In August 2005, following project assessment, recommendations were made for more intensive supervision and technical assistance to be provided by NSDP central and regional staff. Significant adjustments to the system were introduced at that time, and a second assessment was more recently completed in September, 2006.

A Smiling Sun provider demonstrates appropriate infection-prevention by burning medical waste in an enclosed container.
This report is based on the outcomes of the second assessment, as well as adjustments that have been introduced in response to that assessment as of this writing (February 2007).

**The NSDP Quality Monitoring and Supervision System**

Direct management of the QMS system by NSDP partner NGOs was introduced in 2003. Fortuitously, at USAID’s urging, it was simultaneously introduced to all NGO partners, which accelerated the acceptance and use of the system in every clinic. The project consisted of the following elements:

**Planning the QMS Intervention**

A considerable amount of time was devoted to the initial design of NSDP’s Quality Improvement strategy, which was done in collaboration with a sample of NGOs. This included the following steps:

- Review in 2001 of the QMS piloted by NSDP predecessor groups: UFHP, RSDP, and QIP;
- Design of the QMS processes and tools, tailoring them to NSDP needs;
- Validation and testing of the new QMS tools and processes and taking feedback from NGOs to make adjustments;
- A study to assess the community’s views about quality of care and take them into account when refining the final tools.

**NGO Manager Training**

In the initial Round between February and April, 2003, 14 two-day QMS workshops were held for 342 NGO-level clinicians and Clinic Managers, who would be responsible for facilitating the QMS system. Training consisted of:

- Introduction to the concepts of quality of care, supportive supervision, and monitoring, and how these are linked to performance improvement;
- Introduction to the QMS tools and processes, including data management;
- Role-playing and skill-building in “supportive supervision” and practice in problem solving.

Significantly, the NSDP quality improvement intervention emphasized supportive supervision from the outset. This approach departed notably from the prevailing view of supervision as a paternalistic function. The benefits of teamwork and supportive supervision were stressed, not only during training and counseling, but also during subsequent on-site technical assistance visits to the clinics.
The QMS Visits
The monitoring and supervision of quality require a two-day visit to each clinic every six months, i.e., in biannual Rounds. The NSDP-trained NGO supervisor (a physician) and the clinic manager are the QMS team, and they conduct an assessment of the quality of service delivery and compliance to standards at the static clinic and one associated satellite clinic per Round. They prepare graphs of the scores, provide feedback to the staff, conduct root cause analyses of the problems/weaknesses identified, and develop a follow-up action plan. During subsequent visits, along with the regular monitoring of quality of service using the QMS tools, they also follow up on the previous Round’s action plan to track implementation.

Three types of processes and corresponding tools are used to compile the composite quality score for a given clinic in a given Round: Knowledge Quizzes, Process Observations, and Record Reviews. Together they provide a comprehensive overview of the service delivery process and demonstrate the congruity between provider knowledge, skills, and recording practice.

The basic clinical areas in the Essential Service Delivery (ESD) package were initially assessed using three modules (see Figure 1), through a set of specific indicators. One assessed the physical facility, logistics, infection prevention practice, and rational drug use; the second covered counseling, family planning, Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs); and a third covered maternal and child health. In 2006, as the range of services in most clinics increased, a fourth module was added to assess tuberculosis, safe delivery, postabortion care, and special STI services for those clinics offering them. The special STI service indicators monitored in Module 4 are applicable for clinics that implement the special STI intervention among most-at-risk populations.

During the visits, the NGO supervisor conducts the knowledge quizzes for all clinicians (doctors, paramedics, and nurses). S/he and the clinic manager examine records and conduct observations of clinical practice. Each step requires completion of a scoring sheet for provider knowledge, and their service delivery and record keeping practice.

After the visit, the NGO-level clinician computerizes and sends the scores to NSDP and prepares computerized graphs of the scores that are sent to the clinic. The original scoring
sheet and records are kept at the clinics. Following analysis of the information, the supervisor works directly with the clinic staff to coach or mentor staff to improve skills, apply the Quality Improvement (QI) process for problem analysis with the clinic team, or refer broader problems to the NGO or NSDP level for assistance (see Figure 2).

**Figure 2.** The Quality Improvement Process

---

**QMS Data Analysis and Utilization**

Strong emphasis is placed on local (clinic and NGO) utilization of the information generated by the QMS system. The most recent scores are displayed at the clinic level, so that staff can review their weaknesses and address them in accordance with the action plan. At the facilitation level, the QMS team (NGO physician and clinic supervisor) use the data on a continuous basis to monitor improvements, identify problems, take corrective action, and elevate issues to higher levels. The system requires identified problems to be revisited in subsequent visits. NSDP regional and central offices also play significant roles in ensuring that QMS reports are completed and submitted on time, and help solve problems that need to be addressed at higher levels. NSDP monitors scores, and any changes in composite scores are reported in quarterly reports to USAID.

**Key Lessons Learned**

The QMS is clearly an NSDP success story. After four years of full implementation throughout the NGO clinic network, the system is fully functional and highly valued by the clinics, the NGO managers, and the NSDP staff. The fact that the NGOs played an active role in the design, implementation, and modification of the system may be one of the major reasons they have owned and adopted it so enthusiastically.
**Training**
Apart from the QMS tools (modules, handbook, and manual score sheets), the training materials comprised a complete facilitation manual, presentation materials, and CD-ROMs of the database for computerized data entry. The training covered the concepts of supportive supervision and quality of care, the implications in performance improvement, the differences between quality assurance and QI, introduction to the QMS system, practical exercises on using the QMS tools, and management and use of the QMS data.

The external assessment judged the training materials to be excellent. Tools and modules for use at the clinic level are considered practical and are well-understood and actively used.

When visited by NSDP monitors, the clinics can produce the QMS records readily and appear enthusiastic about the learning and skills-upgrading that will benefit their work. Many NGO managers have indicated that they would want to continue to implement the system, even in the absence of outside review, as they see that the future viability of their clinics depends on the quality of services experienced by the clients. They recognize that there is little point in offering services if the quality is not maintained and monitored. Surprisingly, the QMS system appears to function whether the clinic is considered high or low performing, which confirms strong motivation within clinics to seek and apply future training programs.

**Providing Feedback**
Most clinicians and supervisors placed the greatest value on the direct observation of clinical practice. Service delivery deficiencies are pointed out and corrected on site by demonstration or through feedback, but not in the presence of the customer. Correct procedures are then discussed or demonstrated during the feedback sessions as well. This process is more effective because of the immediate connection between problem and solution.

*A supervisor observes a Smiling Sun provider counseling a woman on the use of oral contraceptive pills.*
Supportive supervision appears to be well accepted according to service providers and supervisors. Feedback is provided in a way that helps service providers, rather than being experienced as criticism. The enthusiasm for these visits displayed by clinic staff is a strong indication of its value to them, and all were able to provide the reviewers with specific areas where their performance had improved as a result. These areas generally coincided with the observations of the supervisors as well.

**Challenges**

**NGO Staff turnover**: The application of the QMS model has shown adaptability in light of varied field conditions, with practical modifications introduced to accommodate realities. A high turnover in clinical staff, especially physicians in urban clinics, has forced repeated trainings several times a year, whenever there is enough new staff that require training. In the interim, NSDP staff and NGO supervisors provide on-site QMS coaching and mentoring of individual new staff. Respondents found this mentoring even more valuable than the formal training sessions.

Given staffing and turnover challenges, one effective model of adaptation may prove useful to refine and replicate elsewhere. One NGO used two physicians assigned to urban clinics to conduct the QMS supervision for all of their clinics, even providing the oversight for each other’s clinics. While this system may not be ideal, it enabled the NGO to keep the QMS system operational in the absence of a full-time NGO physician supervisor. Another modification was the use of a system to allow physicians from other NGOs in the network to conduct the QMS visits for a given NGO.

Further flexibility allowed clinicians from satellite clinics to demonstrate their clinical management skills at the static clinic in the absence of clients seeking a particular service. Where no clients sought a given service, e.g., antenatal care, role play exercises in the presence of paramedics from the satellite clinics enabled everyone to observe and give suggestions on how to improve service delivery.

**Need for continued coaching**: While remarkable institutionalization of the QMS system has been achieved, the timeliness and compliance has been dependent on intensive follow-up and coaching by NSDP staff, both from the central Dhaka office and regional coordinators. Although this intensive oversight was recommended in the August 2005 review, it is essential to move forward to a more independent system.

**Need for appropriate expectations**: Inappropriate reliance on QMS to solve all quality-related problems has been a challenge. NGO managements and non-clinical project staff have often referred to the QMS as the ‘fix-it’ for most problems. It is important that, for the system to be sustained, these stakeholders need to be well-tuned to the strengths and limitations of the QMS.

**Utilization of QMS Information**

**QMS Scoring**: A number of NGO managers have raised an issue about the scoring system used to observe clinical practice. The system requires that all sub-indicators under each service be performed correctly to receive a score of one. A mistake or omission on any part of that service will give it a score of zero. Although this all-or-nothing scoring system was deemed inflexible by
disallowing partial scores that show partial knowledge, the NSDP staff strongly favors the approach. They maintain that the indicators are an important minimum set of quality benchmarks, and that acceptance or credit for anything less than a perfect score will reduce the incentive to achieve such a score. They represent that these indicators should be strived for and met by all. Further, they maintain that any variations on this scoring system will be susceptible to variation in the judgment of the supervisors, which would make comparisons between clinics far less useful. The recommendation is to retain the current scoring system.

*Knowledge quiz scores:* The clinic staff acknowledged that the knowledge quiz was valuable to them as a mechanism for receiving continuing education and technical updating, yet they complained that the quiz was the most difficult aspect of supervision, as they do not score well.

The knowledge quiz scores have not improved over time commensurate with improvement in observation of clinical skills and record reviews (prescription writing, completing the Essential Service Package (ESP) cards, and the family planning informed consent forms, etc.). Multiple-choice questions had to be modified for clarity—especially those stated in the negative. The questions are changed for each quiz, which is valuable for knowledge-building, but may show a weak trend in overall scoring. (See Chart 2 on the following page.) Furthermore, these scores were fairly high at the beginning of Round One, so major increases are not likely. Scores will vary over time and with staff turnover.

Most of the respondents to the evaluation at the clinical level valued the knowledge quiz regardless of their scores, because of the opportunity for new learning. Improvement in QMS scores is an indicator in the USAID Performance Monitoring Plan, so the knowledge quiz scores have now been segregated to get a more accurate overall measurement of QI related to practice.

**Applied use of QMS Data:**

Clinical use of QMS Data: The NGO managers review the scores for each clinic to determine whether there are common areas of weakness, and they use that information to organize technical updating sessions. They also use it to follow up on the resolution of problems identified at the last QMS visit.

It is less clear as to whether or not the clinicians are actually using the data. They are all able to locate the QMS records and discuss their contents, but brainstorming discussions reveal that the clinicians are not using the documented data in any regular way. For them, the chief value of the entire QMS system remains the supervisory visit itself and the hands-on mentoring and technical upgrading they receive as a result of that exercise.
NSDP use of QMS Data: The NSDP staff report regular use of QMS data to identify weaknesses and work with NGOs to address them. They rely on the data to set the agenda for NGO quarterly coordinating meetings, and the scores were used to identify the ten best-performing clinics in the network, to commemorate World Population Day.

Validation of QMS Data

To introduce an external review of how the QMS system is working, NSDP developed a validation process to be used by the NGOs. Two full Rounds of QMS validation have been completed.

The first round of data validation was conducted between October and December 2004. QMS data from 49 clinics (18 percent of those that completed the previous Round) was validated. The NGOs’ QMS mean score was 85 percent, but the mean score for NSDP validation of the same clinics was 79 percent. Interestingly, the scores, (which offer little scope for human variation, since the records are physical evidence of the clinic operations) were higher during validation visits. The overall variation may have been affected by:

- Timing of the validation visits: Validations were conducted randomly. Some sites were visited more than six months after the original QMS visit was completed.
- Staff attrition: In many cases, originally assessed staff have since left.
- Subjective variation: Subjectivity may have been partially responsible for the variation.

The second round of data validation was conducted between October 2005 and February 2006. Methodological problems encountered during the first phase were addressed by conducting the validations within two weeks of the completion of a QMS visit. This time, the margin of difference was only four percentage points for the overall mean score. Thirty-nine clinics (approximately 15 percent) were included in the sample, and the NGO QMS score was 79, while that of the validation was 75.

While subjective variation and visit timing were better addressed, the scores could also have improved because the NGOs had become more trusting of the QMS as a self-assessment and improvement tool, rather than viewing it as a tool for monitoring and corrective actions to be taken by NSDP. In short, they were beginning to own the QMS as a system to assist them in their own performance improvement.

Because QMS is entirely managed and the data recorded by the NGOs themselves, USAID strongly encouraged NSDP to develop a validation process to determine whether there is
any significant deviation between the NGOs scores and those of NSDP. Two rounds of validation have been conducted (see results in Charts 2 and 3), and in each case the NSDP scores were generally lower than those of the NGOs, but the differences were relatively small. More importantly, the validation process gave NSDP an opportunity to examine the processes used in the field and offer correction and additional guidance.

Equally important to the validation process is the use of an external review to introduce clinicians to the experience of external oversight and to accustom them to outside review of clinical practice. Physicians are among those most resistant to this idea in most countries. The QMS validation has the potential to evolve into a system that can be institutionalized, leading to a clinic certification process linked to the maintenance of quality.

Such a process could take one of several directions, including:

- Involving the local MOH officials in setting standards and instituting oversight;
- Developing regional teams of MOH and NGOs that develop these standards together; or
- NGOs spearheading the development of a credible professional organization that can generate the necessary expertise and credibility.

**Quality Improvement Audits**

The reliance of NGO managers and non-clinical project staff on QMS to solve all quality problems has been cited earlier as a challenge. The QI Audits were designed partially in order to address this and involve executive committee members, as well as finance and administrative staff in the process of quality improvement.

Beginning in August 2006, NSDP piloted a system of QI audits at selected clinics. These are intended to help NGOs and clinic staff to review their continuum of care in key selected ESP service areas to assess progress and take corrective action. The audits are supposed to augment the QI process at the clinic level, and are also expected to draw other members of the NGO management into the QI process. The QMS is conducted by clinicians only, so the audits should be conducted by non-clinicians.

In each yearly audit at the time of a field visit, the clinic NGO-level manager selects 20 ESP cards (customer records) from the corresponding quarter a year earlier, reviewing appropriate service delivery indicators and identifying any problems with services provided or potential drop-out problems. The ESP cards have records of all ESD delivered from the

---

**Chart 3.** Composite Scores for QMS vs Data Validation (Phase 2) Scores

Sample size 39

![Composite Scores for QMS vs Data Validation (Phase 2) Scores](image)

Knowledge Quiz: QMS = 68, Validation = 70
Skill Observation: QMS = 85, Validation = 77
Records Review: QMS = 85, Validation = 78
Mean Score: QMS = 79, Validation = 75
clinic to a customer and her family. The cards are usually registered under the name of the female spouse in the family. Such an audit serves as a management tool to help NGO managers keep track of clinic performance.

Through the QI Audit, the NGOs are able to identify weaknesses in the follow-up system, especially for immunizations, maternity care, family planning, safe delivery and RTI/STI service. A general idea of the dropout rate from any of these services can be calculated on the spot during the audit. The advantage is that, during the audit visit, the NGO-level manager can give on-site advice and decisions about activities to increase continuity of service and rectify problems.

**Sustaining Quality Improvement Culture**

Institutionalizing a “culture of quality” is an ongoing process, as seen in other similar settings. However, the essential elements include prioritizing areas of focus for service, creating demand for improved quality from the grassroots level, and developing leadership buy-in to the improvement effort. The current level of management support and follow-up provided by NSDP will not be available to NGOs in the long run, and a strong institutional incentive is needed to maintain high-quality services. Since the NSDP infrastructure comprises 33 NGOs (a number that may vary over time) with distinct leadership characteristics, procedures, and norms, their leaders must come to share a single vision of achieving program sustainability through sustained QI.

The most powerful incentives for quality maintenance come from forces external to the clinics themselves. In the increasingly competitive health care market, especially in urban areas, NSDP’s NGOs are finding that the only way to increase their client base is to maintain and expand quality of care. A regular quality review, accompanied by a validation process, may be standardized by establishing a Smiling Sun franchise that requires certification and regular review and oversight. This process could be monitored by the MOH, professional bodies, or other organizations, and could eventually lead to the development of an accreditation system.

---

1 Sustaining Quality of Health Care: Institutionalization of Quality Assurance. QA Monograph, Quality Assurance Project. URC., LLC, September 2002.
5 Ibid.
Developing Mentors to Transfer QMS Training Skills

Creating a culture of continued quality improvement at the clinic level requires continued availability of trained and skilled monitors-cum-supervisors.

To develop and implement a mentoring plan, NSDP identified a core team of four potential QMS mentors, who would be most suitable for teaching others the skills necessary to monitor and ensure quality of care in the Smiling Sun network. The team received training from NSDP on quality of care, supportive supervision, and facilitation skills, developing them as mentors and technical resources that other NGOs can draw upon for further QMS training/orientation.

The four QMS mentors conducted their first QMS training in Dhaka, under observation from NSDP, in October 2006. A total of 63 clinic and NGO managers were trained in two batches.

Conclusions

In conclusion, it should be stressed that to ensure and maintain high-quality ESD, specific actions must be rolled out in a synchronized manner. These include:

• Awareness building among stakeholders, in this case, the NGO leadership and local stakeholders that constitute the decision makers;
• Smooth and routine functioning of the QMS system, with appropriate technical oversight and support from all levels of management;
• A random validation of the QMS from an external source, to ensure correctness and completeness of effort; and
• A smaller scale, but routine audit mechanism to identify quality-related gaps that have led to loss of continuity of service.

Above all, it is important that NGO leaders express ownership of and participate in implementing the QMS system. It must become an integral part of the overall management and operations of the entire health care system.

Also key to QI is accurate monitoring of client satisfaction. Currently, some NGOs monitor client satisfaction by conducting exit interviews or offering suggestion boxes. These systems offer limited reliability, given clients’ reluctance to criticize and the low literacy rates among the poor.

In cases where NGOs already have a close working relationship with local MOH colleagues, it makes sense to involve them in QMS monitoring. Local District Technical Committees (DTCs) are already conducting biannual visits to re-affiliate NGOs with government assigned catchment areas. Including DTC staff in NSDP validation visits, or as participants in regular QMS visits by NGO supervisors, could lead to more equitable access between NGOs and government and better referral systems. Such cooperation could eventually lead to the development of an annual external quality assessment process linked to certification of the clinics.
NSDP is a USAID-funded consortium of eight international organizations, led by Pathfinder International, which provides technical assistance and support to a network of Bangladeshi health care NGOs. The program focuses on delivery of essential public health services to 20 million people through training, quality assurance, NGO institutional development, management, and financing. NSDP partners with more than 30 NGOs whose 320 Smiling Sun clinics and 8,000 satellite clinics work in both disadvantaged rural areas and urban slums. About 6,000 community volunteers augment services in rural areas.

Smiling Sun clinics play a major national role in providing families with high-quality, low-cost family planning, reproductive, maternal, and child health care, treatment for reproductive tract and sexually transmitted infections, tuberculosis diagnosis and treatment, and limited curative care services. There are more than two million visits to NSDP health care providers each month.

Health benefit cards offer free services at Smiling Sun clinics to members of very poor families. Over 60 percent of the poorest Bangladeshis who receive health care in NSDP’s catchment areas are served by NSDP providers. Performance-based reimbursement is increasing access of the poorest of the poor to services and increasing the number of able-to-pay customers as well.

Smiling Sun clinics are expanding services that generate income for the clinics, including safe delivery at clinics and at home by trained paramedics, emergency obstetric care, laboratory and pharmacy services, health care marts, ultrasonograms, and specialized physician care. Mass media and local behavior change communication campaigns include the popular entertainment-education TV drama serial *Enechhi Shurjer Hashi* (Bringing the Smiling Sun). Billboards and advertisements of clinic services in cinemas and on city buses and rickshaws promote health and family planning. Branding and the reputation of Smiling Sun clinics have led to corporate sponsorship of clinics and services.

**NSDP Partners:**
- Bangladesh Center for Communication Programs (BCCP)
- CARE Bangladesh
- EMG, (Emerging Market Group)
- IntraHealth International Inc.
- Pathfinder International
- Research Triangle Institute (RTI) International
- Save the Children
- University Research Co., LLC. (URC)