

Case study: Health and nutrition sector.

Health and Nutrition Vouchers for Marginalized Urban Extreme Poor in Bangladesh



in collaboration with:



With acknowledgment of the Ministry of Health and Social Welfare, the Ministry, LGIs and implementing partners.

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Executive Summary

This study examines the experimental use of vouchers in Bangladesh by 3 different agencies, funded by the EU, to address health gaps for the urban extreme poor by providing essential health and nutrition service delivery through public-private partnerships.

In the last 20 years, Bangladesh has been going through a process of urbanization. A recent estimate by the World Bank (2019) suggests that around 28.6 million people, equivalent to 55% of the total urban population, currently live in slums. Around two thirds of urban population growth are due to rural to urban migration and one-third due to natural population increase. Most of these rural migrants lack the resources to meet their basic needs including housing and health care.



The urban poor face many complex health needs, including a high prevalence of non-communicable diseases, with insufficient access to health care, and high out of pocket payments – 74% of current health expenditure. High user fees and distance to travel are further barriers to accessing services and are a major reason why people postpone or forego healthcare despite increased health needs. The voucher model aimed at reducing the financial barriers to accessing health services for the urban poor and supporting vulnerable populations in accessing health care without suffering financial hardships.

Funded by the EU – the project was designed as three pilots implemented by three different entities: **Concern Worldwide in partnership with SAJIDA Foundation; Dhaka Ahsania Mission (DAM), in partnership with Christian Aid; and Resource Integration Centre (RIC).**

Vouchers, a form of results-based financing (RBF) have been used in many sectors, including health, in low, middle-, and high-income countries. More specifically, health vouchers work as both a financing mechanism to provide subsidized health care to a targeted population and as a programmatic tool to reduce barriers to access and increase use of critical health services. Research has demonstrated that vouchers can effectively increase utilization, enhance equity, and improve quality and availability of care.

Through vouchers, the household can receive a clearly defined health service package at pre-selected health facilities free of charge or at a reduced fee. The subsidy goes directly to the client in the form of a voucher (whether paper or through an electronic token) – that the client can then redeem this at a health provider.

Partnering with the government, and the local municipalities, the implementing partners developed a service package for which the vouchers can be used at the designated public and private hospitals. The service package included treatment for general illness, maternal health, and emergency services. The value of the vouchers were not uniform across the implementing partners either with the type of services or the costs. The reason for this is because the target populations for the implementing partners were different.

Hospitals were identified and contracted to participate in the scheme, based on a set standard criteria to ensure quality of care. Households were identified using poverty and vulnerability targeting criteria. The majority of households targeted made use of the voucher indicating that their access to formal health care improved considerably, as well as changed health seeking behavior. The COVID-19 pandemic led to some disruption in access during the life of the pilots.

While this is a development project, conducted in line with government efforts to improve the healthcare of the residents of slums in Bangladesh, the design could be applicable to humanitarian contexts in which similar financial barriers obstruct access to health services. The response analysis for a humanitarian context, however, may look different, particularly in refugee contexts with challenges around safe access to services.

Finally following an evaluation on of the three pilots, a common model is expected to be used for scaling up within Bangladesh.

01. Introduction

The purpose of the health and nutrition vouchers project in Bangladesh is to improve the health and nutrition status of the urban extreme poor by increasing accessibility, coverage, comprehensiveness and sustainability of existing primary health and nutrition services. The project, funded by the EU, is currently implemented by three partner NGOs, and targets 120 wards within the 10 municipalities. During the writing of this report, the project has reached around 80,000 households, with over 337,000 beneficiaries from among the urban poor.

The project made health services accessible to this target group where they would otherwise have relied on informal care or accrued catastrophic health expenditures. The health vouchers not only met the immediate health needs of the targeted populations, but also contributed to changes in their health-seeking behaviours.

This case study outlines the details of the project design from the experience of the partner organizations. While this is a development project, conducted in line with government efforts to improve the healthcare of the residents of slums in Bangladesh, the design could be applicable to humanitarian contexts in which similar financial barriers obstruct access to health services. The response analysis for a humanitarian context, however, will look different, particularly in refugee contexts with challenges to safe access to services.

The projects described here will not finish until after this report has been completed, and therefore analysis of the long-term impact, including reflections on the voucher project design, is not included. The implementing partners plan to conduct end-lines studies and evaluations at project end.

3



NGO Partners

120

Wards targeted



10

Municipalities



80,000

Households reached

337,000+

Beneficiaries



02. Background

Public health system in urban Bangladesh

Bangladesh has advanced on achieving the Sustainable Development Goals (SDGs) health indicators.¹ Milestones for under-five and neonatal mortality as well as under-five malnutrition were reached.

These successes were attributed to the continued efforts of the government of Bangladesh, development partners, non-government organizations and private sectors. Despite these successes, however, health indicators for urban poor still need to be improved (Govindaraj et al., 2018). This is a consequence of the rapid increase in unplanned urbanization, which is now at 39 percent of the total population (up from 9 percent in 1974) and continues to grow as a result of rural 'push' and urban 'pull' factors.² In order to sustain the public health gains, largely achieved through improvements in the rural health infrastructure, further investments in improving the healthcare system in urban areas is needed (Govindaraj et al., 2018).

The unique urban health governance structure in Bangladesh – which divides roles and responsibilities among several actors³ – has constrained the increased efforts needed for the delivery of urban health services to the urban growing population.

The urban governments are responsible for delivering public health services including preventive and curative care through public hospitals, clinics and dispensaries. They also provide licensing to private health providers. To do this, the Ministry of Local Government provides the financial and human resources; however, these have been insufficient to keep up with growing health needs. Despite the urban government support – citizens still have to pay for health services, including consultations.

The Ministry of Health and Family Welfare (MOHFW), on the other hand, is responsible for technical standards, strategy and policy development, and regulation, as well as for secondary and tertiary care through its own public hospitals in urban areas (Govindaraj et al., 2018). This fragmented governance arrangement is a significant constraint on efforts to improve the health system in urban areas.

2.1 Access to and utilization of healthcare among urban poor

Figure 1 demonstrates the governmental capacity gap in accessible health facilities for urban populations. The data is taken from the Bangladesh Urban Health Survey (UHS), conducted in 2013, which is a representative household survey of slums and non-slums of city corporations⁴ and other urban areas (including municipalities and large towns) with a population of over 45,000. Only 13 percent of the population in city corporations have access to a governmental health facility within one kilometre, compared to 38 percent for other urban areas.

¹ The Sustainable Development Goals or Global Goals are a collection of 17 interlinked global goals designed to be a 'blueprint to achieve a better and more sustainable future for all'. See: <https://www.un.org/sustainabledevelopment/health/>

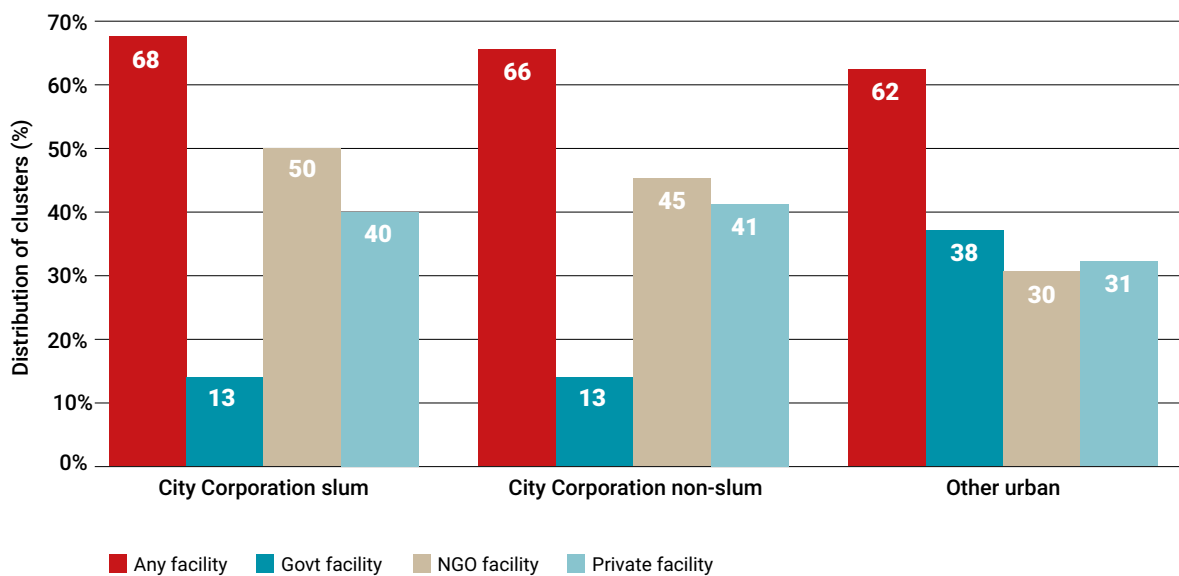
² Pull factors are related to job and sociocultural opportunities, while push factors relate to the inability of rural areas to absorb the surplus labour force entering the economy each year, which is aggravated by climate change–caused riverbank erosion and reduction of available land for agriculture opportunities.

³ Ministry of Local Government, Rural Development and Co-operatives (MOLGRD&C), Ministry of Health and Family Welfare (MOHFW), and local urban governments

⁴ There are 12 city corporations in Bangladesh. Four of them are present in the capital Dhaka. City corporations fall under the same municipal law as the other urban municipalities, which defines the basic character of all municipal areas. Corporations are larger, and the election and nomination of governing bodies is slightly different.

In addition to user fees, distance is an important barrier for urban poor, not only because of travel costs but also due to a greater loss of time, often compounded by long waiting times as a result of overburdened facilities. Perceived lack of quality and limited hours of services are also a barrier. Taking time off work can be problematic for fear of losing the day's income and even the job itself. Access to non-governmental organizations (NGOs) and/or private health facilities is much better, including proximity, perceived quality and more convenient opening hours. However, services tend to be much more expensive.

Figure 1: Availability of health facility within 1 kilometre - UHS 2013



As a result, the urban poor curb their use of formal health facilities, forego treatment or make use of the informal sector. They prefer to visit retail drug shops for advice and treatment or wait for self-recovery. Formal healthcare facilities are visited only when treatment from informal drug shops fails to cure the illness or when serious illnesses or traumatic injury is experienced. High prevalence of non-communicable disease (NCDs), such as hypertension and diabetes, has been found in slum areas of Bangladesh. As a consequence of the multiple access barriers, the urban poor seek care at drug shops. Untreated or inappropriately treated NCDs lead to high levels of illness and death (Tune, 2020; Van der Heijden, 2019; Streatfield et al., 2019; Adams et al., 2020).

When urban poor are seriously ill or injured, they access formal care, but then they face the risk of impoverishment through so-called catastrophic healthcare expenditures – out-of-pocket payments for health services that exceed a given fraction of total household expenditure.⁵ These high health expenses lead to multiple debts, as described in the case stories of some voucher beneficiaries (see Annex 4). Bangladesh is among the countries with the highest rate of impoverishment due to out-of-pocket expenditures for health (Wagstaff, 2020).

⁵ WHO cut off points are >10 percent and >25 percent of household expenditures, but also when the expenditure is so high that household has to resort to negative coping: sell assets, take loan, borrow from family, forgo other needs, etc..

2.2 Provision of healthcare by NGOs and Private sector

The government capacity gap has led to the growth of NGO and private health facilities. In Bangladesh, urban areas fall under the central ministry's purview, which has a very limited budget to run long-term health projects.

Funded by external donors, and in some cases contracted by the government, NGOs have been the principal providers of government-financed primary healthcare service delivery in urban Bangladesh since 1997, offering subsidized or free care for the poor. Urban health projects, such as the Urban Primary Health Care Project (UPHCP) which is co-financed by the Asian Development Bank (ADB), have demonstrated that NGOs can provide primary healthcare with the best value for money.

Similarly, private health facilities provide curative care, including hospitals, clinics, nursing homes, diagnostic centres and pharmacies. Services by medical doctors and non-formal traditional health practitioners also fall under private health facilities. This sector tends to operate without obligatory licences and qualified human resources, however, and there is a lack of regulation or quality control by MOHFW.

Nevertheless, private facilities are more accessible than public and NGO facilities due to their widespread service coverage and longer, more convenient service hours. Many private health facilities also offer services at low fees, making them affordable to the poor, particularly when the transportation costs to access public or NGO facilities are factored in (Govindaraj et al., 2018).

A census of health service providers in or near a sample of slum settlements in Dhaka found that more than 80 percent were private health facilities, 12 percent were public facilities (but with operations contracted out to NGOs) and 6 percent were NGO facilities (Adams, Islam and Ahmed, 2015).

Even though the private sector dominates the provision of primary care among the urban poor, the public sector remains the main provider of inpatient care at the secondary and tertiary public hospitals.



03. Health vouchers

What are they and when are they useful

Vouchers, a form of results-based financing (RBF), have been used in many sectors, including health in low-, middle-, and high-income countries. More specifically, health vouchers work as both a financing mechanism to provide subsidized healthcare to a targeted population and as a programmatic tool to reduce barriers to access and increase use of critical health services (Menotti and Farrell, 2016). Concerted efforts at the demand-side and supply-side lead to a simultaneous reduction of access barriers and improved healthcare provision, generating a strong response from the target population (Gorter, 2013). Evaluations have shown that vouchers can effectively increase utilization, enhance equity, and improve quality and availability of care. Furthermore, there is emerging evidence that vouchers are cost-effective and can change health-seeking behaviour in a sustainable manner (Gorter, 2020).

The concept of RBF in health originated in response to developing countries' felt need to improve access to and utilization of health services, particularly among the poor. Policymakers in developing countries have come to realize that public health services have not yielded the desired health outcomes due to issues concerning the efficiency, fairness and quality of health systems created and maintained through significant tax-based financing. In particular, the utilization and uptake of services has been very low among those who would benefit most from these services, the poor and vulnerable sections of the population. This is especially true for critical services such as maternal and child health (Gupta, Joe and Rudra, 2010). The capacity of the voucher model to work at both demand and supply-side, and use private sector capacity, makes the model attractive for governments to address gaps in public health service provision.

Through vouchers, the client can receive a clearly defined health service package at pre-selected health facilities free of charge or at a reduced fee. The subsidy goes directly to the client in the form of a voucher (whether paper or through an electronic token) – that the client can then redeem at a health provider.⁶

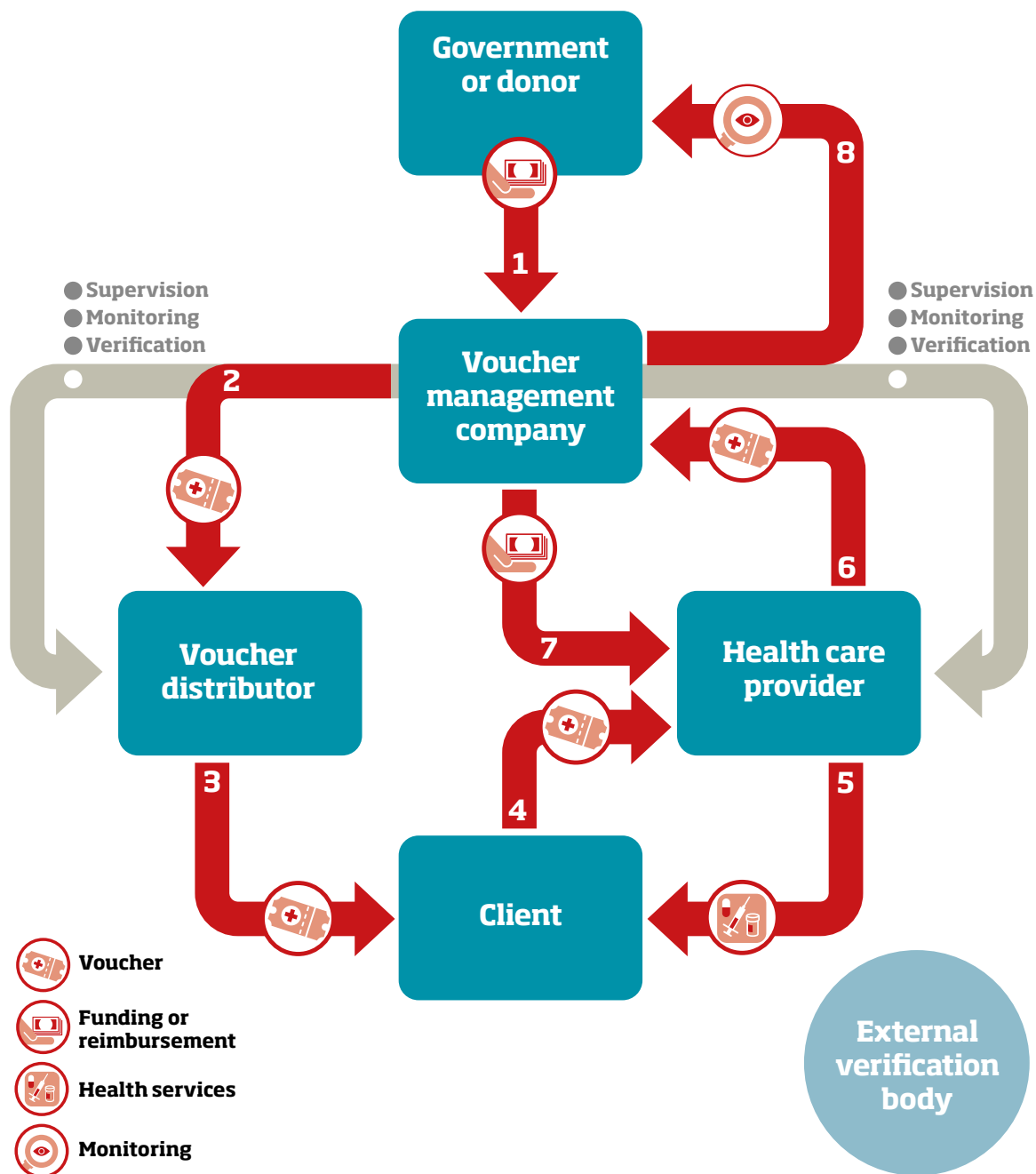
In the case of Bangladesh, the model is successfully being piloted in urban areas with the purchasing of a primary healthcare package and nutrition services from the private sector to address the urban poor's growing demand for health services and insufficient public sector capacity to respond to those needs.

Although there are many variations in the design and implementation arrangements of voucher programmes, they share a number of important characteristics: a funding body (government and/or donors), a governance structure that oversees the programme, and an implementing body (i.e., voucher management agency) that distributes vouchers to target populations, contracts facilities to provide services to voucher clients, and reimburses the facilities for services rendered.

Figure 2 presents how vouchers work. The voucher management agency receives funding and contracts the healthcare providers. The agency organizes the distribution of the vouchers to the target population, as well as sensitization on their use and redemption. The clients (or in this case the beneficiaries) redeem the voucher at a healthcare facility. The health facility returns the voucher to the agency and receives payment against vouchers redeemed. An external body verifies and reconciles against the services claimed. Verification can also be done by a monitoring unit of the voucher management agency, which is semi-independent from the unit implementing the vouchers. In the Bangladesh voucher pilots, the monitoring units of the NGOs verify the services, overseen by the ward counsellors and municipal authorities.

⁶ Can be a public, private or NGO provider.

Figure 2: Diagram of how vouchers work



04. Challenges encountered

Why use health vouchers in urban Bangladesh

The voucher pilots discussed in this case study are part of an EU-supported project implemented by the Government of Bangladesh (GoB). The project, which is in line with the Health Care Financing Strategy of the GoB, *Expanding Social Protection for Health: Towards Universal Coverage*, addresses the health needs and rights of the residents of urban slums.⁷

The project has three components:

- 01** *Grants made available to NGOs for strengthening/supplementing access to primary healthcare and nutrition services in urban areas, with a focus on the extreme poor population.*
- 02** *A grant made available to MOHFW and the Ministry of Local Government, Rural Development and Co-operatives (MOLGRD&C) for taking up capacity-building and institutional reform activities, such as workshops and training programmes.*
- 03** *Technical assistance to develop the capacity of MOHFW and MOLGRD&C in managing urban health programmes and implement institutional reforms.*

The urban poor have many health needs, with insufficient access to healthcare, and high out-of-pocket payments – 74 percent of current health expenditure according to World Bank.⁸ Expanding the capacity of the health system through the voucher model, by making use of the private sector, supports the GoB in accelerating health coverage for the urban poor.

The objective of this specific project is to improve the collaboration between MOLGRD&C and MOHFW; and to strengthen the capacity of the MOLGRD&C to address its urban health responsibilities and that of the MOHFW to coordinate and develop its stewardship of the urban health sector. The voucher model is expected to improve that collaboration through establishing models for urban essential health and nutrition service delivery through public–private partnerships, in addition to addressing the health gaps of the urban extreme poor.

This model is not completely new in Bangladesh, as the government under the MOHFW has also successfully implemented a voucher scheme for maternal health in 55 districts in rural areas. However, this is the first time that vouchers have been piloted in urban areas and for a much larger package of health services.

⁷ See: <http://socialprotection.gov.bd/wp-content/uploads/2017/03/HCF-Strategy-Bd-2012-2032.pdf>

⁸ <http://wdi.worldbank.org/table/2.12>

05. The pilot projects

5.1 Introducing voucher pilots

The urban health voucher pilots are being implemented by various NGOs. In 2014, the European Union Delegation (EUD) in Bangladesh issued a first call for proposals to improve primary health services delivery for the urban poor. BRAC, an international development organization based in Bangladesh, and Concern Worldwide were selected. The EC committed an amount of EUR 4 million to implement a pilot for 32,100 health vouchers and one for micro health insurance⁹ (MHI) for 4,000 households, for a period of three years (December 2016–March 2020). Implementation experienced unexpected setbacks, however, which hampered the contracting of primary healthcare facilities, reducing the geographical reach. Nevertheless, external evaluators concluded that both the vouchers and MHI improved health-seeking behaviour and increased the utilization of health services by the urban extreme poor (icddr,b, 2019).

In 2017, a second call was launched, seeking proposals for piloting a voucher scheme wherein selected private health facilities in a municipality would deliver primary healthcare services.

The second call led to the selection of three NGOs: **Concern Worldwide, in partnership with SAJIDA Foundation; Dhaka Ahsania Mission (DAM), in partnership with Christian Aid; and Resource Integration Centre (RIC)**. The EUD contracted the NGOs to implement the three voucher pilots, each for approximately EUR 2 million. It is these three voucher pilots which are described in the case study.

The objective of the three pilots is two-fold: to improve the utilization of sustainable, integrated and comprehensive health and nutrition services by the urban poor in the pilot areas, while at the same time piloting the voucher model for future utilization by the GoB. Based on the learnings of each voucher pilot, one common model would be developed to scale up throughout Bangladesh. However, considering the differences in the nature of the various urban areas of city corporations, secondary municipalities, and small municipalities, it was never the intention to implement one model throughout the country. Rather, the intention was to better understand the differences and share this understanding with government, which would make their own policy decision, depending on the scale/type of urban areas.

Table 1: Budget, and start/end date for the three pilot projects

Organization	Target Municipalities	EU contribution (€) ¹⁰	Start /end date	Project duration
DAM-CA	Satkhira and Savar	2,017,620	Feb 2018 -July 2021	36 months + 6-month no-cost extension (NCE)
Concern SAJIDA Foundation	Chandpur and Feni	1,914,461	Feb 2018 -July 2021	36 months + 6-month NCE
RIC	Chapai Nawabganj, Kaliakair, Naogaon, Narsingdi, Tangail, Tarabo	2,016,177	Feb 2018 -Mar 2021	33 months + 5-month NCE

⁹ MHI or community-based health insurance is a kind of micro-insurance for health in which resources are pooled to mitigate health risks and cover healthcare services in full or in part. These are mostly defined by a target population consisting of low-income individuals or households, voluntary participation of the enrolled individuals or households, and provision of health insurance services in exchange for premiums paid by the enrollees. In the case of this pilot, the project subsidized 50–100 percent of the premium for the target population.

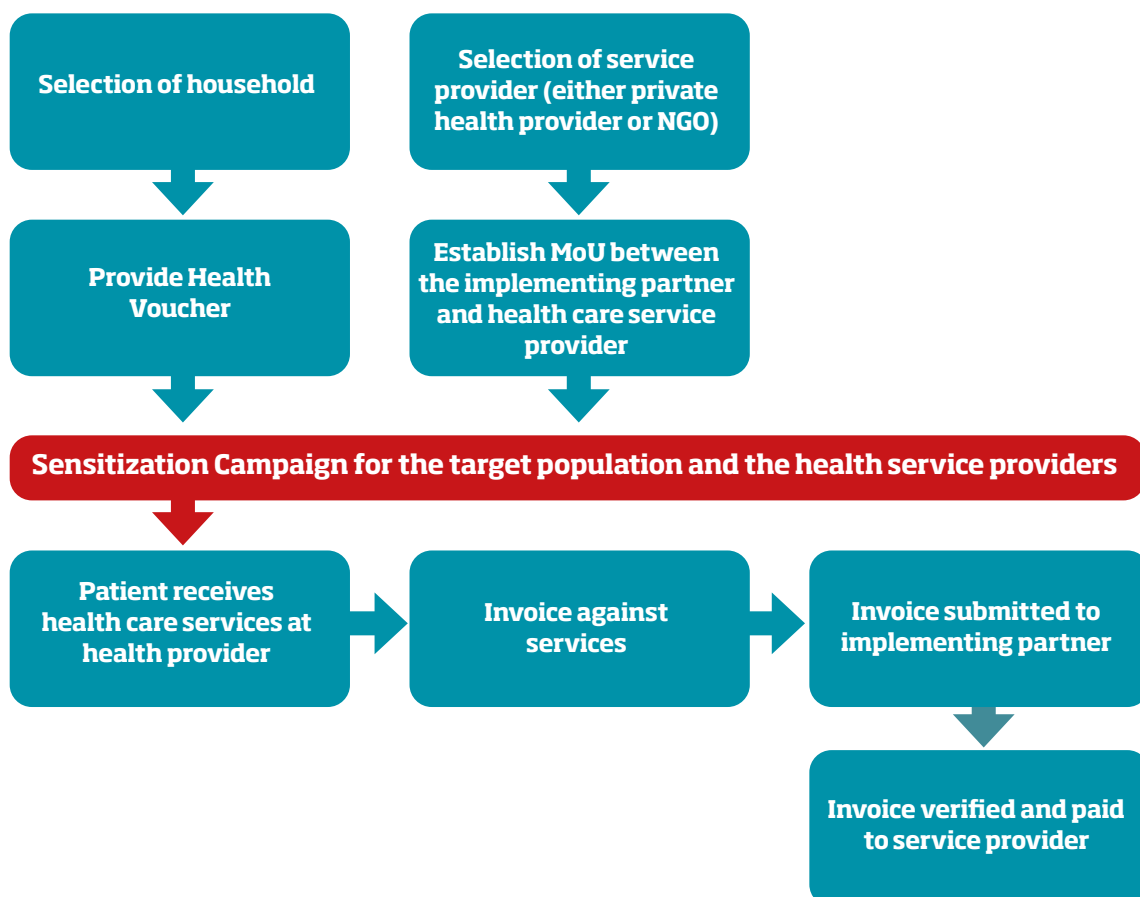
¹⁰ Implementing NGOs contributed 25 percent of the overall amount; the EU contributed 75 percent of the total.

The NGOs are implementing the voucher pilots in close collaboration with the local government institutions (LGIs): municipal and (sub)district authorities and elected representatives. MoUs were signed between the NGOs and municipality which outlined roles and responsibilities, including raising public awareness about health, nutrition and the use of vouchers; targeting beneficiaries; coordinating with private health facilities; and developing a municipal strategy on ways to address health needs in the future.

5.2 How are the voucher pilots being implemented

Figure 3 (and partner-specific flow charts, see Annexes 1–3) demonstrates the flow chart for the three voucher pilots. The voucher management agency – in this case, the NGOs, selects the households and existing health service providers to participate in the voucher scheme, based on specific criteria. Thus selection of both the beneficiaries and the service providers is conducted in close collaboration with local authorities from municipalities and (sub) district health offices. It is important to note that the process for Concern-SAJIDA Foundation was different because they used a smart card (see Annex 3).

Figure 3: Health voucher flow chart for the three pilots



Voucher distributions are then organized: door-to-door and, in the case of smart cards (Concern-SAJIDA Foundation), through enrolment camps after initial door-to-door invitations. Throughout the whole process, households and health service providers receive continuous sensitization about the programme and the service package.

The services provided, value of the voucher card, the relevant health services offered and where the voucher card can be used, are communicated to the households through meetings at the community level – which are held before the voucher distribution.

The process for receiving a health service includes the patient arriving at the health facility and presenting the card to the reception area – often a dedicated counter for the pilot. Staff also guide voucher beneficiaries to the corresponding medical services.

On a monthly basis, health providers submit their invoices to each NGO with which it is contracted to receive payment. All the NGOs have their own internal system of submission of invoices, reconciliation of invoices and verification of the services. After verification, health service providers are paid.

5.3 Voucher card design

Figures 4 and 5 present the design of the voucher cards used by each pilot. RIC uses a simple paper voucher with a handwritten unique number for each household. DAM uses a paper voucher with a QR code for the unique voucher number of the household. The QR code (Figure 5) can be scanned and linked to the web and android-based information platform. Concern-SAJIDA Foundation uses a smart card voucher, which can be read by a card reader and linked to the web-based information platform. Each qualifying household receives a form of a voucher card.

Figure 4: Voucher design for each project



Voucher card
Dhaka Ahsania Mission

Voucher card
Resource Integration Centre

Smart Card Concern

Figure 5: Backside voucher card DAM - with QR code

The figure shows the backside of a voucher card with three main sections:

- Top Left Table:**

নং	পরিচালকের নাম	পরিচালকের ঠিকানা	সদ্য পেরিড	করণ	নিম্নসহকারী স্বাস্থ্য সেন্টার	সেবা গ্রহণের ক্ষেত্রের নাম
- Top Right Table (সেবার ধরন):**

সেবা গ্রহণের তারিখ	সেবা গ্রহণের মাস	সেবার বিবরণ	সেবা প্রদানকারী প্রতিষ্ঠান	সেবা প্রদানকারীর ঠিকানা
- Bottom Left Table (সেবার ধরন):**

সেবা গ্রহণের তারিখ	সেবা গ্রহণের মাস	সেবার বিবরণ	সেবা প্রদানকারী প্রতিষ্ঠান	সেবা প্রদানকারীর ঠিকানা
- Bottom Right:** A photograph of a woman and a QR code.

5.4 The voucher service package




The services that can be redeemed with the voucher are based on a predefined service package.¹¹ This includes:

- 01 Maternity Care: antenatal care (ANC), safe delivery care, postnatal care (PNC), maternal nutrition, neonatal care, post abortion care;
- 02 Adolescent Health;
- 03 Family Planning;
- 04 Management and Control of Sexually Transmitted Infections (STIs, including HIV/AIDS);
- 05 Management and control of Reproductive Tract Infections (RTIs);
- 06 Reproductive Health;
- 07 Integrated Management of Childhood Illness, Nutrition, and Immunization;
- 08 Communicable Diseases Control;
- 09 Non-communicable Diseases Control;
- 10 First Aid and Emergency Service;
- 11 Diagnostic Services.

Table 2 presents the voucher values for the three pilots. The values vary between the three pilots as these are based on the estimates each NGO made in relation to service uptake and its costs, based on the pricelist of the Bangladesh

¹¹ This was predefined by the donor at the pre-proposal phase.

Table 2: Details of the voucher values in each pilot (conversion rate for October 2020)

Dhaka Ashania Mission assisted by Christian Aid	Concern Worldwide with SAJIDA Foundation	Resource Integration Centre
		
Maximum value is BDT 60,000 (612 Euro) per household/per year	Maximum value is BDT 24,200 (247 Euro) per household/per year	Maximum value is BDT 20,500 (209 Euro) per household/per year
Breakdown: Any outpatient service BDT 10,000 (612 Euro) ph/py	Breakdown: General illness BDT 4,700 (48 Euro) ¹⁴ py	Breakdown: General illness Outpatient services BDT 3,000 (31 Euro) ph/py
Inpatient services Delivery care BDT 50,000 (510 Euro) ph/py 5% of total voucher cards	Maternity care for ANC & PNC BDT 6,600 (67 Euro) ph/py	Maternity care Including delivery BDT 17,500 (178 Euro) ph/py
	Delivery care Normal delivery BDT 5,200 (53 Euro) ph/py Caesarean delivery BDT 12,900 (132 Euro) ph/py ¹⁵	

Private Clinic Diagnostic Owners Association, and the market rates for health services in their target areas.¹² Note that prices in larger cities where Concern-SAJIDA Foundation and DAM are working are higher than those in the smaller cities where RIC is implementing the pilot.

The voucher services were also packaged differently. Concern-SAJIDA Foundation separated out maternity care, emergency care and general illness. The latter basically encompasses all care unrelated to maternity or emergency care. DAM split the package between outpatient and inpatient services, with maternal care, such as ANC and PNC and other general health services, being available in outpatient services and delivery care in inpatient services. Finally, RIC split the package between maternity care and general illness (this being everything unrelated to maternal care).

NGOs also set a cap amount per household. Concern-SAJIDA Foundation and RIC set this overall maximum value for which one household can obtain services each year at approximately the same amounts, while DAM set this value significantly higher, specifically for delivery care, which includes caesarean sections.¹³ However, DAM capped the number of inpatients to 321 deliveries for three years in the two intervention areas; above this number, special permission had to be obtained. Again, the cap was set based on costs of the health services and available budget.

¹² NGOs used their previous experience with the 'Red Card' which was used in the Urban Primary Health Care Project (UPHCP) and also targeted the urban poor by providing a package for essential health services. Therefore, NGOs used this as a baseline for a better understanding of household health expenditures. The UPHCP was developed, financed, and implemented by the GoB (with financial and technical support from ADB and other development partners). The project had a design of contracting primary healthcare services to NGOs to improve and support urban health across Bangladesh in response to the growing urban population and increasing difficulties in unaided access to healthcare of the urban poor.

¹³ Because there is a cap for the health services, serious and unexpected accidents or emergencies would deplete the voucher. However, monitoring reports indicated that households were careful not to use the entire amount of the vouchers.

¹⁴ Concern project increased values (conversion rate at December 2020).

¹⁵ Since there is a cap for maternal health – should there be two pregnant women in one household – special permission would have to be obtained by the NGOs to modify the amounts to include additional coverage for other pregnant women within the household.

5.5 Who are the beneficiaries?

The three pilots cover 10 municipalities throughout Bangladesh (see Table 3), targeting the poorest households. Households were identified against specific selection criteria, with priority given to people with vulnerabilities, including using an income threshold to define the poverty level.

Ward counsellors and municipal authorities in each municipality were closely involved in identifying and selecting beneficiaries. Finally, the lists were endorsed by the municipalities.

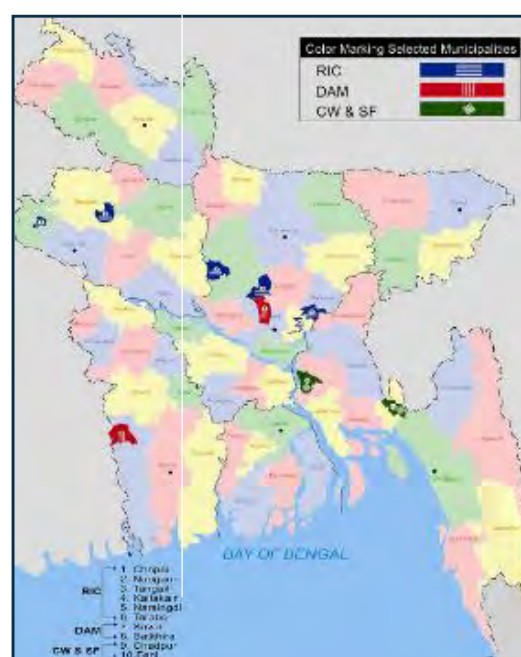
Table 3 presents the names of the municipalities and their population, along with the number of wards targeted by the projects. **Figure 6** presents the number of households who received a voucher card and proportion of total population in the municipalities benefiting from the vouchers.

The three pilots target 120 wards within the 10 municipalities, reaching around 80,000 households with over 337,000 beneficiaries (four to five members per household). Around one-sixth (16 percent) of the total population of around 2.1 million people in the 10 municipalities received a voucher.

Table 3: Targeted Municipalities, populations and number of poor wards in each municipality

NGO	Municipality	Population 2018*	# wards with poor
DAM	Savar	361,265	9
	Satkhira	143,140	9
Concern	Chandpur	200,864	15
	Feni	198,275	18
RIC	Chapai Nawabgonj	228,287	15
	Kaliakair	198,516	9
	Naogaon	190,163	9
	Narsingdi	184,562	9
	Tangail	211,463	18
	Tarabo	190,365	9

Figure 6: Municipalities covered by voucher pilots



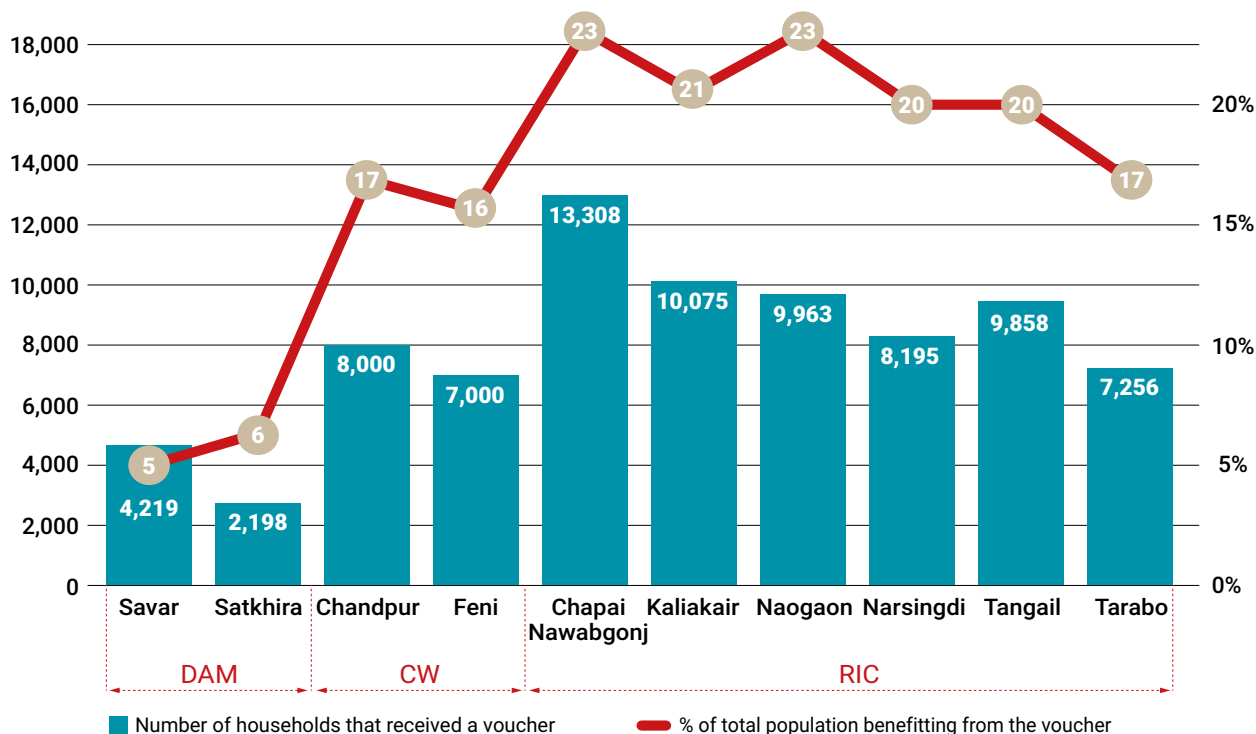
* Population census 2011 Bangladesh Bureau of Statistics projected to 2018 using urban growth rates, World Bank

Notice there are considerable differences in the number of beneficiaries between the three pilots; with DAM having the lowest number, Concern-SAJIDA Foundation targeting more than double the number of beneficiaries than DAM, and RIC as much as 10 times more. Reasons for the very large differences are twofold: 1) population sizes are different, with RIC having the highest number due to its decision to work in six municipalities instead of two; 2) poverty levels targeted (and targeting tools) are different, and therefore the proportion of the overall population in the municipalities targeted ranges from 5 percent in the DAM project to 21 percent in the RIC project.¹⁶

Poverty in Bangladesh fell significantly between 2010 and 2016, especially in rural areas, with a decrease from 35.2 to 26.4 percent. However, urban poverty rates did not decline much, and pockets with poor and extreme poor remained (respectively 18.9 percent and 7.6 percent). It is these pockets which are targeted by the voucher pilots.¹⁷

DAM targets the extreme poor and highly vulnerable (women-headed households, elderly, people with disabilities and socially marginalized groups), reaching 5 percent of the total population in the two municipalities. The other two projects are targeting 16 percent (Concern-SAJIDA Foundation) and 21 percent (RIC) of the total population in the target municipalities.

Figure 7: Number of households which received a voucher per municipality, and percentage of the total population which received the voucher



16 Concern-SAJIDA Foundation used the following selection criteria: extremely poor families living in a slum, squatting and/or pavement-dwellers; household income of maximum BDT 6,000 (70 USD) per month; only one earning member in the family; low income and expenditure spending ratio; high expenditures for medical purposes; number of meals per day (fewer than two or three meals per day), and poor households who did not have access to a free health card from the NGO-Service Delivery (NHSDP) project, Marie Stopes Bangladesh, BRAC or any other organizations in Feni and Chandpur municipalities. Special attention was also given to target female-headed households, the elderly, people with disabilities and socially and professionally marginalized groups.

17 Precise poverty data for the target municipalities are not available, but the projects do target relatively poor districts in which the municipalities are located. See World Bank poverty data for districts: <http://www.worldbank.org/en/data/interactive/2016/11/10/bangladesh-poverty-maps>

5.6 Contracting of private healthcare facilities

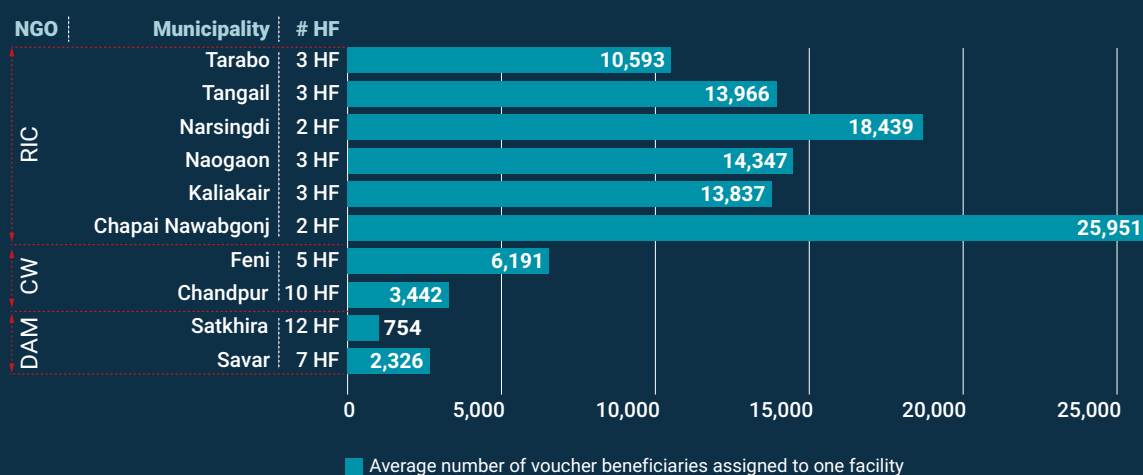
With the support and coordination of the municipalities,¹⁸ NGOs developed a selection criteria for identifying suitable healthcare facilities to participate in the voucher project. The process was as follows:

- 01 Mapping of potential healthcare facilities in each target area based on the following selection criteria:**
 - willingness to participate;
 - ease of access (on foot or by low-cost transport) for the beneficiaries. Special attention was given to distance to ensure that beneficiaries did not have any additional transportation fees to access the health facility;
 - capacity to provide the services available in the voucher package;
 - 24/7 availability for maternal services.
- 02 Assessment of the quality of the potential health facilities using a quality checklist developed by each pilot. Quality of medicines was also taken into consideration as part of the whole 'quality of the potential health facility'.¹⁹**
- 03 Price negotiation and agreement on frequency of payment.**
- 04 Finally, signing of the MoU between the selected health facility and NGO.**

All three projects developed a comprehensive checklist to assess the overall quality of the health facility and capacity to participate in the voucher project. The assessments included aspects of client friendliness, availability of female staff, and staff technical capacity, diagnostic and pharmaceutical capacity, use of SOPs/manuals, safety, infection prevention and waste management. Each NGO formed a committee consisting of technical/medical staff from municipalities, sub(districts) and NGOs to assess potential health facilities.

Overall, about half of the mapped health facilities failed to meet the selection criteria due to poor quality of care. However, the proportions were very different for each project: Concern approved almost all (17 of 20); DAM somewhat more than two-thirds (31 of 40) and RIC only about one-third (19 of 58). This is perhaps due to the different quality of health services in the different areas and/or difference in the original mapping methods used.

Figure 8: Number of service providers contracted, and average number of beneficiaries assigned to one health facility



¹⁸ In the case of Concern and DAM, also the district health authorities, and the Private Clinic Diagnostic Owners Association.

¹⁹ See Annex 5 for the checklists NGOs used.

Projects negotiated the prices with each individual health facility, resulting in some differences between providers. Price lists from the local Private Clinic Diagnostic Owners Associations were taken as a benchmark, final prices were negotiated, and a final price list was developed and included in the MoU.

Figure 8 presents the number of health facilities contracted in each municipality. DAM approved 40 health facilities but contracted 31. Concern contracted all 15 approved providers. RIC approved 19 but contracted 16. Reasons for not contracting certain facilities were related to disagreement during negotiations or issues of administrative capacity on the health facility side.

The average number of beneficiaries served by one health facility in each municipality is also shown in Figure 7. There are considerable differences between these numbers, ranging from fewer than 2,000 beneficiaries per health facility in the DAM project, to around 5,000 in the Concern-SAJIDA Foundation project, while the numbers for RIC are between 10,000 and 26,000.

As described, the projects mapped all suitable private health facilities, assessed them, and contracted with those which qualified. The proportion of facilities approved was lowest in the RIC project, while RIC targeted many more beneficiaries. Hence, the average number of beneficiaries assigned to one health facility was much higher in the RIC project than in the other two.

Almost all the health facilities contracted for the voucher projects are large hospitals, apart from a couple of NGO clinics contracted by Concern-SAJIDA Foundation.

As hospitals are large and unfamiliar to most the beneficiaries, each hospital arranged a designated reception desk or room with hospital staff to assist the clients in navigating their way around the facility and use of the vouchers (**Figure 9**).

Figure 9: Hospitals that participated in the voucher project and reception area designated for the voucher project beneficiaries



Rose Medical Centre,
Chapai Nawabganj



Reception area Lab One Hospital,
Chapai Nawabganj



Tanha Healthcare Hospital,
Kaliakair

5.7 Health service provision at the community level in addition to vouchers (RIC project)

In addition to contracting of health facilities, RIC's medically trained field officers (FOs) provide medical services at the household level; including medicines for minor illnesses and referrals when needed. This intervention is important to note because, as beneficiaries receive medical attention directly at the household level, the use of the voucher card is relatively low when compared to the other two projects (see below). FOs conduct NCD screening, which leads to a very good uptake of treatment services of NCDs at the health facilities using the voucher cards (see below).

When medically indicated, FOs also refer voucher holders to visit the health facilities with the voucher. In case of emergencies, cardholders can directly access the health facilities.

5.8 Voucher distribution and community work

All three projects organized public ceremonies to announce the voucher project and distribute the vouchers, which was done against a beneficiary list (**Figure 10**). Government officials including mayors, ward councils and district/sub-district authorities also participated. Beneficiaries were notified beforehand of the event and distribution activities in their community.

Figure 10: Voucher card distribution ceremonies



Ceremony at ward level,
Tarabo



Ceremony at ward level,
Satkhira

Social behaviour change communication (SBCC) activities were implemented, including health education to raise awareness about the relevance of accessing essential health services and to improve health-seeking behaviour. Community volunteers were trained in these sensitization activities to support the beneficiaries (**Figure 11**).

RIC trained 2,078 volunteers (one in every 30 households); Concern-SAJIDA Foundation 418 (one in every 36 households); and DAM trained 49 volunteers (one in every 130 households). Among those trained volunteers under the Concern-SAJIDA project, Chandpur municipality already agreed to employ them under different routine health awareness-related activities.

The volunteers, who are also part of the communities, supported NGO staff with household visits, sensitization campaigns and supporting vulnerable groups to access health services. These volunteers are different from RIC's field officers.

Figure 11: Examples of community work

Field worker Asma Mariam conducting session to orient target households to improve health and nutrition behaviour and preventive practices in a slum under Concern-SAJIDA lead project in Chandpur



5.9 Role of the local government institutions

MoUs were signed between each NGO and mayors of each municipality to formalize the arrangements for implementation of the vouchers and establish mutual roles and responsibilities.

Municipalities are expected to facilitate project implementation, including coordination among all stakeholders; raising awareness about vouchers; and engaging ward counsellors to assist with beneficiary identification, voucher distribution and coordination with the health facilities.

The project was also used as an opportunity for the NGOs to actively encourage the municipalities to allocate more of their budget to targeting the poor for their health needs. Most municipalities committed specific funds for this. 23 DAM also supported in the development and finalization of Savar and Satkhira Municipality Health Services Strategy Paper, to be able to continue the health services through the allocation of a budget and other initiatives.

In addition, the mayor of Chandpur²⁰ has decided that the municipality itself will finance and continue with vouchers for 800 households with at least one beneficiary with a disability, using the same materials and information platform and working with the trained volunteers. It was possible through a planned advocacy approach at ministry level and local level right from the beginning of the project. The steering structure lead by the MOLGRD&C of the EU Urban Health Programme played a pivotal role to make it possible.²¹

The health authorities at (sub)district level also played an important role in providing support to ensure the quality of the health facilities. They supported in developing referral mechanisms between facilities for family planning services and for treatment of voucher beneficiaries at secondary- and tertiary-level government hospitals.

Figure 11: Examples of community work



Medical FO measuring
blood pressure - RIC



Courtyard meeting in
Satkhira - DAM

06. Project results

6.1 Introducing voucher pilots

Each NGO collected baseline data during the first phase of the pilot. Data showed that use of the formal health sector for primary healthcare was less than 25 percent among all target populations during 2019.

For instance, in the communities targeted by RIC, only 4 percent of households used a public health centre, and for NGO and private clinics/doctors this was respectively 3 percent and 16 percent. The large majority (77 percent) did interface with the informal sector, including 'village doctors' and traditional healers.

In the Concern-SAJIDA Foundation project, the proportions are about the same. In both projects, people interviewed said they would access public district hospitals if they were seriously ill or referred by a village doctor. However, in several municipalities none of the target population reported accessing district hospitals due to the distance between their community and the public health facilities.

6.2 Utilization of the voucher cards

The total number of vouchers that were distributed in 10 municipalities was around 80,000, covering 337,000 persons. However, not all vouchers were used. This was most likely due to the migration of households for economic reasons. In addition, due to the unpredictable nature of illnesses and health issues, some did not have a need for health services, and therefore did not use the voucher. It was expected that some vouchers would not be utilized, and this was noted in the risk analysis during the design of the project.

The voucher project had a positive impact, with the large majority of households targeted making use of the voucher card. This indicates that their access to formal healthcare improved considerably (see Figure 11).

The DAM project concentrated on the use of the formal health sector for maternal care and found that the use of antenatal care improved (51 percent from 45 percent), and the proportion of women delivering in a health facility increased from 34 percent during the baseline to 76 percent at the end of 2020, while postnatal checks increased from 27 to 90 percent.

Figure 12 presents the proportion of health voucher cards that were used at least once. Eighty percent of DAM's beneficiaries used the vouchers from the time they were distributed until December 2020. For Concern-SAJIDA Foundation, this figure was 100 percent, and for RIC it was 77 percent. There are marked differences between the municipalities. For instance, in Naogaon, only half of the households used the voucher, while in Narsingdi, all the households who received the vouchers used their card. It is not yet clear why some vouchers in certain areas were not used, however the COVID-19 lockdown did impact the usage of the vouchers as there was a reduction in visits to health facilities during this time (see **Figure 13**).

Figure 12: Proportion of vouchers used per municipality

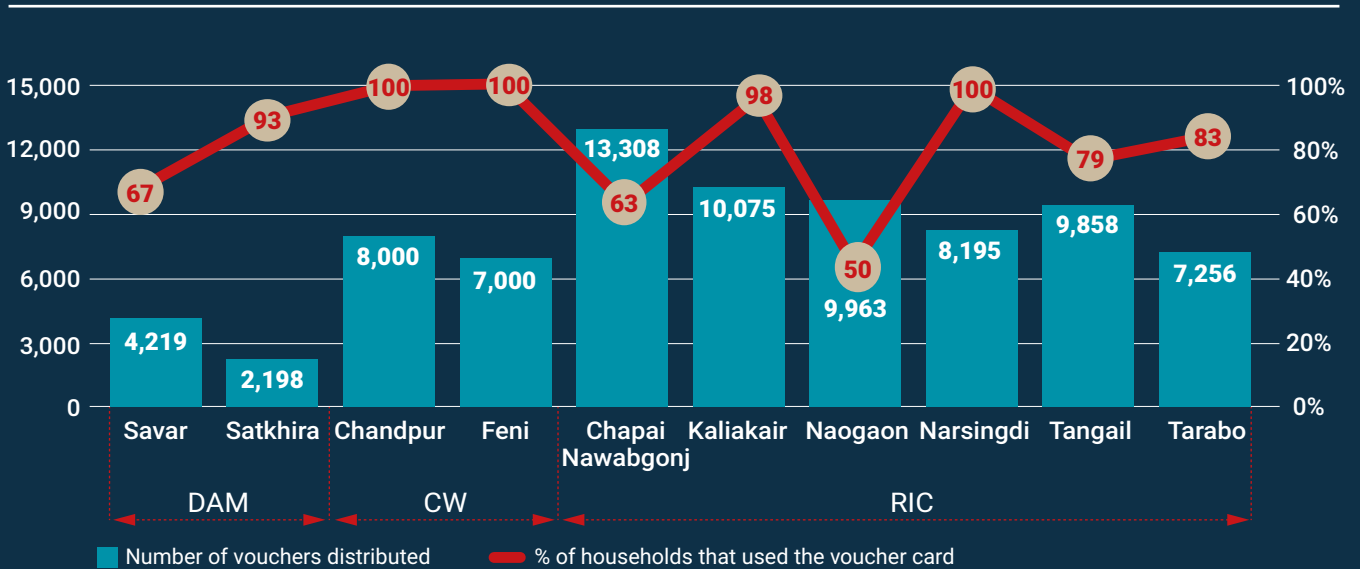


Figure 13: Annualized rate of consultations through the voucher card for one household (start service provision to March 2020)

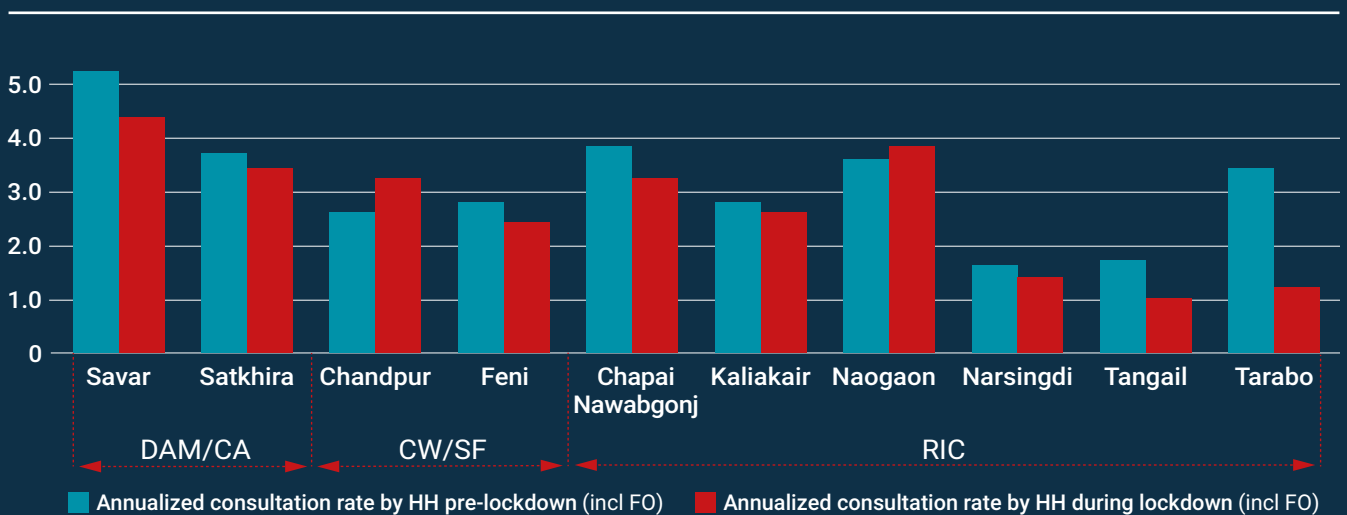


Figure 13 presents the annualized rates²² for medical consultations through a voucher card. The pre-lockdown time frame is from the beginning of the voucher distribution until March 2020. The lockdown time frame is between April 2020 and December 2020. The graphs represent both time frames, with the number of consultations (on annual basis) before and after the start of the COVID-19 lockdown.

Both figures present the voucher use by all three NGOs, as well as the number of medical consultations provided by the field officers in the RIC project. For the final comparison of the rates, we summed in the RIC project the consultations provided by the field officers through the vouchers.²³ In most municipalities the consultation reduced during the lockdown. However, households benefiting from the RIC project continued to utilize the field officers through phone consultations, while Concern-SAJIDA Foundation contracted more health facilities in February 2020 (see below).

There are differences between the three pilots with regards to the annualized number of consultations for each household. The DAM project has the highest rates, followed by Concern-SAJIDA Foundation and then RIC. This is in line with the number of health facilities contracted in the vicinity of the target beneficiaries, with the DAM project having contracted the highest number of health facilities. The short distance between health facilities and beneficiaries made it convenient for the target population to access care when needed. Choice and lower client volume might have also played a role as well.

There are also differences in voucher use during the time – before and after March 2020,²⁴ as the COVID-19 lockdown affected the uptake of health services, particularly during the months of April and May 2020.

In June 2020, the usage rates started to increase slowly; however in December 2020, they had still not returned to the levels observed in March 2020 (data not shown).

The average rate for DAM went down from 4.7 to 3.9 medical consultations per household per year. For RIC, the rate decreased from 2.8 to 2.0. For Concern/SAJIDA Foundation, the rate increased, from 2.7 to 2.8, but should have increased even more, as the number of contracted health facilities rose considerably in February 2020 from 5 to 15 (in Feni from 2 to 5 and in Chandpur from 3 to 10), thereby reducing the distance for the beneficiaries to the health facilities, removing an important barrier to uptake. The shorter the distance, the more use people make of the health facility.

It can therefore be concluded that the annual consultation rate would have been much higher if there had been no lockdown due to COVID-19, because the communities were just starting to use the vouchers, and it is assumed that they would have continued to seek health services. Anticipating potential low service uptake, all three NGOs developed a COVID-19 Response Plan to save beneficiaries from further shock. NGOs reported fear and hesitation in going to hospitals. With approval from the EU Delegation, projects distributed cash grants to voucher holders through mobile-based cash transfers, meant to better respond to unforeseen incidences.

As described above, the urban poor do not have regular access to formal primary health, and therefore forego treatment when there is no urgent health need. The health information provided, together with the vouchers, enabled beneficiaries to change their healthcare-seeking behaviour. Beneficiaries expressed that they were more likely to access healthcare when necessary because they no longer feared the high costs.²⁵ Timely use of healthcare improves overall health and prevents worse outcomes due to delays in treatment.

²² Annualized rates calculated using the available data (number of medical consultations for a certain period).

²³ As described above, in the RIC pilot, the consultations were provided through the voucher after referral, as well as by the field officers directly at the household level. The data shown here sum up the consultations provided by the health facilities and the field officers.

²⁴ The lockdown started on 26 March 2020.

²⁵ See Annex 4 for beneficiary stories.

6.3 Provision of health services

Because each NGO had their own design for the voucher pilot, analysing the results of the services used by the vouchers was a challenge.

While there was existing data for the services utilized, the data was not comparable between the NGOs because there was no agreement on how to categorize the services and their types. Additionally, the three pilots did not start at the same time – with voucher distributions happening at different months of the year for each pilot (RIC started first voucher distribution in April 2019, while DAM started earlier in the year and Concern started distribution in July 2019). For this reason, only data from RIC is represented in this study (Figure 14).

For RIC, 34 percent of the services were for non-communicable diseases, followed by maternal health. This in line with the objective of the vouchers – improve access to healthcare for non-communicable diseases.

The data below does not, however include consultations made by RIC’s field officers. While those consultations did not count towards the voucher project, the high number of usages demonstrates a willingness by the community to seek health support when needed. This therefore represents an improvement in health-seeking behaviour, where previously the community delayed seeking support. Figure 14 demonstrates the consultations made by the field officers. Note that, despite the lockdown, the community continued to utilize the support and services of the field officers, except Tarabo.

Figure 14: Breakdown of types of consultation - RIC project

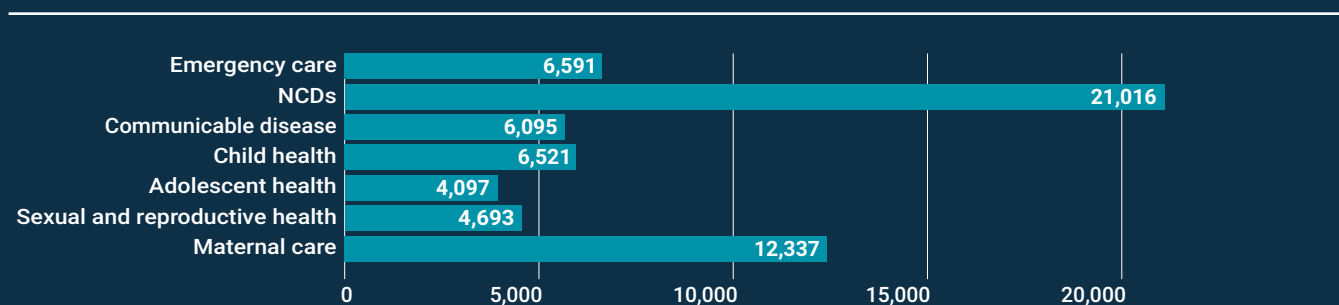
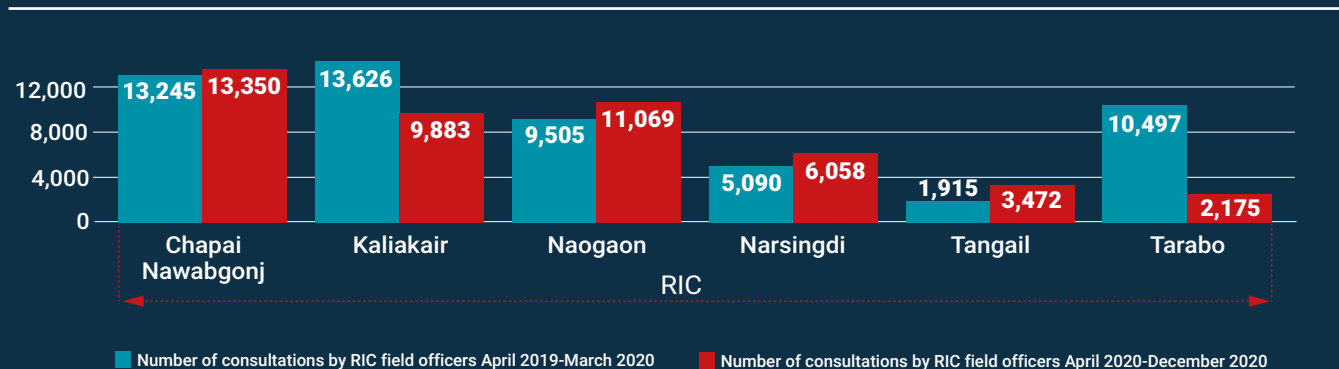


Figure 15: Consultations by RIC field officers



6.4 Feedback on the vouchers

Local stakeholders consider the voucher model highly successful.

Municipal and (sub)district authorities reported that the voucher projects helped to improve the working relationship with the private sector and was useful in improving quality control of private health facilities. The new mayor of Chandpur municipality has successfully negotiated with private providers to offer services at reduced rate, as the municipality is planning to launch a new health project for families with disabled members, funded by the municipality. This project is entirely based on the Concern-SAJIDA Foundation model. This is important because it has the potential to pave the road for future strategic purchasing of the private health sector to serve the extreme poor. As a result of the success of the vouchers, municipalities increased their budget to assist the poor with urgent health needs through a special fund accessible through the ward counsellors.

Private providers were also quite happy with the vouchers, as it has helped them to improve the quality of their services, such as client friendliness and infection prevention and control (IPC). The vouchers also brought in more clients to their facilities. Some providers will also continue to provide services at a discounted price for the poor (outside of the voucher scheme). Increased quality and willingness to provide services for the poor at a reduced price benefits the whole population living in the catchment areas of these facilities.

According to monitoring data, beneficiaries reported an improvement in their knowledge of health issues and when and where to access essential health services, including immunization and other preventive services. High satisfaction with the voucher services was also reported, however beneficiaries expressed the desire to include additional services in the voucher package. Some also expressed the need to increase the amount allocated for the outpatient care. Nonetheless, data indicated that due to the voucher scheme, beneficiaries managed to receive non-voucher services at a 40 percent discount. This was because the poor became visible for key actors, including government officials, and as part of corporate responsibility efforts of the private health facilities which opted to support the poor. Hospital officials also wanted the continued business of these beneficiaries.

Beneficiary stories (Annex 4) highlight how beneficiaries made use of the vouchers – particularly in seeking health-care services – where they would otherwise not have been able to do so.

Moreover, Concern-SAJIDA used a hotline number as a part of their Complaint Response Mechanism (CRM) system. All these complaints were systematically analysed and necessary actions were taken by designated staff. This was also part of ensuring quality services from the private sectors.

07. Monitoring and evaluation

7.1 Fraud control

All three NGOs set up an appropriate data collection and management system, to ensure the monitoring of activities (**Figure 16**). While Concern uses the smart card with a web-based claims processing platform, DAM has a combination of QR code, paper documentation and a web-based claims processing platform. RIC relied solely on paper documentation. NGOs also continuously received feedback from beneficiaries and health service providers.



Figure 16: Implementation meeting at an empanelled private hospital at Chandpur.

© Concern-SF

Each voucher service provided by the private providers is reported. Private providers submit records of each voucher service, including details of the service and procedures or medicines received. Invoices are checked to ensure that the service provided falls within the framework of the voucher package and that all necessary documentation is present.

Monitoring field teams also interview a random subsample of beneficiaries to verify if the services reported have been provided. In case of discrepancies, facilities are given a warning and, if necessary, contracts are terminated. Since fraud control was strongly implemented by all three NGOs from the beginning of the pilot, little or no fraud has been observed. However, a proper evaluation will indicate whether or not there were possible instances of fraud, particularly around targeting and misuse of the voucher.

Once invoices have been checked, verified and approved, payments to the health facilities are made.

7.2 Quality assurance

All three projects perform quality assurance of the services, albeit at different frequencies.

DAM's quality team plans for assessment visits every four months. DAM also applies a monitoring checklist while conducting visits to the clinics and beneficiaries.

Concern-SAJIDA Foundation M&E team implements annual outcome monitoring visits, which include quality assessments, while project staff conduct regular (bimonthly) monitoring of the quality of the contracted health facilities using a short checklist.

RIC's field officers conduct frequent monitoring visits to the clinics.

Furthermore, field staff from all projects interview clients at their homes to hear about their experiences at the health facility.

Feedback from the quality control activities is given to the private providers during monthly and/or quarterly meetings, where representatives from the local government are present.

08. Challenges and lessons learnt

There were two main challenges reported by the implementing NGOs. The first was building trust between the NGO and the community – particularly in ensuring that their personal data would be protected. All three NGOs reported beneficiary sharing of information as a challenge. Technology was only an issue for Concern, given its use of smart technology (smart card health service delivery), and it took time for both the beneficiaries and the service providers to become familiar with this technology.

The COVID-19 pandemic was also a challenge. The lockdowns meant that beneficiaries were not able to access health services. There was also fear of contracting the virus within health facilities, so beneficiaries in some cases avoided receiving healthcare when needed. Finally, several clinics and hospitals became overwhelmed and were forced to prioritize COVID-19 patients over other patients.

As previously noted, the pilot would provide learning to be able to develop a common model to scale up the voucher project throughout Bangladesh. However, at the time this case study was written, it was still too early to assess the impacts of the voucher projects and the development of a common model for upscaling. However, more learnings will be documented and consolidated in order to develop a feasible model for roll-out, particularly around the composition of the voucher, and potential issues with fraud.

In conclusion, it is important to note that while this case study is specific to a development context, the design and the learnings can be applied to the humanitarian context. This is particularly significant, as the vouchers can also be linked to social protection programming to reduce catastrophic costs related to healthcare, especially if targeting the most vulnerable, as this project is doing.



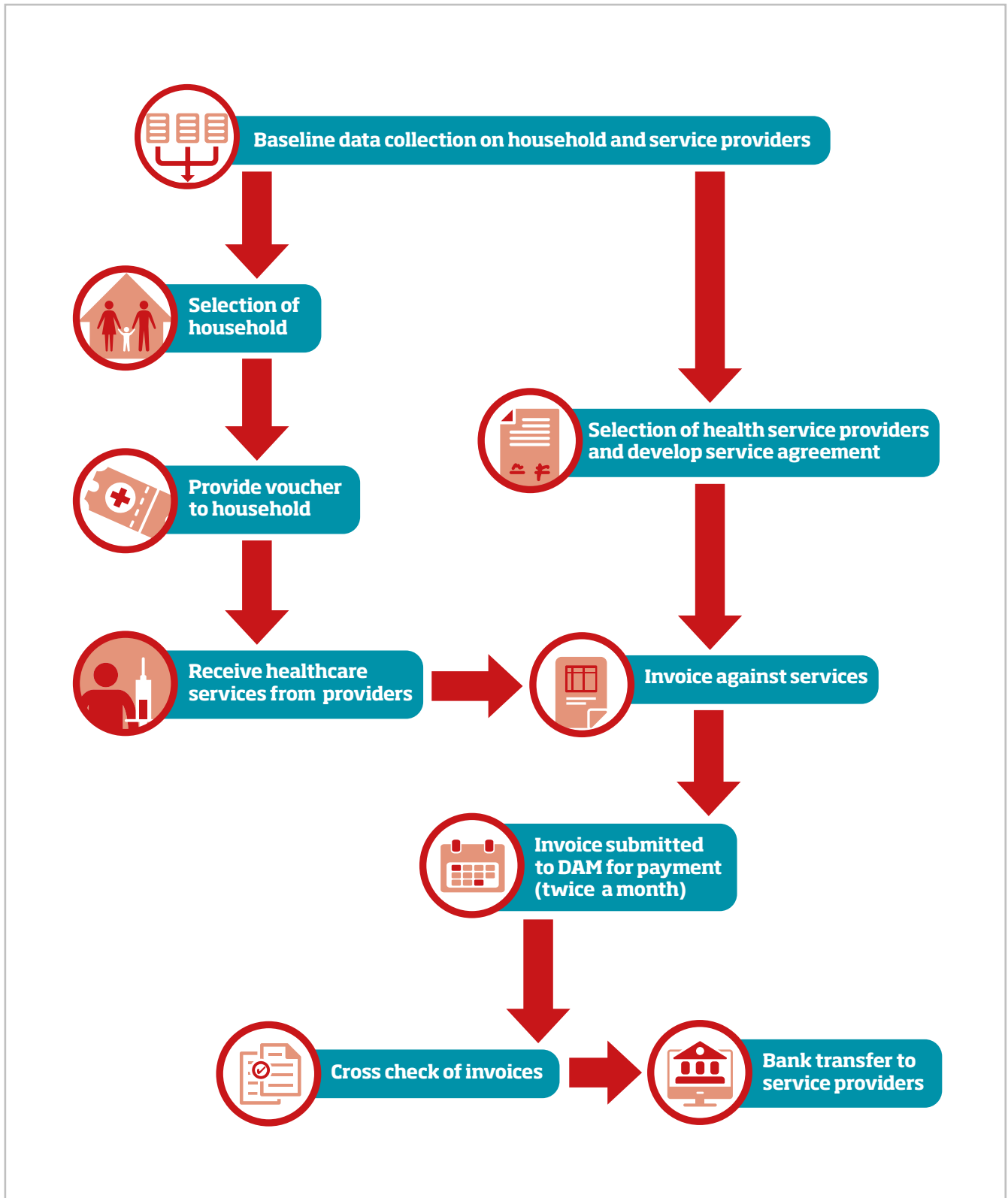
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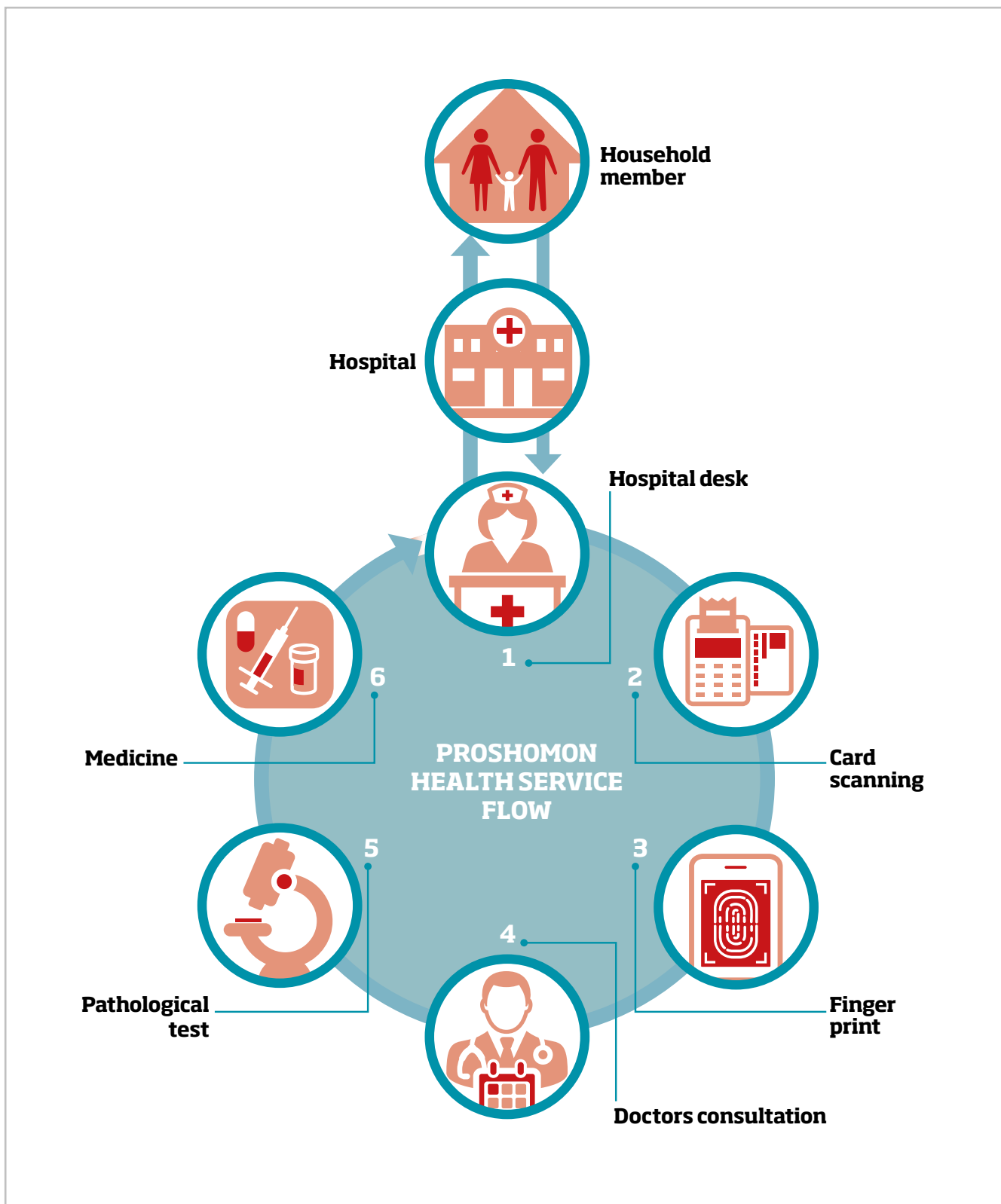
10. Annexes



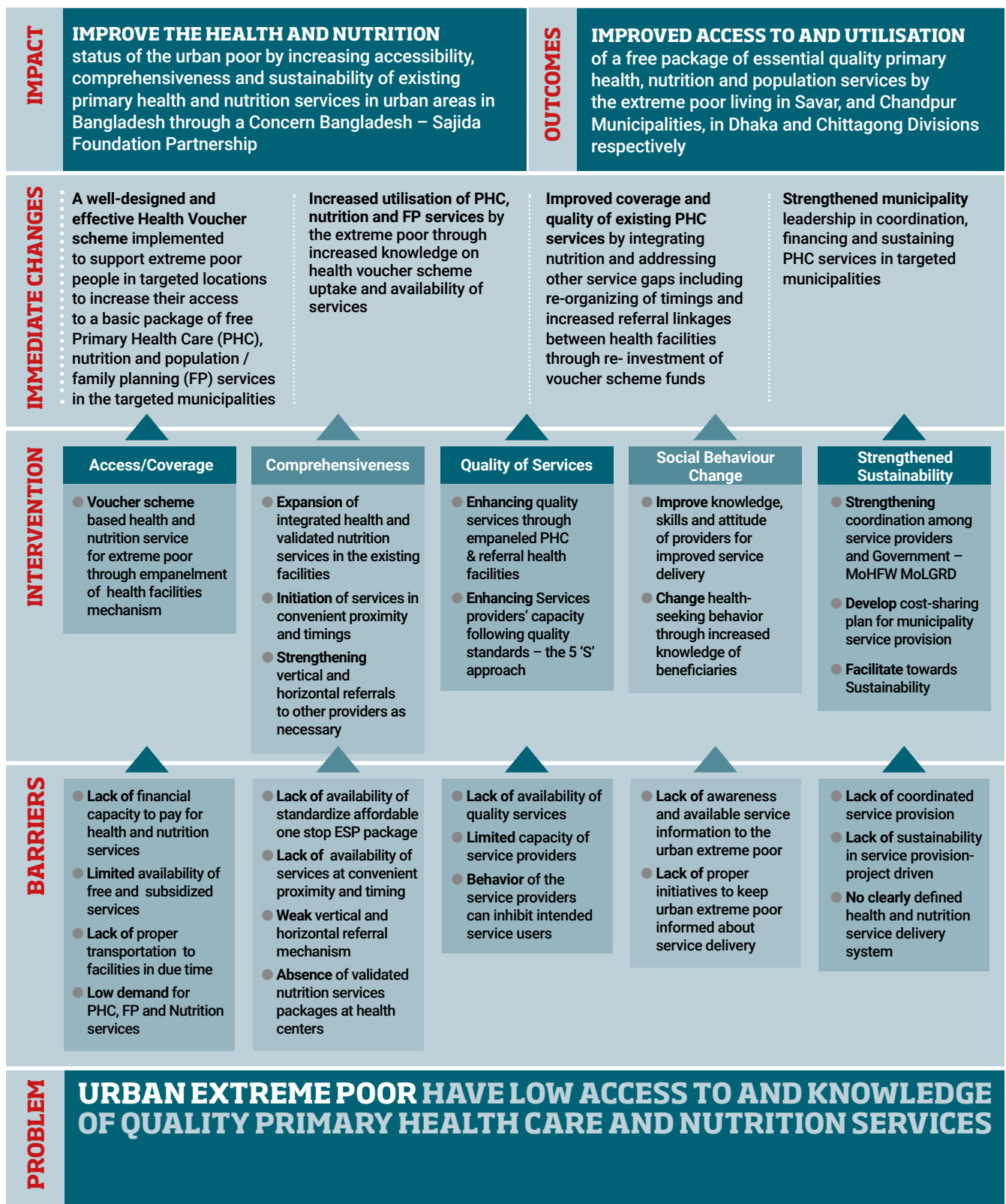
Annex 1: DAM health voucher management flow chart



Annex 2: Concern service delivery flow chart



Annex 3: Concern and SAJIDA Foundation theory of change



Annex 4: Beneficiary stories



From DAM

Ruma Begum, a homemaker from a very poor family, has changed to a healthier lifestyle to control her hypertension, with the support of the Health and Nutrition Voucher Scheme for Poor, Extreme Poor and Socially Excluded People PEPSEP project.

Ruma's husband worked as a day labourer, which means inconsistent and unreliable income. The family prioritize food expenses and forwent using some of that money for health expenses.

Ruma Begum was enrolled as a beneficiary of the PEPSEP project and received a card from Dhaka Ahsania Mission (DAM). With this, she, her husband and children were eligible to receive healthcare.

One day, Ruma Begum became very ill. She contacted DAM's community volunteer, who helped her access DAM's contracted clinic – Satkhira National Hospital. She learned that she is suffering from high blood pressure, after running several diagnostic tests (covered by the voucher). She was prescribed medication, but also received information about changing her eating habits to better control her blood pressure. Following her diagnosis, she has received several follow-up visits by DAM's community volunteer.

Ruma is grateful for the project's health services, stating, 'it is not feasible to receive such good medical care without a voucher card.' She also noted that she would have never received a diagnosis without the voucher project – which has changed her life. She has become an advocate for healthy eating habits and continues to educate her neighbours about high blood pressure and how to manage it.

Annex 4: Beneficiary stories



Kulshoma with her baby. RIC

From RIC

Kulshom, a 32-year-old housewife, lives with her husband and three children in Narsingdi Pourashava. Kulshom delivered her fourth child with the support of the health voucher provided by RIC.

During her pregnancy, she often complained of pain in her stomach. She was advised to go see a doctor by members of the community. Going to the doctor was not an option because her family prioritizes other expenses, particularly as her husband is a day labourer. She learned about the RIC project and registered to become a beneficiary. She received the voucher card for her and her family.

She also enrolled herself in the 'Golap Health and Nutrition Group', where she learned the uses of the voucher card, and the list of hospitals/clinics enrolled in the project, where she can receive health support.

She used the voucher for her first two antenatal check-ups at Central Hospital at Narsingdi. She was diagnosed with anaemia and was prescribed medication. Despite this, her anaemia continued, and she was admitted to the hospital, with the help of RIC's community volunteer.

That same day, she went into labour. Doctors noted that her case was complicated as she was anaemic. With the help of doctors and nurses, she gave birth to a baby boy. She stayed at the hospital an extra day to recover. The hospital bill was covered by the voucher project.

Kulshom, along with her family members, were happy she was able to receive the proper treatment and deliver a healthy baby despite the complications. She was also thankful for RIC, and the doctors and nurses at the hospital for their support.

Annex 4: Beneficiary stories

From Concern Worldwide-SAJIDA Foundation

Panna Begum (28 years old) lives with her family in Chandpur municipality. Her husband, who previously worked as day labour, is now unemployed. The family struggles financially as a result.

Panna and her husband have two children. Panna's first child was a home delivery, carried out by a 'dayee' (local-level, untrained midwife) in January 2018. Soon after the delivery, the baby developed birth asphyxia, which was diagnosed when Panna's husband Badsa took the baby to a nearby hospital. Panna gradually began noticing a delay in her child's development, and he was thus diagnosed with autism.

When Panna got pregnant with her second child, she had complications early on in her pregnancy. She did not, however, have the financial resources to see a doctor, until she heard of the PROSHOMON project. She learned of the maternity service from the SBCC meeting organized by SAJIDA Foundation's Chandpur office.

**Panna Begum
and her second child.
Nov 14, 2019. Proshomon**



Panna registered for the PROSHOMON project and, owing to her family's financial situation, they were selected for the Smart Health Card. Thereafter, she received support for maternal services and recommendations from the field workers during the SBCC orientation.

Panna gave birth to her second child via a caesarean section at Midland Hospital on 30 July 2019. Neither mother nor child had any complications, particularly as Panna continued to receive PNC services from the hospital.

Panna was very much grateful to the PROSHOMON project, stating that without the Smart Health Card she would have been unable to receive this kind of life-saving services. In her words:



I would not be able to get the health services if I did not receive the card. My child is in good condition and I am coming for check-up as per the schedule the doctor suggested. My family will also avail the services using this card if they have any health problems. I could not afford the delivery cost in my last pregnancy and had to suffer a lot for that. I always pray to the Almighty for the betterment of the PROSHOMON project.

Annex 5: Checklist for Health Facility Assessment

PEER QTA CHECK LIST (Technical)						
NAME OF THE CLINIC AUDITED:						
DATE OF AUDIT :						
AUDITED BY:						
	Observation item	Not observed/ Not applicable	Standard not achieved	Standard partially achieved	Standard in place at beginning of visit	Comments
		NA	0	1	2	
A	Clinical Governance					
1	Clinic signboard visible and well maintained and service flow chart is placed as per instruction				√	
2	External condition of the building well maintained				√	
3	Clinic exterior clean and there is no litter or other refuse distracting from the external décor of the clinic.				√	
4	Range of opening hours 24/7 are clearly displayed				√	
6	Staffs properly dressed with name badges			√		
7	Designated spaces available and properly labeled with room number			√		
8	There are hand washing facilities for clients				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
B	Availability of Basic Client Services					
1	Out patient curative care for patients				√	
3	Child vaccination services	√				
4	Any modern methods of family planning	√				
5	Antenatal care services			√		
6	EmOC services				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
C	Availability of Basic Amenities for Client Services					
1	Water supply				√	
2	Client Latrine / Separate Toilet for Women				√	
3	Privacy during consultation				√	
4	Regular electricity				√	
5	Land/mobile phone				√	
6	Emergency Ambulance services				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
D	Availability of Basic Equipments for Client Services					
1	Stethoscope				√	

2	Thermometer				√	
3	Blood pressure apparatus				√	
4	Adult weighing scale				√	
5	Child or infant height & weight scale				√	
6	Light source (is it Spot light or Torch Light)				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
E	Availability of standard items for infection control					
1	Sterilization equipment - Functional autoclaving mechanism in place				√	
2	Safe disposal of sharps				√	
3	Disinfectant - Chlorine, Phenyl, detergent, soap etc				√	
4	Arrangement for decontamination available and used <ul style="list-style-type: none"> • Colored buckets marked for decontamination • Water for washing and rinsing of instruments • A mop/cloth in a mug with a 0.5% Chlorine solution for cleaning examination table and other surfaces • Bleach in dark container properly stored • Plastic spoon, Plastic basket/bucket with perforated bottom for holding instruments • Wooden stirrer • Utility gloves • Macintosh • Large plastic bucket for immersing and cleaning instrument • Tooth brush • Goggles 				√	
5	Surgical gloves				√	
6	Masks				√	
7	Guideline for standard precautions - Training Manual on Quality of Care				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
F	Capacity to conduct basic laboratory tests & Imaging					
1	Haemoglobin (Hb)%				√	
2	Complete Blood Count (CBC)				√	
3	Blood grouping & Rh typing				√	
4	Cross matching				√	
5	Venereal Disease Research Test (V DRL)				√	
6	Hepatitis B				√	
7	Urine/RE				√	
8	Random Blood Sugar (RBS)				√	
9	Serum creatinine				√	
10	Ultrasonography				√	
11	Chest X- ray				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
G	Normal Labour					
1	Initial assessment, accurate and documented (risk assessment)					No indoor services. Diagnostic and doctor consultation only
2	Partograph recording complete, each section and Partograph board is placed in labour room					No indoor services. Diagnostic and doctor consultation only

3	AMTSL documentation or observation : Use of oxytocin,Delivery of placenta by control cord traction ,Massage of uterus after placental delivery					No indoor services. Diagnostic and doctor consultation only
4	Cord Management done correctly	v				No indoor services. Diagnostic and doctor consultation only
5	Neonatal assessment: Apgar, documented					No indoor services. Diagnostic and doctor consultation only
6	Neonatal resus: equipment present and functioning					No indoor services. Diagnostic and doctor consultation only
7	Recording of all events with times and clear signatures					No indoor services. Diagnostic and doctor consultation only
8	Daily clinical record and discharge advice documented					No indoor services. Diagnostic and doctor consultation only
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
H	Caesarean section					
1	Indication for caesarean section documented					No indoor services. Diagnostic and doctor consultation only
2	Informed Consent taken					No indoor services. Diagnostic and doctor consultation only
3	OT note					No indoor services. Diagnostic and doctor consultation only
4	Daily clinical record and discharge advice documented					No indoor services. Diagnostic and doctor consultation only
5	Neonatal assessment: Apgar, documented					No indoor services. Diagnostic and doctor consultation only
6	Neonatal resus: equipment present and functioning					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
I	ANC (Antenatal Care)					
	Observation / Documenatation					
1	ANC register/ Health record: 1. All cases attending logged, standardised, in one register (only for maternity)	v				No specific ANC register
2	Provider take history and keeps records of the followings: Privacy in consulting rooms					No specific ANC register
2	Menstrual history: LMP, whether regular or irregular, History of amenorrhoea,					No specific ANC register
3	Obstetric history: No.of children, age of last child, mode of delivery, any complication in previous pregnancies					No specific ANC register
4	Medical history: H/O diabetes, hypertension, Juandice, smoking,					No specific ANC register
5	History of family planning method use					No specific ANC register
6	Provider Conducts Physical Examination on the followings: General examination of mother (Height, weight, BP, edema, anemia, jaundice and nutritional status) in every visit.					No specific ANC register
7	Height of uterus/fundal height					No specific ANC register
8	Fetal movement					No specific ANC register
9	Position and presentation of fetus					No specific ANC register
10	Fetal heart sound (FHS)					No specific ANC register
11	Pelvic examination					No specific ANC register
12	Urine analysis/ sugar albumin at every visit/ As per Protocol					No specific ANC register
13	Hb checked and results available					No specific ANC register
14	Blood group					No specific ANC register
15	Iron/Folic acid) prescribed					No specific ANC register
16	Provider Discusses Relevant Issues during counseling as follows: Danger signs of pregnancy					No specific ANC register
17	TT immunization					No specific ANC register

18	Birth planning					No specific ANC register
19	Breast feeding					No specific ANC register
20	Counselling on health education at every visit					No specific ANC register
21	ANC four visits					No specific ANC register
22	Post partum contraception					No specific ANC register
23	1st PNC visit within 24 hours and 2nd PNC visit within 48-72 hours					No specific ANC register
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
J	PNC (Postnatal Care)					
1	Observation/Documentation	v				No specific PNC register
2	PNC register/ Health record: 1. All cases attending logged, standardised, in one register (only for maternity)					No specific PNC register
3	Privacy maintained					No specific PNC register
4	Record card available and complete					No specific PNC register
5	1st PNC visit within 24 hours, 2nd PNC visit within 48-72 hours, 3rd PNC visit within 7 days and 4th PNC visit with 42 days					No specific PNC register
6	Provider screens (take history) for delivery information: mode of delivery, place of delivery, any complication during and after delivery.					No specific PNC register
7	Provider Examines the Mother: General examination: Temperature, BP, Pulse, Oedema, Anemia, Jaundice.					No specific PNC register
8	Examination of Breast: Condition of the nipple, Engorgement					No specific PNC register
9	Per abdominal exam: Height of the uterus, P/V bleeding, perineal tear, foul smelling discharge					No specific PNC register
10	Provider Examines the Baby: General Exam: Weight, Temperature, Respiratory rate, Jaundice					No specific PNC register
11	Umbilicus					No specific PNC register
12	Conjunctiva					No specific PNC register
13	Congenital abnormality					No specific PNC register
14	Provider Discusses Relevant Issues during Counseling as: Early initiation & Exclusive breastfeeding up to 6 months with colostrums at birth					No specific PNC register
15	Delay bathing atleast three days after birth					No specific PNC register
16	Post-partum contraception					No specific PNC register
17	Immunizations- Vaccines are properly stored					No specific PNC register
18	New born danger signs					No specific PNC register
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
K	Nutrition Services					
1	Salter scale, weight machine, length/height board or height sticker, MUAC tape are available and used.	v				No specific service
2	Filled up GMP card and keep recording in the facility.					No specific service

3	Maternal Nutrition- Advises are properly given to pregnant mothers					No specific service
4	Counseling for adolescents , Iron/Folic acid, Diet					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
L	Adolescent Friendly Health Services					
1	Do you offer health service to adolescents?				√	
2	What type of services do you offer to adolescents?				√	
3	Do the young people know where they can get Youth Friendly Health Services?				√	
4	Does the facility have comfortable sourroundings for youth?				√	
5	The privacy and confidentiality of all young people who visit health service delivery point is maintained				√	
6	Service providers are motivated to provide health service to young people in ayouth friendly manner				√	
7	Do the youth get services irrespective of their status(sex, marital status, religion, race, sexual orientation)?				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
M	Women friendly Health Services					
1	Staff have positive attitude towards the care of women to ensure a congenial atmosphere.				√	
2	Women's dignity is respected, privacy and confidentiality is maintained.				√	
3	There is a teams spirit, which inspires the hospital and the community to cooperate actively in ensuring women's rights.				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
N	Waste Management in the clinic					
1	Waste management mechanism is present at the clinic.				√	
2	4 colors bucket are present in the clinic in the appropriate place.				√	
3	Guideline available at the clinic for waste disposal.				√	
4	General waste, medical waste and harmful chemical waste are separated properly.				√	
5	Waste is removed from the clinic by another orgnization/GOB.				√	
6	MOU is available with this organization/GOB.				√	
7	Waste disposal at the premises of the clinic.				√	
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
0	CRM					

1	What are the methods for submission of complaints - written or oral?								
2	Is there any mechanism at the clinic to receive complaints from the clients?								
3	Are the complaints recorded?								
4	Do the beneficiaries know how the complaint will be submitted and recorded?								
5	Is there any criteria to help clearly identify between different types of complaints?								
6	What are the steps to be followed once the complaint is submitted and the timeframe for processing the complaint?								
7	Do the beneficiaries get feedback after finishing the process?								
Net Total									
Total Score									
Number of Standards Assesed									
Percentage									
Final Total Score									
Number of Stanards Assesed (Total)									
Final Score in percentage:									

PEER QTA CHECK LIST (Technical)						
NAME OF THE CLINIC AUDITED:						
DATE OF AUDIT :						
AUDITED BY:						
	Observation item	Not observed/ Not applicable	Standard not achieved	Standard partially achieved	Standard in place at beginning of visit	Comments
		NA	0	1	2	
A	Clinical Governance					
1	Clinic signboard visible and well maintained and service flow chart is placed as per instruction					
2	External condition of the building well maintained					
3	Clinic exterior clean and there is no litter or other refuse distracting from the external décor of the clinic.					Not observed
4	Range of opening hours 24/7 are clearly displayed					
6	Staffs properly dressed with name badges					
7	Designated spaces available and properly labeled with room number					
8	There are hand washing facilities for clients					Three hand washing point exist
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
B	Availibility of Basic Client Services					
1	Out patient curative care for patients					
3	Child vaccination services					
4	Any modern methods of family planning					
5	Antenatal care services					
6	EmOC services					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
C	Availibility of Basic Amenities for Client Services					
1	Water supply					
2	Client Latrine / Separate Toilet for Women					
3	Privacy during consultation					
4	Regular electricity					
5	Land/mobile phone					
6	Emergency Ambulance services					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
D	Availibility of Basic Equipments for Client Services					
1	Stethoscope					
2	Thermometer					
3	Blood pressure aparatus					
4	Adult weighing scale					
5	Child or infant height & weight scale					
6	Light source (is it Spot light or Torch Light)					
Net Total						
Total Score						

Number of Standards Assesed					
Percentage					
E	Availability of standard items for infection control				
1	Sterilization equipment - Functional autoclaving mechanism in place				
2	Safe disposal of sharps				
3	Disinfectant - Chlorine, Phenyl, detergent, soap etc				
4	Arrangement for decontamination available and used <ul style="list-style-type: none"> • Colored buckets marked for decontamination • Water for washing and rinsing of instruments • A mop/cloth in a mug with a 0.5% Chlorine solution for cleaning examination table and other surfaces • Bleach in dark container properly stored • Plastic spoon, Plastic basket/bucket with perforated bottom for holding instruments • Wooden stirrer • Utility gloves • Macintosh • Large plastic bucket for immersing and cleaning instrument • Tooth brush • Goggles 				
5	Surgical gloves				
6	Masks				
7	Guideline for standard precautions - Training Manual on Quality of Care				
Net Total					
Total Score					
Number of Standards Assesed					
Percentage					
F	Capacity to conduct basic laboratory tests & Imaging				
1	Haemoglobin (Hb)%				
2	Complete Blood Count (CBC)				
3	Blood grouping & Rh typing				
4	Cross matching				
5	Venereal Disease Research Test (V DRL)				
6	Hepatitis B				
7	Urine/RE				
8	Random Blood Sugar (RBS)				
9	Serum creatinine				
10	Ultrasonography				
11	Chest X- ray				
Net Total					
Total Score					
Number of Standards Assesed					
Percentage					
G	Normal Labour				
1	Initial assessment, accurate and documented (risk assessment)				
2	Partograph recording complete, each section and Partograph board is placed in labour room				
3	AMTSL documentation or observation : Use of oxytocin,Delivery of placenta by control cord traction ,Massage of uterus after placental delivery				
4	Cord Management done correctly				
5	Neonatal assessment: Apgar, documented				
6	Neonatal resus: equipment present and functioning				
7	Recording of all events with times and clear signatures				
8	Daily clinical record and discharge advice documented				
Net Total					
Total Score					
Number of Standards Assesed					
Percentage					
H	Caesarean section				
1	Indication for caesarean section documented				
2	Informed Consent taken				
3	OT note				

4	Daily clinical record and discharge advice documented				
5	Neonatal assessment: Apgar, documented				
6	Neonatal resus: equipment present and functioning				
Net Total					
Total Score					
Number of Standards Assesed					
Percentage					
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	Observation / Documentatation				
1	ANC register/ Health record: 1. All cases attending logged, standardised, in one register (only for maternity)				
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2	Menstrual history: LMP, whether regular or irregular, History of amenorrhea,				
3	Obstetric history: No.of children, age of last child, mode of delivery, any complication in previous pregnancies				
4	Medical history: H/O diabetes, hypertension, Juandice, smoking,				
5	History of family planning method use				
6	Provider Conducts Physical Examination on the followings: General examination of mother (Height, weight, BP, edema, anemia, jaundice and nutritional status) in every visit.				
7	Height of uterus/fundal height				
8	Fetal movement				
9	Position and presentation of fetus				
10	Fetal heart sound (FHS)				
11	Pelvic examination				
12	Urine analysis/ sugar albumin at every visit/ As per Protocol				
13	Hb checked and results available				
14	Blood group				
15	Iron/Folic acid prescribed				
16	Provider Discusses Relevant Issues during counseling as follows: Danger signs of pregnancy				
17	TT immunization				
18	Birth planning				
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21	ANC four visits				
22	Post partum contraception				
23	1st PNC visit within 24 hours and 2nd PNC visit within 48-72 hours				
Net Total					
Total Score					
Number of Standards Assesed					
Percentage					
J	PNC (Postnatal Care)				
1	Observation/Documentation				
2	PNC register/ Health record: 1. All cases attending logged, standardised, in one register (only for maternity)				
3	Privacy maintained				
4	Record card available and complete				
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6	Provider screens (take history) for delivery information: mode of delivery, place of delivery, any complication during and after delivery.				
7	Provider Examines the Mother: General examination: Temperature, BP, Pulse, Oedema, Anemia, Jaundice.				
8	Examination of Breast: Condition of the nipple, Engorgement				

9	Per abdominal exam: Height of the uterus, P/V bleeding, perineal tear, foul smelling discharge					
10	Provider Examines the Baby: General Exam: Weight, Temperature, Respiratory rate, Jaundice					
11	Umbilicus					
12	Conjunctiva					
13	Congenital abnormality					
14	Provider Discusses Relevant Issues during Counseling as: Early initiation & Exclusive breastfeeding up to 6 months with colostrums at birth					
15	Delay bathing atleast three days after birth					
16	Post-partum contraception					
17	Immunizations- Vaccines are properly stored					
18	New born danger signs					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
K	Nutrition Services					
1	Salter scale, weight machine, length/height board or height sticker, MUAC tape are available and used.					
2	Filled up GMP card and keep recording in the facility.					
3	Maternal Nutrition- Advises are properly given to pregnant mothers					
4	Counseling for adolescents , Iron/Folic acid, Diet					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
L	Adolescent Friendly Health Services					
1	Do you offer health service to adolescents?					
2	What type of services do you offer to adolescents?					
3	Do the young people know where they can get Youth Friendly Health Services?					
4	Does the facility have comfortable sourroundings for youth?					
5	The privacy and confidentiality of all young people who visit health service delivery point is maintained					
6	Service providers are motivated to provide health service to young people in ayouth friendly manner					
7	Do the youth get services irrespective of their status(sex, marital status, religion, race, sexual orientation)?					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
M	Women friendly Health Services					
1	Staff have positive attitude towards the care of women to ensure a congenial atmosphere.					
2	Women's dignity is respected, privacy and confidentiality is maintained.					
3	There is a teams spirit, which inspires the hospital and the community to cooperate actively in ensuring women's rights.					
Net Total						
Total Score						
Number of Standards Assesed						
Percentage						
N	Waste Management in the clinic					
1	Waste management mechanism is present at the clinic.			Y		

Case study: Health and Nutrition Sector



in collaboration with:

