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CONCERN WORLDWIDE (U.S.) Inc.
CONCERN WORLDWIDE BANGLADESH
CHILD SURVIVAL PROGRAM
Saidpur and Parbatipur Municipalities

USAID-CONCERN-MUNICIPALITY PARTNERSHIP

MIDTERM EVALUATION REPORT

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Acronyms

AI	Appreciative Inquiry
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BP	Blood Pressure
CDD	Control of Diarrheal Disease
CHP	Community Health Promotion
CHV	Community Health Volunteer
C-IMCI	Community Integrated Management of Childhood Illness
CORE	Child Survival Collaborations and Resources Group
COSAS	Coverage Survey Analysis System
CRWRC	Christian Reformed World Relief Committee
CSP	Child Survival Program
CSGP	Child Survival Grants Program (USAID)
CSTS	Child Survival Technical Support Project
CWI	Concern Worldwide Incorporated
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus
EG	Entry Grant
EmOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
ESP	Essential Services Package
FGD	Focus Group Discussion
FP	Family Planning
FT	Field Trainer
FPAB	Family Planning Association of Bangladesh
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HICAP	Health Institution Capacity Assessment Process
HMIS	Health Management Information System
HPSP	Health and Population Sector Programme
HR/D	Human Resource/Development
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Ratio
INACG	International Vitamin A Consultative Group
IOCH	Immunization and Other Child Health Project
ISA	Institutional Strengths Assessments
KPC	Knowledge, Practice and Coverage Survey
LAMB	Lutheran Aid to Medicine in Bangladesh
LFA	Logframe Analysis
LOP	Life of Program
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation

MBBS	Bachelor of Medicine and Bachelor of Surgery
MCHC	Maternal and Child Health Care
MCWC	Maternal and Child Welfare Center
MO	Medical Officer
MHC	Municipal Health Committee
MHS	Municipal Health Services
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Government and Rural Development
MSH	Management Sciences for Health
NGO	Non-Government Organization
NSDP	NGO Service Delivery Project
ODU	Organizational Development Unit
OJT	On the Job Training
OPV	Oral Polio Vaccine
PBR	Parbatipur
PHC	Primary Health Care
PLA	Participatory Learning for Action
PP	Private Practitioner
PVO	Private Voluntary Agency (US-based NGO)
RA	Research Assistant
RMP	Rural Medical Practitioner
SBC	Social Behavior Change
SNID	Special National Immunization Day
SWOT	Strengths, Weakness, Opportunities, Threats
STO	Senior Training Officer
TBA	Traditional Birth Attendant
THC	Thana Health Complex (Now Upazilla Health Complex)
TO	Training Officer
TOT	Training of Trainers
TT	Tetanus Toxoid
UHC	Upazilla Health Complex
UHFPO	Upazilla Health & Family Planning Officer
UFHP	Urban Family Health Partnership
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHC	Ward Health Committee
WHO	World Health Organization

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A. SUMMARY

Program description and objectives
The USAID-Concern-Municipality Partnership Child Survival Program (CSP) is a four-year project that follows a successful two-year Entry Grant. The goal of the project is to contribute to the reduction of maternal and child mortality and morbidity, and increase child survival through the development of a sustainable Municipality Health Service in the Saidpur and Parbatipur municipalities of Bangladesh. The project seeks to strengthen the municipalities' capacity to deliver specific child survival activities of good quality, which can be sustained within existing Municipal, and Ministry of Health and Family Welfare (MOHFW) resources. Through a capacity building partnership on multiple levels, the CSP seeks to improve services in Immunization (EPI), Vitamin A, Maternal and Newborn Care, IMCI (Integrated Management of Childhood Illnesses – acute respiratory infections (ARI), diarrhea, and malnutrition), and Community Health Promotion (CHP).

The major program strategies include developing the management capacity of municipality managers and supervisors, developing the technical capacity of the municipality staff on selected child survival activities and strengthening the municipalities community approach through training, facilitation and supporting the formation of health committees.

There are five program outputs:
- A developed Municipality Health Planning and Management System
- Institutionalized and well managed activities (related to the interventions areas)
- A sustainable Community Health Promotion System
- Competent and independent Municipality staff and supervisors
- Improved Child Survival Program planning and management.

Main Accomplishments to Date
Through the support of municipal authorities, the CSP has succeeded in building capacity for delivering health services at every level, from the municipal health committees to the communities. All capacity indicators and the five program outputs listed above in the Detailed Implementation Plan are on target, or have already been achieved.

CSP advocacy and training support have increased municipal health service staffing and quality. Ward Health Committees (WHCs) are established in every ward. Some are almost ready to function independently, with little input from the CSP. Ward Health Committees are selecting, supporting and supervising Community Health Volunteers (CHVs) and Traditional Birth Attendants (TBAs) and organizing community level health promotion events.

The CSP succeeded in significantly raising immunization and Vitamin A coverage rates during the Entry Grant with USAID, and monitoring data indicate that these levels have been maintained. TBAs have been trained in clean, safe delivery and referring women with danger signs during delivery and postpartum period to health facilities. Project

operations and qualitative research have documented increases in facility deliveries and other positive maternal and newborn care practices. CHVs are very active in communities and community awareness of danger signs, indicating the need to seek health care for mothers and children, has increased significantly.

Main Constraints and Obstacles
Early in the project, Concern had to overcome considerable local political obstacles to secure the support and commitment of the municipality/local authorities to take action at the institutional level to use their own resources to improve the health status of the population. Obstacles were so great that the CSP had to leave one municipality and select another municipal partner following a change of political leadership. Close collaboration with project partners and stakeholders over a long period established the trust necessary to overcome barriers and engage in joint planning. The resulting CSP partnership may serve as a model for other municipal health programs in Bangladesh. Concern Bangladesh has already received requests from other municipalities to replicate the CSP.

Resource constraints to serve a largely poor population inhibit some project efforts to improve health services. These factors are largely out of the project's direct control. Maintaining the service and quality gains already accomplished in the program, while at the same time shifting focus to the other program interventions will require a number of adjustments in the day to day management of the program. Significant advocacy, facilitation and technical assistance inputs will be needed to engage all health providers in improving access to quality referral care. Fortunately, all stakeholders have expressed strong commitment to the additional efforts needed to further improve maternal and child survival in their communities.

Major Capacity Building Efforts
The major CSP capacity building efforts have focused on strengthening the municipality health system by joint planning, training and support at all levels. Skills training in planning, program implementation, data collection and analysis, problem solving and consensus building encourage institutionalization of maternal and child survival health services.

The Institutional Strengths Assessment (ISA) and Health Institution Capacity Assessment Process (HICAP) are organizational self-assessment tools employed by the project to understand baseline organizational situations, establish mutually agreed upon organizational objectives, and assess progress over time. Both tools are founded on the principles of appreciative inquiry. These have helped Concern and the municipalities to set capacity goals and specific programmatic plans.

Prospects for Sustainability
The CSP's institutional partner is the Municipal Authority/Paurashava with a tripartite partnership of communities, WHCs and the Municipal Health Services (MHS) with the shared goal of increasing health capacity and improving sustainable health status through the municipalities. The program is so thoroughly integrated with the partners, that the term "CSP" is synonymous with the partnership. Municipal governments and WHCs are

raising funds locally to support improved services, including providing emergency transport and covering medical costs for the poorest members of the community. These efforts are developing mechanisms for financial support after CSP funding ends.

Project advocacy efforts insure that health is well placed on municipal government agendas. This indicates that program impacts will probably continue long after the funding period ends. Building advocacy skills can have a spill-over effect into other municipal programs that can support the child survival program. Communities already express a commitment to cleanliness and environmental sanitation that they attribute to the community health promotion activities of the CSP. Locally sustainable material inputs are used, therefore supplies and equipment used by the CSP is not a major consideration after the CSP ends.

Priority Recommendations

- For additional impact on mortality reduction, the CSP needs to shift focus away from EPI and Vitamin A, which have been largely successful, to newer areas of maternal and newborn care and integrated management of childhood illness

- The CSP will need to engage in networking, coordination and advocacy with all major health care providers in the project area to address the main causes of maternal and child mortality by improving quality curative care in referral health facilities in the municipalities.

- To move the CSP towards sustainability, the CSP should make concerted efforts to implement an exit strategy for WHCs, CHVs and strengthening the municipality health management information system (HMIS).

- To reach the majority of children with life-threatening illnesses, the project must find ways to include private practitioners in quality of care improvement efforts.

- To impact on key household decision-maker behaviors, the CSP should find ways to promote greater community-level male involvement in the program.

B. ASSESSMENT OF PROGRESS TODATE

B.1. Technical Approach

B.1.a. Project Overview

When the CSP began with a USAID/BHR/PVC Entry Grant in 1998, the municipal governments of Saidpur and Parbatipur did not have health on their agenda. This was in spite of the 1995 Government of Bangladesh (GOB) circular requiring formation of health committees at the municipal and ward levels. The 1977 Paurashava Ordinance had already charged municipalities with responsibility for EPI and Vitamin A services as well as environmental sanitation, infectious disease control, community health promotion, and a variety of other public health duties.

Concern Worldwide (U.S.) Inc. was awarded the Entry Grant to develop a CSP in two urban locations, Mymensingh and Saidpur. The March 1999 municipal elections in Mymensingh resulted in a new cabinet that was not supportive of the Concern CSP capacity building approach. Due to conflicts of interest and insurmountable differences between the CSP and the new municipal cabinet ministers, Concern Bangladesh had to withdraw from Mymensingh and select another municipal partner. Parbatipur, in Dinajpur District adjacent to Saidpur, was selected from several municipalities as one with interests that were the most compatible with the CSP.

The purpose of the CSP is to strengthen the capacity in each municipality to deliver specific child survival services of good quality and to improve the health status of mothers and children which can be sustained within existing Municipal and MOHFW resources.

The CSP program methodology is based on the assumption that health security is achieved when people improve their knowledge, attitude and capacity for positive health practices. Participatory community development and capacity building are essential elements of community empowerment, which enable community members to reduce risks, and recognize and seek care for life-threatening conditions. The municipal health care systems are simultaneously strengthened at the institutional and community levels to address priority public health problems.

The three main strategies of the CSP are: 1) to develop the management capacity of municipality managers and supervisors via training, facilitation and participatory planning methods; 2) to develop the technical capacity of municipality staff on selected Child Survival activities via training and workshops, on-the-job training, and the development of a staff support system; and 3) to strengthen the municipalities' community approach through training, facilitation and supporting health committees with the resulting community based health promotion process.

The CSP Detailed Implementation Plan (DIP) described planned program activities in detail for years 1 & 2, allowing for detailed planning for years 3 and 4 after the necessary municipal health structures were in place. This allowed the project to focus on building capacity in the municipalities. The CSP strengthened MHS, assisted in the establishment of WHCs, and helped them train TBAs and the select, train and place CHVs. Technical interventions, in the addition to improving the quality of TBA care and motivating care-seeking behaviors, focused heavily on improving EPI and Vitamin A coverage and quality. These were selected as priority activities since most other health services are not the direct responsibility of municipal governments. As of the midterm evaluation, the program has implemented the workplan according to the schedule provided in the DIP. Exceptions, along with the rationale, are noted in the individual technical implementation sections in this report.

The CSP conducted considerable formative research in preparation for the more technically challenging interventions after the second year. As anticipated, the midterm evaluation process has provided the basis for the detailed action plan for the remainder of the project. (See the Action Plan section on page 43.)

As previously mentioned, the DIP contains five program outputs to provide the framework for the program plan: 1) a developed municipality health planning and management system; 2) institutionalized and well managed activities; 3) a sustainable community health promotion system; 4) competent and independent municipality staff and supervisors; and 5) improved child survival program planning and management for Concern.

Since the time the DIP was approved, the project has developed intermediate, or process monitoring indicators, which are measured on a regular basis by the CSP HMIS for each of the five outputs. Based on the HMIS, project records and the management information system, the project has already achieved, or is on target in achieving targets in all five output areas.

Over the next year, the program will refine definitions and measurement methods of the outputs to reduce subjectivity and further articulate program impact.

(See Table 1 in Annex A that lists program interventions, estimated program effort and USAID funding from the Detailed Implementation Plan and Section J-4 specific measurable indicators. Program technical interventions are discussed in detail in the technical sections; crosscutting activities including Behavior Change Communication and Community Health Promotion are discussed in section B.2.)

B.1.b. Specific Technical Interventions

This section addresses the major technical intervention activities, progress towards technical objectives and outputs since the beginning of the CSP grant, major accomplishments thus far, and challenges to intervention implementation. (Note that Community Health Promotion is a crosscutting approach and addressed in section B.2.a. Community Mobilization).

The CSP selected EPI, Vitamin A, TBA training and CHP as initial activities, since these interventions are under the control of the municipal government. The CSP strategy was to get these interventions well established before moving into other areas. At the midterm, this strategy proved to be wise. The DIP planned for the major efforts in IMCI and Maternal Newborn Care to be implemented in years 3 and 4. The program strategy has now been expanded to include assisting the MHS to coordinate these other technical areas with referral health facilities in the project area.

(Planned next steps and rationale are discussed in the technical intervention section; recommendations are in Section E.)

EPI (12% program level of effort years 1 & 2)

Based on findings from the EPI Facility Assessment, completed during the Entry Grant, the CSP focused on improving management and technical efficiency, community support and quality of the cold chain. The CSP worked closely with the Immunization and Other Child Health Project (IOCH) and WHCs to develop a community level registration system for newborns and pregnant women. Project staff provided on-the-job field support to improve vaccination technique and cold chain maintenance, and improve record keeping, reporting, and the monitoring system. [DIP p. 76, 2002 first semester report, site visits].

The CSP focuses EPI efforts on:

- Improving quality of care both at outreach and fixed (institution) centers
- Increasing the demand and participation in availing the services
- Improving both management and technical skills of the service providers
- Establishing functional coordination between municipality and other relevant stakeholders both in Government and NGOs for sustained cooperation [DIP year 2 first semester report]

Specific EPI program activities include:

- Regular refresher training for all stakeholders
- Government policy updates including changes in the government HMIS and population estimates relative to the (1991) census (the report from the 2001 census is not yet available).
- Support for extensive stakeholder involvement in the SNIDs.
- Regular review/planning meetings with Municipality Health staff.

- CSP representation at Upazilla Health Meetings and IOCH EPI Coordination meetings
- Supervision support for EPI facility management and disease surveillance and reporting

Technical assistance from the CSP team, particularly the Field Trainers, has considerably improved municipal EPI service delivery. Quality has improved in sterilization, injection techniques, registration of clients, follow-up of dropouts, etc. The CHVs and TBAs provide support in session management, and house-to-house client tracking. Field Trainers, many of whom have several years of experience as vaccinators with Concern, provide the majority of the technical support.

The HMIS helps the municipality track progress towards EPI targets, especially monitoring the vaccine coverage rate. Municipalities use the computer generated statistical reports to assess program performance and monitor program plan implementation against established targets. Colorful graphic charts tracking EPI, Vitamin A and ANC coverage are prominently displayed in municipality offices.

The CSP is also instrumental in mobilizing support for Special National Immunization Days (SNIDS), one of which occurred during the MTE fieldwork. Varieties of community groups, including scouts, assist at vaccination sites throughout the project area.

The project uses the Coverage Survey Analysis System (COSAS), a more accurate method of EPI coverage validation than those used in most PVO child survival projects. The COSAS measures the number and type of vaccinations, but also analyzes the timing of vaccinations to derive the "fully effective coverage". This method was used by IOCH, the USAID mission follow-on to BASICS I. Percentages calculated in this way are often significantly lower than those derived by usual EPI data collection.

Effective EPI coverage increased in Saidpur from 43% to 70%, and in Parbatipur from 49% to 89% by the end of the Entry Grant. The CSP information system, taking data from immunization cards, estimates that current coverage is over 80%, exceeding end of project targets. This is well above the 65-70% coverage level required to avoid periodic measles outbreaks in preschool children.

Additional program efforts undertaken during the current grant focus on improving EPI service delivery. These efforts include refresher training, strengthening supervisory skills, data analysis and dissemination, advocacy for staff and equipment and community mobilization.

The project monitoring system measures five EPI program quality elements. Each has shown measurable improvements from January 2001 to December 2002 as illustrated in table 1.

Table 1: Comparison of EPI Performance Monitoring Criteria, Saidpur Municipality 2001-2002

Performance Element	Jan '01 - Dec '01	Jan ' 02 - Jun '02
Sterility & Hygiene	64%	87 %
Cold Chain	60%	91%
Record Keeping & Reporting	74%	92%
Vitamin A Administration	70%	92%
Vaccine Administration	78%	84%

Source: Saidpur CSP, An Overview, 2002

Support for EPI in the second half of the project will continue to focus on cold chain quality, strengthening MHS supervisory capacity and refreshing Concern project staff immunization technical skills. These activities will prepare for turning over most of the EPI and Vitamin A program implementation and supervision to the Municipalities early in the second half of the project.

Challenges and Constraints

Sustainable progress has been constrained by the temporary status of municipal health department staff, several of whom were abruptly laid off at one point during the project. In Parbatipur, some EPI workers, including some supervisors are employees of the Upazilla Health Complex, and are not permanent members of the MHS staff.

Vitamin A (8% of program effort)

Vitamin A distribution is a component of the regular EPI services as well as the SNIDs. The project tracks Vitamin A data from the MHS facilities and includes this information in the HMIS reports. Postpartum women can receive a high dose Vitamin A capsule at the time they bring the child for their first immunizations. Content on consuming Vitamin A rich foods as well as the importance of Vitamin A supplements are included in training curricula for stakeholders in all levels. CSP information, education and communication (IEC) products, including wall murals with messages, were observed in several locations around the project area. Project EPI community mobilization efforts also contribute to increased Vitamin A coverage.

A MOHFW policy change from allowing capsules only in the first two weeks postpartum to up to 6 weeks postpartum has encouraged health workers to pay more attention to this activity. Trained TBAs obtain Vitamin A from the municipalities, who keep the records, and administer the dose to their clients. In principal, women delivering in health facilities also receive supplements, but this is not within the control of the CSP. Women who deliver, neither in facilities nor with the assistance of CSP trained TBAs, are unlikely to receive Vitamin A capsules, unless they receive them at EPI sessions. Thus, the CSP approach working with TBAs and the EPI program is designed to approach Vitamin A coverage at multiple levels but does not have access to all new mothers.

The vast majority of TBAs, both trained and untrained, promote early and exclusive breastfeeding to their clients. Breastfeeding is the recommended strategy for promoting Vitamin A intake for infants under 5-6 months of age. TBAs also provide counseling about Vitamin A supplementation to postpartum women during their postnatal checks. (Concern Bangladesh, TBA Study 2002).

Challenges and Constraints

There are constraints to effective coverage for both children and postpartum women. Vitamin A capsules are not available for women during the SNIDs. Only child doses are provided. In addition, SNID tally sheets do not provide for recording supplements to women. This is consistent with the SNID/Vitamin A programs in other countries. Tracking postpartum Vitamin A supplement coverage, and supplements provided to children who have completed immunizations, is not well developed in Bangladesh. Targeting and coverage is a problem in many developing countries and needs to be addressed by the national government program, especially since SNIDs for polio eradication and Vitamin A distribution are scheduled to end soon. This will severely decrease mass distribution of supplements to children.

The role of Vitamin A in preventing of blindness "and other diseases" is emphasized in messages to the community, but not the important role Vitamin A plays in reducing infectious disease morbidity and mortality in children. There is a perception among CSP staff that mothers would not be receptive to messages that Vitamin A will prevent mortality. Additional qualitative investigation could assess the determinants of positive behaviors relative to Vitamin A. This would help the project to know what information is more effective in motivating families to consume Vitamin A rich foods and obtain supplements for children and lactating women.

Postpartum Vitamin A supplementation is particularly important in Bangladesh, since most newborns, especially low birth weight infants have little or no Vitamin A stores in their livers. A significant percentage of Bangladeshi women have low or deficient levels of Vitamin A in their breastmilk. Infants fed with breastmilk low in Vitamin A are more likely to develop deficiency and have weak immunity when exposed to infectious diseases. (West 2002) (Miller 2002) There is also strong new evidence that Vitamin A deficiency interferes with iron metabolism and contributes to childhood anemia. (LINKAGES).

Integrated Management of Childhood Illness (20% of program effort)

The CSP has adopted the IMCI approach to address three major child survival interventions: pneumonia, diarrheal disease control and nutrition. Malaria is not included, because it is not a major cause of child morbidity and mortality in the project area. Vaccine preventable diseases, including measles, are included as part of EPI and Vitamin A activities. Prevention and treatment of malnutrition itself has several sub-interventions: breastfeeding promotion, maternal nutrition, prevention and control of micronutrient

deficiencies, (including anemia), and promotion of appropriate complementary feeding for weaning, and during illness.

The CSP conducted formative research in preparation for implementation of the IMCI components of the program early in 2002. Focus group discussions with TBAs, CHVs, WHC members, municipality health staff, private providers and health facility personnel were included in the analysis. Project staff acknowledged that more time was needed for in-depth discussions with each of these groups. Nevertheless, the reports yielded valuable information that will help to develop messages to be disseminated to mothers on diarrheal illness, pneumonia, and malnutrition. Information on private provider behavior, coupled with participatory situation analysis conducted in the CSP Behavior Change Communications (BCC) Strategy has provided a basis for the more intensive C-IMCI efforts planned for the second half of the project.

The three key components of the generic IMCI approach are 1) improving health worker case management skills, 2) improving the overall health system, and 3) improving family and community health care practices. The CSP, appropriately, has decided to focus on the third component initially, but will attempt to address the second component in the second half of the project.

The CSP trains Field Trainers (FTs) in IMCI promotion, who in turn train Ward Health Committee members, CHV's and TBAs to deliver messages on the danger signs of diarrhea, pneumonia, and malnutrition in communities. CHV's educate 20-30 families each, while TBAs provide IMCI related information individually to their clients during postpartum checks.

The primary behavioral message focuses on taking children exhibiting danger signs to health facilities for case management. The project staff considered training TBAs and CHVs to count respirations, but decided against doing so because of concerns about accuracy. They chose, instead, to emphasize prompt referral to health facilities. Given the urban setting of the project, most facilities can be reached within a reasonable amount of time.

Additional pneumonia danger signs included as training topics in the DIP include ill child, drowsy, cough, chest indrawing, fever, and rapid breathing. More information on Community Health Promotion, which currently contains most of the C-IMCI activity, is discussed in the crosscutting approach section. Section B-2.

Challenges and Constraints

At the time the DIP was written, the national IMCI adaptation process was underway in Bangladesh. Piloting was scheduled to begin in selected districts shortly thereafter. The CSP had hoped to assist national implementation by training both government and private providers in IMCI case management. At the time of the MTE, however, piloting was taking place in only three districts, outside of the project area. Without a national IMCI

program in place, the CSP staff felt it was not appropriate to move forward with the anticipated "training of all municipal health staff and 96 private providers in case management protocols per MOHFW policy guidelines."

PVO Community IMCI is in its infancy in terms of lessons learned in effective program approaches. Effectiveness of current project efforts at community education and behavior change motivation was studied recently during the BCC strategy development. Further investigation is scheduled in year 3 to refine the program approach to implementation and measurement of effective behavior change in support of IMCI. In January 2001, after the CSP DIP was approved, CORE released the C-IMCI framework "Reaching Communities for Child Health: Advancing PVO Technical Capacity and Leadership in Household and Community IMCI." The framework was endorsed by the entire CORE membership in April 2001. This framework is only now reaching PVO field projects. Without substantial implementation examples, many CSP projects were reluctant to begin C-IMCI implementation. This should change in the next few years as the first PVO projects are completed and the results are disseminated.

There is convincing evidence that several child health interventions contained in C-IMCI can substantially reduce child mortality in high mortality settings if good population coverage is achieved. Even when the facility-based IMCI is implemented on a national scale, IMCI component III will be required to achieve sufficient coverage to impact on infant and child mortality. C-IMCI promotes sixteen "Key Community IMCI Practices" to prevent illness, improve home care, and increase use of health services. None of the suggested activities contradicts current MOHFW policies and in fact, many are already promoted by the Concern CSP.

Staff capacity to address the training needs to implement this intervention should be assessed by Concern, and additional training will probably be required. Providing for the input of updated information on strategies into the project for this, and other program components, will need to be addressed.

As in many similar situations internationally, IMCI is still viewed as a collection of disease-specific interventions. Integration has not yet occurred in terms of viewing child health holistically, but the foundation is present in the multi-faceted development approach Concern employs in its development programs. Described in C-IMCI documents as "the development platform" upon which the C-IMCI program elements can be built, these activities make success of the C-IMCI more likely. The challenge will be to remain engaged as the implementation issues of the integrated approach are refined, and then adapted, to the situation as it exists in the CSP area. In the meantime, the CSP is approaching the components of C-IMCI in the most reasonable way possible. After discussions of the BCC strategy in Year 3, the project will need to develop ways of integrating the individual components.

The Entry Grant Review conducted in June 2001 accurately described the challenges of implementing IMCI in urban areas, where the municipalities, not the MOHFW, are responsible for health services. Project activity and training reports document TBAs,

CHVs, WHC members, and Imams were provided training on Pneumonia, Malnutrition and Diarrhea. Health facilities have not been included. Due to the lack of referral health facility assessments, it is difficult to determine the type of capacity building support the CSP will need to initiate over the next few years. There is no guarantee that health facilities will agree to participate in the necessary service quality improvements.

Maternal and Newborn Care (28% of program effort)

The CSP maternal and newborn care intervention has three major components:

- Promoting increased attendance at antenatal clinics (ANC)
- Promoting of clean, safe home delivery through training Traditional Birth Attendants (TBAs)
- Recognition of obstetric complications and prompt referral for emergency obstetric care (EmOC)

(Community mobilization in support of these activities is described in the Community Health Promotion section.)

The CSP has trained 156 TBAs in the two municipalities. TBA training objectives were clearly described in the DIP (p. 57). GoB certified TBA trainers provide 21 days of training interspersed with time to practice some skills before moving on to others.

Training topics include promoting attendance at ANC, clean, safe delivery, referral to health facilities for obstetric complications, immediate newborn care, and postpartum checks. The training also provides TBAs with the opportunity to spend a day working in the health facility. This has helped provide a linkage and improve communication between the CSP, MOHFW and Upazilla level Health and Family Planning workers in the area.

TBAs provide messages to motivate mothers to vaccinate their children, obtain Vitamin A supplements, use ORS for children with diarrhea, and recognize and seek care for infants with dangers signs of pneumonia, diarrhea or malnutrition as part of their routine postnatal visits. These activities are designed to support the other CSP program interventions.

Municipality Health Staff and Concern FTs currently provide TBA refresher training. In monthly refresher sessions, the FT provides for continuity and support, curriculum reviews, discuss birth preparedness, data collection and assist in problem solving. Topics included in the training include cord care, respiratory resuscitation, breastfeeding, keeping the baby warm and follow up postnatal checks.

In May 2002, Concern completed a follow-up study comparing performance behaviors of 109 trained TBAs with 32 untrained TBAs. Mothers with recent births were included in the study to triangulate information provided by the TBAs. The study showed that 58% of trained TBAs visit with mothers during the antenatal period, compared with 22% of

untrained TBAs. Trained TBAs offer some antenatal services at these visits, but not the same services expected to be available at ANC clinics, (e.g., blood pressure and weight measurement, urine or blood screening and eye tests).

TBA training and other CSP efforts have improved maternal health practices in the area. Women with three or more ANC visits has doubled from 40% (KPC 1999) to 80% (TBA study, 2002). Institutional deliveries have increased from 24% (KPC 1999) to 31% (TBA study, 2002). Combined data from both municipalities indicate overall deliveries by a trained attendant (trained TBA and health facility) to be 64% project-wide from baseline figures of 52% in Saidpur and 35% in Parbatipur. Data from the TBA report also suggest that trained TBAs encourage mothers to adopt family planning measures at almost three times the rate of untrained TBAs (36.4% vs. 13.8%). A summary report of the study as Attachment F is included.

Challenges and Constraints

Access and Quality of Emergency Obstetric Care Referral Services
At the beginning of the program, suitable emergency obstetric services were limited, especially in Saidpur. Care at the 50-bed referral hospital was perceived to be unreliable and often of poor quality. While not specifically attributable to the CSP, the situation has improved somewhat in Saidpur since the DIP. The 50-bed hospital now has capabilities for cesarean section and blood transfusion.

A full range of EmOC services is available at the LAMB Hospital, located just outside of Parbatipur. Access to care for the poorest families is a high CSP stakeholder priority. Services are available for women who cannot pay for them at the Lamb Hospital, but the hospital uses it's own criteria to make financial eligibility determinations. Due to previous experiences with clients misrepresenting financial need, Lamb Hospital has not been willing to accept recommendations for free care from anyone outside of the hospital, including municipal officials. The hospital is experiencing significant decreases in external financial support and each free case is in reality an "out of pocket" expense. Hospital officials expressed willingness, however, to discuss ways of increasing access to care for poor families with the CSP and municipal authorities, while at the same time explaining their need to protect the financial viability of the hospital.

TBA Training

TBA training is based on the MOHFW curriculum developed in the early 1990's. Further government investment in TBA curriculum development stopped when the GOB moved away from a TBA strategy for maternal care. CSP training managers have updated the curriculum in the CSP, but how updates will continue after the CSP ends is not yet defined.

During focus group discussions during the MTE fieldwork, TBAs described a need for someone to answer questions about problems they experience during and after assisting deliveries. One example cited was handling a newborn with breathing difficulties. Health

professionals with extensive delivery experience best provide the technical training in safe delivery and newborn care to answer questions like this. Training to strengthen program continuity, data collection, motivation support, and many other program aspects, is well implemented by the Field Trainers.

Assessing individual TBA technical performance needs strengthening, as most supervision is currently done either by group meetings, FT observation visits, or by the WHCs. Methods to identify weaknesses in individual TBA delivery performance using the monitoring system should be included.

Because of the high levels of illiteracy among TBAs, and the volume of information that must be retained by them to perform safe deliveries, care must be taken not to overload them with too much additional information nor activities. Effectiveness of training methods and materials in content retention require periodic evaluation as was done by CSP during the TBA assessment in January 2002.

Quality of Care in Antenatal Clinics

The 1999-2000 Bangladesh Demographic and Health Survey (DHS) included a series of questions on components of quality antenatal care. Respondents were asked if they had received certain services during at least one of their antenatal visits. For 913 births in urban areas nationally and 1,271 births in the Rajshahi Division, the following percentages of women received specific standard antenatal care (ANC) services:

Table 2: Components of Antenatal Care in Bangladesh, 1999-2000

	Informed of signs of complica-tions	Woman Weighed	Height Measured	Eyes tested	Blood pressure measured	Urine sample given	Blood sample given	Rec'd iron tablets
Urban	27.5	59.9	47.6	27.7	47.5	39.5	34.9	50.0
Rajshahi	15.2	38.1	32.8	21.7	29.3	17.9	15.8	41.4
National Average	15.9	35.3	27.4	16.4	28.9	19.2	15.7	36.4

Source: DHS Bangladesh 1999-2000

Specific project area ANC services have not yet been assessed, but one assumes health facilities assessments would yield comparable results. Verbal autopsies conducted in the CSP BCC strategy audience analysis implied some of the maternal deaths studied might have been related to eclampsia. Poor quality antenatal services, such as those measured in the DHS, may not detect treatable maternal complications in the antenatal period. Until the MTE, the project focused on increasing ANC coverage, but did not focus on the services available at the clinics.

Changes in technical approaches from the DIP

No major changes in technical approaches have been made. Technical interventions have been implemented consistent with year 1 and 2 in the LFA and the budget. The CSP accelerated training for the WHCs to engage support from communities and the municipal cabinets.

The extensive time and effort required for the CSP to establish the MHCs and increase quality of EPI services meant that work on quality of health services with private providers and MOHFW facilities has been minimal. The evaluation team agrees that this investment was crucial to establishing support for the additional CS activities scheduled for years 3 and 4. Although this was anticipated in the DIP, the time remaining in the LOP may not be sufficient to see full implementation of the technical strategies. (Please see discussion of a no cost extension request in the Financial Management section.) In addition, Concern did not offer the IMCI case management training for the reasons given in the IMCI technical intervention section.

B.1.c. Tools, approaches, operations research and special studies

Use of Research and Technical Assistance in Program Planning

The Concern Bangladesh Country Director cited that emphasis on using research for program development is a major CSP contribution to Concern's programming. Concern Bangladesh has conducted more qualitative and quantitative research than is usually seen in new child survival programs. These studies can provide the basis for additional program elements. There are three full time positions dedicated to research, though the two field research assistants have been performing substantial administrative support to the project.

The project has benefited from outside technical assistance. Fortunately, there are numerous indigenous technical assistance organizations in Bangladesh. Talented public health professionals are also available, as independent consultants, or from NGOs, PVOs, private research institutions and government organizations. Concern has successfully accessed these resources, decreasing the necessity for expatriate technical assistance and minimizing technical assistance costs.

Concern staff are committed to evidence-based programming. This is demonstrated by employing a variety of participatory learning for action (PLA), focus group discussions (FGD), and interview techniques to learn about the local situation to support program planning. CSP stakeholders are enthusiastic about "lessons learned" from similar projects and have participated in cross-visits to other municipal and child survival health programs.

Concern conducted Institutional Strengths Assessments (ISAs) at the international, national and field levels with subsequent follow-up discussions and action plans. Concern Bangladesh's Organizational Development Unit (ODU) used Appreciative Inquiry to conduct two "Health Institution Capacity Assessment Process" (HICAP) studies to assist

municipalities to document progress towards goals. A report of FGDs in preparation for IMCI implementation was completed in January 2002.

In April 2001, the Concern Bangladesh Health & Nutrition Manager presented on experience using Appreciative Inquiry approach to Institutional Assessment (HICAP) at the Annual CORE meeting and in May 2002 presented at the Global Health Council at a Community Participation roundtable.

Early in 2002, Concern Bangladesh completed "An Assessment of the Effectiveness of TBA training on TBA practices for Safe Maternal and Newborn Care." This paper was accepted by the Child Survival Technical Support program and presented to CORE PVO members and other Child Survival professionals at the "Data for Action" workshop in September 2002.

To develop the BCC Strategy, a local consultant guided the CSP team through an Audience and Institutional Analysis, published in June 2002. This analysis included in-depth interviews, focus group discussions, observations and verbal autopsies of maternal and child deaths. The BCC strategy is important for many reasons. The most significant is highlighting the importance of focused attention to changing the behavior of the decision-makers within the household. Most often, these decision-makers are husbands and grandmothers. Male household members, in turn, are heavily influenced by the teachings they receive from the Imams. The BCC studies and strategy will help the CSP target program activities to these groups, in addition to activities targeting mothers.

DIP reviewers emphasized the need for the CSP to work with private providers. The BCC strategy highlighted this as well. This recommendation has been acknowledged throughout the project, and the CSP has organized FGDs and orientation meetings for these groups. PVO child survival experience in this area is limited, but working with private providers has been receiving much more attention in recent years. The experience gained through CSP efforts in this area will be valuable for other PVOs working with projects in similar settings.

Challenges and Constraints

The high proportion of staff and stakeholder time devoted to research was raised as an issue during the BCC strategy development. Research activities may not leave sufficient time for effective implementation. The amount of information already collected is probably sufficient to implement much of the rest of the program. With the exception of Health Facilities Assessments, Quality of Care baseline information, and private provider training needs assessments, limiting additional research to improving the monitoring and evaluation system, including the HMIS, will allow more time for program implementation.

B.2. Crosscutting Approaches

B.2.a. Community Mobilization

Community Health Promotion (CHP)

Municipal Health Committees (MHCs) have been formed in both of the municipalities consisting of a Chairman, Ward Commissioners, Municipal Medical Officer (Saidpur only) and representatives from government, NGO and private health facilities. These committees have regularly scheduled meetings. The CSP has assisted these committees to develop annual workplans and budgets. The municipal governments acknowledge this as a major accomplishment of the CSP. With the assistance of the Concern Organizational Development Unit, the project has used the HICAP Appreciative Inquiry tool (described elsewhere), to motivate the municipalities and provide a self-assessment of progress.

MHCs and WHCs (15 in Saidpur, 9 in Parbatipur) were formed with broad representation from several sectors in the communities. Coalescing primarily around increasing EPI and Vitamin A coverage, ANC attendance, clean delivery and referrals for EmOC, the Concern CSP partnership has achieved remarkable success in galvanizing every sector of the municipalities for action in improving the health status of the population. (See Strengthening Local Partner Capacity in the Capacity Building section B.2.c.)

By the time of the MTE, all WHCs were in place and functioning (exceeding the end of project target of 80%). Ward Health Committees select TBAs and CHVs for training and provide support and supervision for them while they are performing their duties.

Ward Health Committees monitor CSP activities and provide feedback to all stakeholders. In addition, municipalities organize a number of yearly community awareness-raising activities, such as AIDS day, Safe Motherhood Day, Breastfeeding Week, "ideal mother" and "ideal father" competitions to recognize positive health behaviors, and support of the SNIDs. Communities have responded enthusiastically with heavy attendance at events. Strong and enthusiastic CHV response to provide service to their communities has been impressive. CHVs have been observed in their communities or helping at events far in access of their volunteer commitment. (Additional information on the roles of CHVs, TBAs, and WHCs can be found in B.2.b Communication for Behavior Change,. B.2.c. Capacity Building and the Maternal and Newborn Care technical section.)

Media and Social Marketing
Television is widely available in the project area, but not a significant source of health information for the project target groups. Community radio is not yet common in Bangladesh. The CSP uses folk singers, street drama groups, and community art (such as wall murals and rickshaw painting) for community health education

Challenges and Constraints

Male Involvement
Men are major decision-makers in household care seeking behavior, yet they have not been targeted to a significant degree by the CSP. The BCC strategy paper also recognized their importance as one of the target populations. Men often complain that they do not know how to recognize life-threatening household situations and are unfamiliar with the benefits of health prevention behaviors. The project area is primarily Muslim, and Imams have major influence on men's perceptions and behavior. The project has provided orientation to Imams, and wants to engage them more substantially in CSP activities. (See Behavior Change Communication for additional information on this topic.)

Community Health Volunteers
Because the CHVs are primarily students, or older adolescents, there is concern that their involvement with the program will change, as they grow older and assume adult responsibilities. Some volunteers, primarily girls, report their families are not supportive of their involvement because their parents do not know what they are doing. The MTE team made several recommendations about broadening the population sector eligible to be CHVs, how the municipalities can recognize volunteers and how the WHCs can educate their parents about their contribution to the communities.

Political and Security Factors in Community Mobilization
Security is not a general consideration for working in communities in the project area. On the other hand, political general strikes, or "hartals," disrupt program plans to some extent on a regular basis. In general, however, program activities continue during such disruptions, but they may be delayed or scaled back. In general, CSP participants show remarkable resilience in adverse conditions, another indicator of widespread support for the program. There is always a risk that politics could influence community health promotion activities. If political offices change hands, community support could be affected.

B.2.b. Communication for Behavior Change

Up to the CSP midterm, the focus for BCC efforts has been the municipal health system, including municipal health committees, WHCs, TBAs and CHVs and “awareness raising” training for communities. All levels of the MHS have been trained to deliver messages regarding EPI, Vitamin A, and danger signs of diarrhea, ARI and obstetrical emergencies. TBAs deliver behavior change and health awareness messages at postpartum checks and appear to be effective in motivating mothers to attend ANC sessions, take their children to EPI and go to health facilities in emergencies. CHVs support EPI drop-out tracking and deliver messages to the community on care seeking for danger signs of ARI and diarrhea, or malnutrition.

Focus group discussions with mothers of children under one year of age indicate a direct relationship between instructions from the CSP-trained TBAs and their decision to seek

care at a health facility for obstetric complications. Measurement of the percentage of home deliveries versus health facility deliveries undertaken in the TBA study indicates a decrease in home births and subsequent increase in health facility births. This is one internationally recognized positive maternal and newborn care behavioral indicator. (See Maternal and Newborn Care in the technical section) Mothers also stated that motivational messages from CHVs have influenced their decisions to take sick children to health facilities for treatment.

The BCC approach has evolved since the time of the Entry Grant from giving basic information and messages to WHCs, TBAs, CHVs and MHS to developing a comprehensive BCC strategy. The breadth and detail of the strategy especially the audience analysis and consensus building was impressive.

The implementation of the specific BCC strategy will start in year 3. The project's monitoring and evaluation system, including planned improvements, will be used to monitor effectiveness after sufficient time has elapsed for the strategy to influence behavior.

Most of the BCC plans will be incorporated into the overall Action Plan for the second half of the project. Measurement of the BCC strategy effectiveness will be done using qualitative (FGD and key informant interview) and quantitative (LQAS and/or KPC, health facility statistics, MHS data) methods.

Challenges and Constraints

The challenge for the CSP will be to implement the strategy with sufficient time remaining in the project to demonstrate its impact.

(Specific issues relative to CS intervention behavior change are discussed in the technical sections. See also discussion of no-cost extension application discussed in the Financial Management section.)

B.2.c. Capacity Building Approach

Concern's definition of Capacity Building, as stated in the policy paper, is as follows:

" . . . An approach to programming which emphasizes enabling and strengthening individuals, groups, organizations, networks and institutions to increase their ability to cope with crises and to contribute long-term to the elimination of poverty."

Concern's work is guided by two key documents, an organizational policy statement and a current Concern Worldwide Strategic Plan. These two documents, as well as country-specific strategic plans guide overseas programs. Other policy papers, including the capacity building policy approved in April 2001, serve as the framework for Concern's overseas activities and serve to align them with current best practices in each policy area. The capacity building policy addresses strengthening local development partners,

including CBOs, local NGOS and state organizations that have common development interests.

(i) Strengthening the PVO Organization

The capacity building indicators listed in the beginning of the DIP were limited to the functioning of the two partner municipalities. Specific indicators for Concern Worldwide and Concern Bangladesh were not articulated. Concern Worldwide, Concern Bangladesh, and the CSP Field Offices in Saidpur and Parbatipur, however, have participated in the Institutional Strengths Assessment (ISA), followed by office-wide discussions and action plans. Concern Worldwide completed a follow-up questionnaire from CSTS. Another ISA is planned for mid-2003 at which time the results will be compared with the original studies.

Capacity Building in Concern Bangladesh
Concern Bangladesh has an entire department, the Organizational Development Unit (ODU) and has full time staff devoted to staff capacity building. Concern Worldwide's commitment to staff capacity building is reflected in the organizational structure of the Concern Bangladesh country office. The lessons learned from the CSP are more likely to be disseminated throughout the entire Concern Bangladesh development program. At the same time, the CSP will benefit from capacity building from other programs, whether or not they involve health. For example, the lessons learned about transparent financial management gained from the Rural Development Program can be used to benefit the sustainability of the WHCs' emergency health funds in the CSP.

Training programs, such as IMCI management training and cross visits to other projects in Bangladesh and Nepal (described elsewhere) contribute to Concern Bangladesh's capacity to implement CSP programs. Increased health program capacity has enabled Concern Bangladesh to obtain funding for similar programs in other parts of the country.

The ODU contributed to the HICAP, participatory program planning, organizing the cross-visit to India and facilitating the MTE. These are only a few of the examples of the valuable contributions this unit plays in the CSP.

Capacity Building in Concern Worldwide (U.S.)
Since joining the Child Survival Grants Program in 1998, Concern Worldwide staff members have been active participants in the annual CORE Headquarters Workshop, as well as the HIV/AIDS and Social/Behavior Change CORE Working Groups. CORE has been a venue for frequent sharing of project innovations, such as the HICAP studies. The CSP Coordinator from Concern Bangladesh traveled to Washington, D.C. in 2000 to attend the DIP review workshop and CORE Headquarters Workshop. In September 2002, he presented the TBA Training Assessment study at a CSTS sponsored workshop "Data for Action in PVO programs". The Bangladesh CSP is featured in the CSTS CSP Review (2001). Concern Worldwide also provided USAID/Washington documentation for the annual USAID Child Survival Report to the United States Congress.

Concern Worldwide acknowledges that the extensive amount of effort and documentation required to participate in the CSGP has helped the organization improve and develop programs in high priority areas. Through this involvement, the PVO community is also becoming more aware of the unique contribution that Concern has to offer Child Survival with some of their innovative approaches to health programming.

(ii) Strengthening Local Partner Organizations.

CSP capacity building assistance to specific municipal structures are described in detail below:

a) Municipal Authorities (Chairmen and Ward Commissioners)

At the time of the MTE, Chairmen and Ward Commissioners were very vocal in their support of the capacity building assistance from the CSP. Several ward commissioners were members of the MTE core team. The CSP has developed an effective partnership ensuring municipal participation in the program**.** The support of the municipal authorities and health staff were critical to the CSP success in working with the Municipal Health Committees and Ward Health Committees. Providing orientation and training on new roles and responsibilities in providing health services and support to develop better planning, financial and administration systems, the CSP has encouraged the municipal leaders to provide leadership in implementing MOHFW health policies. The CSP advocates at the municipal and national level to fill vacant health positions, on issues relevant to institutional health development, and for equitable health care for the very poor.

b) Municipal Health Services (MHS)

The CSP has strengthened the MHS Departments on several levels from senior management to addressing client needs. The CSP has updated municipal health staff on GOB/MOHFW policies and strategies and provided technical support to improve MHS health management capacity. Staff training and follow-up for HRD support in technical and information management has improved planning and management of health services. Health planning assistance has resulted in monthly review and planning meetings, and support for emergency health preparedness and response. The CSP has collaborated with the MHS in conducting research for better design, monitoring and evaluation of services.

Partners are now mobilized on multiple levels to advocate and support better quality of care in health services MHS control. Since participating in Learning Exchange visits, municipal health staff members state they have a better vision of improvements they can make in their municipalities. With CSP support, the MHS assisted and supported the development of Ward Health Committees, helping them to comply with the GoB circular.

Challenges and Constraints

Challenges to the program include lack of control over health supplies, such as sterilizers and disposable needles, which are only available through MOHFW sources. Outstanding requests for sufficient sterilizers have gone unanswered for several months. Unstable funding sources, and the temporary nature of municipal staff appointments, make planning difficult. In Parbatipur, some EPI staff are seconded from the Upazilla Health Complex. There is concern that these employees may be recalled at some time in the future. The MHS has no authority over public and private referral centers in their areas, so they do not directly control the quality of the services delivered in those facilities.

As the CSP addresses quality of care and more technically challenging child survival interventions, intensive support for MHS management will necessarily have to taper off. Phase out of day-to-day support is part of the exit strategy. Additional management and advocacy training for the WHCs will be needed to facilitate this process.

c) Municipal Health Committees (MHCs)

Through major training and advocacy activities, the CSP has made major contributions to improving EPI services and providing community health promotion. Through baseline and follow-up appreciative inquiry health systems assessments, (HICAP), joint meetings and FGDs the CSP has enabled the municipalities to determine where they started and measure their progress towards mutually agreed upon capacity goals. A quote from the follow-up HICAP summarizes the major changes the CSP felt have taken place since the baseline HICAP:

> "For the CSP, capacity building is both a means and an end. Therefore during this period of capacity development activities, (the) CSP tried to involve (the) community as well as the . . . municipal representatives to conceptualize and develop understanding about (the) entire project goal and its benefit . . . the project also tried to empower people to realize their potential, involve them to use their capabilities better and assured ownership and sustainability of the process".

The municipalities are the actual implementers of all program activities. Concern plays the role of advocate, trainer, and facilitator but in a seamless way. Integration is so complete that when one speaks of the CSP, it stands for Concern staff and stakeholders together. There has been a reduction in misunderstandings between the partners, positive changes in health behaviors and community confidence in MHS staff has increased through this collaboration. There is also a greater community commitment to cleanliness and environmental sanitation.

As the CSP addresses quality of care and more technically challenging child survival interventions, the intensive support for MHS management will necessarily have to taper off. Phase out of day-to-day support is part of the exit strategy.

d) Ward Health Committees (WHCs)

Intensive on-site facilitation by Concern CSP Field Trainers has helped the municipalities form WHCs in every ward. Because of a phased-in approach, some WHCs have existed for around 2 years, while others are newly formed. While they are a political entity, multiple sectors of the community are represented, from businessmen and schoolteachers, to CHVs and TBAs. Field Trainers, most of whom have social science and primary health care backgrounds, train TBAs and CHVs in health promotion. Social mobilization and support is fostered with urban health rallies and public health campaigns. The HMIS measures WHC, TBA and CHV meeting attendance and adherence to workplans.

Measuring Capacity Building Progress
Indicators selected in the DIP apply the HICAP Appreciative Inquiry technique for the Municipal Health Department to assess their own progress. (Qualitative indicators can be validated to measure "process change" based on a tree assessment scale developed by CRWRC.) The HICAP is a powerful tool for motivating participation in the process of organizational change. This approach was adopted after discussions with the CSTS Director in 2000 and is scheduled for review during his visit in February 2003.

Two municipal capacity indicators, *"2 Municipal Health Committees and 80% of Ward Health Committees are functional"* and *"At least 6 Municipal Health/ Inter-Agency Coordination Meetings are held annually"* have already been fulfilled.

Challenges and Constraints

Ward Health Committees are political entities and are subject to influences from outside of the committee members and the communities they serve. Sustainability of WHCs could be enhanced if one WHC was able to help another. Some reservation has been expressed by Concern Bangladesh about the political complications that might arise from this seemingly benign gesture. Those who live in the area and the WHCs themselves can best answer if the above concerns are justified.

Further indication of progress towards the program outputs and objective measures to determine if "interventions are institutionalized" or municipality staff and supervisors "are competent and independent" (outputs 4 and 5) remain to be refined.

(iii) Health Facilities Strengthening

The DIP acknowledged the crucial role health facilities must play in providing curative care to achieve mortality reduction. The need to focus on establishing municipal health capacity precluded extensive involvement with facilities in the first half of the project. Current involvement with health facilities primarily involves data collection for Monthly Activity Reports as well as a health facilities data collection tool. Information collected includes areas of maternal/newborn care and certain child illnesses, in addition to EPI and Vitamin A data. These data have been a helpful complement to other aspects of the government HMIS, but in some cases, only report on numbers of cases, or numbers of

training inputs. Without information on target populations, measurement of coverage increases attributable to the CSP is difficult.

Linkages between the health facilities and community health workers, especially the TBAs, have strengthened facility participation in TBA skill updates. Interviews with mothers reveal that care seeking at health facilities has increased for both mothers and children because of CSP activities.

Challenges and Constraints

Government health facilities face continuous resource constraints. With a national health budget of approximately $4 per person per year, government facilities lack sufficient drugs and treatment to treat a largely poor population. Other quality issues include poor logistics, unreliable availability of staff and poor health worker morale. Inadequate interpersonal communication skills adversely affect provider-client relationships. When services are considered poor, community members often by-pass the closest facilities and travel long distances to NGO facilities. Providing access to health care for the poorest sectors of the community continues to be a problem for municipalities. The second half of the CSP will focus on joint problem solving to increase access to quality health services for the poorest community members.

The BCC strategy development process included SWOT (Strengths, Weaknesses, Opportunities and Threat) analysis of the CSP. The report stressed that while there was partnership with municipalities, which do not have their own services facilities, there was "no or inadequate strategic partnership with available service institutions" and "(a) weak monitoring and evaluation system, especially to monitor the institutional strengthening/system development efforts" (p. 17). The evaluators interpreted the latter comment to mean formal health facilities, since the aforementioned HICAP is monitoring processes in the development of the Municipal Health Systems. Without the ability to influence quality of care at referral health facilities, the impact of the CSP on mortality is very limited. Backup referral sources for curative services are an essential component of C-IMCI and maternal and newborn care.

(iv) Strengthening Health Worker Performance

As mentioned in the technical intervention section, strong training and support from the Field Trainers to municipal health workers has significantly strengthened EPI and Vitamin A service delivery. Ward Health Committees monitor MHS health worker performance and provide feedback to the supervisors. WHCs supervise TBAs and CHVs with support from CSP Field Trainers and the MHS.

The CSP expanded the role of the CHV beyond the twice a year SNIDS and Vitamin A campaigns. CSP experience has shown that the CHVs embrace the expanded responsibilities, are eager to learn and serve the community. CHV's are nominated by the Ward Health Committees and trained by the CSP. Assisted by the MHS, Ward Health Committees supervise the CHVs and reinforce their work with community members.

(See the Maternal and Newborn Care technical section for information about TBA training and support. .Strengthening Municipal Health Service workers is addressed in several other parts of this report, including the EPI and Vitamin A technical section. Training in planning, service delivery, supervision, record keeping and data analysis have resulted in significant improvement in the quality of services.)

Challenges and Constraints

Until now, the CSP has not been significantly involved in health facility worker training Poor quality care at local facilities has been identified as a major impediment to mortality reduction. If CSP advocacy efforts result in the health facilities consenting to conduct quality of care self-assessments, the CSP may become actively engaged in improving health facility worker performance. Improving provider interpersonal communication skills is another way the CSP can improve quality of care, without requiring significant additional outside resources.

There are several types of private providers in the project area. Some treat sick children more than others do. Homeopaths, for example, are the provider of choice for small infants. Rural Medical Providers, drug sellers and homeopaths all have different backgrounds and means of getting information about illnesses and treatments.

Addressing the quality of care given by private providers was identified early in the project as an essential component of addressing sick child case management. The CSP has conducted research and held meetings with private providers. One training strategy alone will not be sufficient for all categories of private providers. This will make addressing this programmatic need a major challenge for the CSP. A much stronger emphasis on private provider participation and training is included in the Action Plan for the second half of the project.

Six female Field Trainers do monthly TBA refresher training, but only one of them has delivery experience. While the training provided to the TBAs keeps the program functioning well and assists in monitoring and support, needs for significant technical advice on delivery are unlikely to be met this way (see the Maternal and Newborn Care technical section.). Part of the exit strategy will require that duties currently performed by Field Trainers will need to be turned over to the MHS.

The CSP will need a means to monitor individual TBA performance and determine if the CSP program strategy in maternal care is working. Improving performance monitoring will alert the CSP if TBA performance begins to deteriorate for any reason and allow for corrective measures. CSP monitoring system refinement could determine whether or not women are able to reach facilities in sufficient time to address complications successfully, since TBAs are not trained in obstetric first aid.

(v) Training

The CSP Coordinator and the Senior Training Officer (STO) jointly develop training curricula and methods. Field Trainers collaborate with the CSP Coordinator and STO to facilitate most trainings, with expert consultant trainers used when necessary. TBAs and CHVs train community members. Training effectiveness is assessed by self-reported behavior change in focus group discussions and interviews. In addition, pre and post testing is used to evaluate trainings (for example EPI, TBAs, CHVs). Field Trainers provide on the job training and support, providing opportunities for some direct skills observation.

The STO appears to have a solid background in training methodology, material development and adaptation of materials. He has responsibility for all capacity building of the CSP team and partners, which is a very large and diverse group with widely varying training needs.

Challenges and Constraints

Staffing has not been sufficient, given the CSP's heavy multidisciplinary and multilevel training strategy. This has resulted in planned training courses postponed or canceled due to lack of trainers. Concern has decided to hire a Training Assistant to address this issue. Teaching aids are not adequate for the amount and sophistication of CSP technical training, especially as the CSP moves into higher level technical training in IMCI and Maternal Newborn Care, and may engage in health facility worker training. There are sufficient funds in the budget to address these needs.

The CSP is not devoting sufficient attention to training follow-up activities in every intervention to determine the effectiveness and sustainability of the training approaches. This is largely due to the staffing constraints mentioned earlier and has implications for training plans for the second half of the project. Training needs assessments require strengthening to appropriately organize training activities and allocate the necessary resources. Clear behavioral training objectives and measurement methods will aid in evaluation of training activities after they are implemented.

(vi) Quality of Care (QOC)

The first years the CSP devoted significant attention to improving the quality of MHS technical services. Quality case management at facilities and by private providers has been a major issue in CSP discussions, but the project has not had much opportunity to directly impact curative care services. Health providers attend CSP meetings, but substantive joint programming has not taken place.

To have significant impact in the Maternal and Newborn Care and IMCI interventions, the CSP will have to address the quality of referral services. The KPC results showed that up to 70% of the population first seek care from private providers. Therefore, the CSP must engage these providers in quality improvement efforts.

Significant formative research has been done with all major health providers, including private practitioners. The CSP can use this information to assist municipalities to coordinate health providers and try to persuade them to participate in quality improvement. Effective advocacy and consensus-building skills are essential. Concern has the experience to provide training in both.

Challenges and Constraints

Some factors affecting quality of care in health facilities are not under the control of the facilities, especially drugs and supplies, but the municipalities can advocate through multiple channels for improvements. Concern can assist health facilities wishing to improve QOC by providing technical assistance with health facility self-assessment and training plan development.. Some QOC issues involve the need to improve counseling and management skills. Concern can also assist in these areas.

With some exceptions, PVO Child Survival programs are only recently recognizing the importance of working with private providers. Effective behavior change strategies have been implemented only on a limited scale. Donors, however, are beginning to show increasing interest in this area because of the essential role private providers play in household case management. The CSP will have to make deliberate efforts to keep abreast of developments in this area. If the CSP is successful in developing effective new approaches, sharing the lessons learned will benefit the PVO Child Survival community overall.

B.2.d. Sustainability Strategy

Concern Worldwide retains a broad-based definition of sustainability as *the capacity of a health system to function effectively over time with minimum external inputs.*

The CSP's institutional partner is the Municipal Authority/Paurashava with a tripartite partnership of communities, WHCs and the MHS. The goal of the partnership is to increase health capacity and improve sustainable health status through building the capacity of the municipalities.

The MTE team assessed perceptions of program sustainability at every level. Members of municipal cabinets, Municipal Health Committees and Ward Health Committees, all felt the Municipal Health Structure would continue after CSP support ends. While an exit strategy has been discussed since the onset of the program, the MTE evaluation fieldwork devoted substantive attention to this topic. According to the DIP, there are plans to share experiences with other PVOs involved in urban health programs in Bangladesh, including lessons learned during project phase out.

Some more established WHCs acknowledged be ready to operate more independently from intensive CSP involvement, but would only be sustainable if they learned some of the Field Trainer's skills. These skills include facilitation and motivational techniques, leadership skills and transparent financial management.

WHC fundraising at the local level to support priority activities bodes well for continuation after the CSP. Some WHCs have secured significant additional financial support from local private donors. In-kind contributions of access to vehicles, or meeting space, also demonstrate the community's willingness and ability to support CSP activities. If the older WHCs mentor the newer, weaker WHC's the number of sustainable WHC's might be increased. However, as mentioned earlier, this approach may have negative political implications that need to be explored locally.

During FGDs conducted by the MTE team, TBAs expressed confidence in their sustainability. Their remuneration comes from their clients and they all intend to remain in their communities. They stressed, however, that they need technical refresher training periodically to maintain the quality of their care. Clients are the primary providers of the clean birth materials, so neither the CSP, nor the municipalities provide basic supplies. (See the Maternal and Newborn Care technical intervention section.)

The project plans to devote more time to exit strategy planning in the third year of the project. In addition, a successful BCC strategy in support of community and household healthy behaviors does not require outside support after the end of the project.

Challenges and Constraints

Sustainability of MHS staffing levels in both municipalities is tenuous due to unstable funding levels. If staff positions were converted from temporary to permanent, many MTE participants felt sustainability of municipal health staff would be more likely. Revenue collection and budget allocations are out of the control of the CSP, aside from the advocacy role it already plays. Municipalities are highly politicized. If the current elected officials are replaced with members who have other priorities, the advocacy and support elements that have made the CSP successful could be threatened. Efforts to institutionalize health into the municipal agenda can help to mitigate the threat.

The CSP is very heavily training oriented. Each technical area requires periodic refresher training. Finding local sources for refresher training support is a major sustainability need.

The fact that CHVs are drawn from one demographic cohort raises concern about the length of time that individual CHVs will remain volunteers as they grow older and assume adult responsibilities. As municipalities assume responsibility for the recruitment and training of CHV's, there will be a need to develop plans for periodic recruitment and training of new volunteers.

C. PROGRAM MANAGEMENT

C.1. Planning

Concern makes extensive use of participatory planning with stakeholders. Program planning includes all program partners, especially members of the municipal and ward health committees. Concern's national office collaborates extensively with national MOHFW offices, NGOs, PVOs, and other international organizations. Multiple departments including ODU, HR, and Financial Management are also included in project planning.

The DIP workplan is on schedule. Detailed planning for the third and fourth years was completed following the outcome of the MTE (See the Action Plan.) Budget allocations by category were made, with allowance for detailed planning later in the project. Program management was justifiably reluctant to initiate IMCI case management training until the national IMCI program was in place

The evaluation consultants were very impressed with the strong professional skills that Concern's staff have in carrying out participatory and consensus building activities. CSP stakeholders also demonstrated considerable skills in participatory methods of information gathering and consensus building in planning and problem solving, proof of the positive effect of the program.

Challenges and Constraints

The CSP role in implementing the IMCI component still needs significant clarification. (The Action Plan is included at the end of this report.) Since the national IMCI program will not likely be in place soon, the CSP will need to plan IMCI implementation accordingly.

C.2. Staff Training

The project has invested significant effort in training stakeholders and community level workers, but has devoted less effort to updating Concern staff training in the CSP interventions. Strengthening the EPI system and initiating programs for CHV training appear to have been within the realm of preparation and experience existing in Concern Bangladesh staff from the beginning of the project. Field trainers, many of whom have had years of experience as vaccinators, are well-qualified to provide EPI refresher training to municipal health staff. Participatory program planning and use of adult learning techniques are strong in the existing Concern Bangladesh staff. The Concern ODU Training Officer also professionally implements contemporary consensus building methods and both national and field staff members appear to be comfortable using them.

Challenges and Constraints

There is a need, however, for increased emphasis on assessing staff capacity and training needs to manage and implement several new and technically challenging activities. Principles of epidemiology, quality health programming, client-provider relationships, Quality of Care issues, and multidisciplinary approaches to public health programs require different skills and preparation than the majority of the field staff have at this time.

The CSP Coordinator and Team Managers could benefit from visiting other CSPs where many of the issues the CSP staff face have been addressed. There are currently no other active USAID/Washington-funded CSPs in Bangladesh. There are, however, current programs in Nepal, India and Cambodia. PLAN/Nepal, for example, recently received a cost extension (formerly known in the CSGP as a "follow-on" or "extension" CSP grant.) That project has used Lot Quality Assurance Sampling (LQAS) methods effectively for monitoring and evaluation for several years and may serve as a learning laboratory for LQAS experience. In addition, several other organizations working in Bangladesh have implemented CSPs in Bangladesh in the past. These groups include CARE, World Vision, Save the Children (US) and World Relief. World Relief implemented the Hearth model community program for addressing malnutrition. This relatively new approach to sustainable community nutrition programs was described with other similar programs in a BASICS publication. Many PVOs have since adapted the Hearth Model to their CSP nutrition programs.

Concern Bangladesh health managers visited the JSI C-IMCI project in Nepal and have training in some aspects of IMCI implementation. Community IMCI training has not yet been offered in the Asia region. Discussions are underway within CORE for a PVO regional Community IMCI workshop to be held early in 2003. As mentioned earlier, the DIP planned for IMCI implementation in years 3 & 4. There have been many developments in PVO C-IMCI implementation strategies since the DIP was written two years ago. New strategies are presented annually. The CSP staff will be challenged to remain current with these developments since they occur so rapidly.

C.3. Supervision of Program Staff

The organogram in the DIP seems to imply that the Regional Manager, not the CSP Coordinator, has direct supervisory responsibility over the field staff. However, in practice, the CSP Coordinator has direct influence over the CSP activities of the STO and the CSP Team Leaders. The CSP management staff controls the technical implementation activities; the Regional Program Manager provides administrative supervision. There are specified job descriptions and regular performance reviews. Team Managers for each Municipality are responsible for supervision of Field Trainers and Research Assistants in their respective areas. The Regional Program Manager, in consultation with the CSP Coordinator, conducts performance reviews. Management style is largely supportive and teamwork is highly valued.

C.4. Human Resources and Staff Management

Concern Bangladesh has taken positive steps to retain qualified and experienced Child Survival staff though promotions to positions with greater geographic and programmatic responsibility. This can serve to counter some of the career issues raised below that can make professional health staff retention difficult. Concern also facilitates staff transition into other programs after a particular project (such as the CSP) ends, one reason many staff have been with Concern for many years. Concern also makes strong and deliberate efforts to promote gender equity in hiring.

There is a plan for flow of technical information from the Concern Worldwide (US) headquarters to the field level. The Program Manager and the CSP Coordinator will copy all correspondence from Concern Worldwide US to the Country Director, Assistant Country Director and the Regional Manager, even if it is of a technical nature and requiring action. Thus, the information goes directly to the field technical staff, but Concern Bangladesh senior management is kept "in the loop." In this way, technical updates can benefit the CSP, as well as the rest of Concern Bangladesh.

Challenges and Constraints

Concern has had to address similar issues in organizational structure and personnel policies as other PVOs working in Child Survival Programs. Problems arise when programming focus changes from a collection of small operational projects to more sophisticated capacity building or mentoring projects. The organization's comparative advantage lies not in direct service delivery, but in the ability to bring a collection of partners to a more complex level of functioning. These changes frequently require staff with different skills such as proposal writing, satisfying donor's (increasingly complex) reporting requirements, facilitating stakeholder decision making and empowering other organizations to implement effective development programs. .Programs must hire and retain health professionals with significantly higher educational preparation and experience than operational projects generally require. These professionals can ask for, and expect to receive, greater responsibilities and consequent compensation. Finding qualified candidates willing to accept posts in remote, or rural areas can also be difficult. These jobs often require long hours and working through days off and holidays. They can also require extended periods away from families and the professional contacts in the city. Where significant salary increases would cause internal organizational discord, some organizations have been successful by providing a more generous compensation package. Other organizations have found physicians will see such positions as professional "dead ends" no matter what is provided, while other health professionals such as master's prepared nurses, nutritionists, health planners, or health educators may not.

The organograms in the DIP do not reflect the joint management that is the reality in the project. New project documents should address the actual management structure of the program in the organograms.

Field Trainer (FT) responsibilities are unevenly distributed between the two project sites. FTs in Saidpur have responsibility for significantly more population per field trainer than in Parbatipur. They are assigned to cover three wards each, regardless of the number of households in each ward.

C.5. Financial Management

Financial reports are forwarded to Concern Worldwide for submission to USAID Washington quarterly. Because of slow start-up during the formation of the Municipal Health Committees, several training activities and learning visits have been postponed until after the MTE. In addition, unfilled budgeted positions have caused the project to be under-spent at the mid-point. This is a common situation, especially in a new CSP.

The MTE process gave the project the opportunity to assess activities and staffing. Positions allocated in the DIP that are still needed can be filled early in the second half of the project. The MTE follow-up Action Plan accelerates spending in years 3 and 4, but probably not to the extent where a no-cost extension request will not be necessary. An additional year would provide greater opportunity to observe the effects of the BCC strategy, lead to greater sustainability of the IMCI and Maternal and Newborn Care components, and allow time for quality of care efforts to take effect. Concern will probably request to extend the project implementation period until September 30, 2005. Findings from the MTE support this request.

C.6. Logistics

Project reports and the Institutional Strengthening Assessment (ISA) reports indicate some delays in equipment and supplies have been a problem during the project implementation. Ground travel and telecommunications to Saidpur and Parbatipur hamper timely communication and transport to a greater extent than in some other Child Survival Projects assessed by this Evaluator. The latest ISA action plan dated February 2002 spelled out specific plans to address these concerns.

Concern Bangladesh staff in Dhaka addressed comments about computers in the reports and clarified that the CSP wanted to be sure sufficient capacity was present in the municipalities before providing the computers. There are plans to provide the hardware in the near future.

C.7. Information Management

Objectives, indicators, logframes, HMIS monitoring reports, research and evaluation reports are shared among all stakeholders. Until now, the color graphic depiction of CSP monitoring data has been generated in the Dhaka office. The municipal health staff and

health facilities provide the data from which the reports are generated. Copies of the printed reports are distributed back to the municipal health offices and to municipal health committees where they are displayed.

Research Assistants at the field level and Dhaka collect data on program outputs and compare them with project workplans and indicators to measure progress towards goals. Combining existing MHS data, primarily regarding EPI and Vitamin A coverage, with CSP process indicator tracking, Concern generates the reports.

Research Assistants compile monthly Activity Reports. TBA training inputs provide the primary tracking for the Maternal and Newborn Care intervention in these reports. Additional data collection focuses on EPI and Vitamin A, areas where the municipalities have primary responsibility. While the Logframe Analysis contained knowledge indicators in three IMCI areas, impact indicators were not articulated at that time. The project does not currently track data related to IMCI component, except cases of certain diseases, such as diarrhea or ARI.

Data are also routinely collected from the Municipal Health Services and health facilities in the area. Process indicators, such as number of meetings held and training inputs, is included in these reports in addition to limited coverage data.

TBAs and CHVs collect demographic data on every family in their catchment area, specifying 0-12 month olds, 1-5 year olds, and women of childbearing age. There is a column for comments, but it does not appear to indicate births and deaths. A third form is completed by the municipality and covers health statistics collected by the municipality and other providers. In addition to EPI and TT data, Vitamin A, health center deliveries, trained TBA deliveries, ante and post natal care, family planning, ARI, diarrhea and malnutrition data are collected. There is apparently no place on the form, however, to track maternal complications.

Challenges and Constraints

The BCC report states: "there is no continuous system to review maternal and child deaths, including near miss, and thus no functional mechanism to use this information for awareness building, mobilization of local people including local level advocacy," Some major project activities have only knowledge indicators, but no behavioral indicators related to them in the monitoring and evaluation system. The project cannot track progress towards impact in these areas. The project tracks training inputs in all areas, but they are not considered reliable measurements of impact on target behaviors.

The CSP system of data collection, analysis and use needs strengthening. During the second half of the project, the monitoring and evaluation system, including the Health Information System will need revision to demonstrate the contribution the project is having on maternal and child survival. Data should be collected, and analyzed, as close to where it will be used as possible. For sustainable use of data for decision-making, CSP

partners should be involved in this process to the greatest extent possible and generate their own reports as part of the exit strategy.

C.8. Technical and Administrative Support

The New York Headquarters benefited significantly from the strong technical assistance and support offered by Breda Gahan and Robert (Rob) Williams during the Entry Grant and in the first half of the current grant period. Nine CS technical support visits, each lasting several weeks, were made to the CSP before the MTE. Ms. Gahan provided frequent technical and managerial support to the Concern Bangladesh CSP as well as serving as a liaison with the CORE group and serving on CORE technical working groups. She provided extensive technical guidance to the project based on over 10 years of health field experience in developing countries. In 2002, Concern Worldwide, Inc. (US) hired an experienced PVO Child Survival Grants Technical Advisor, Michelle Kouletio. She has extensive experience working in a large US based PVO as well as managing a CSP in Africa. She has work experience as a contributing member of a CORE working group. In July 2002, she participated in LQAS training from which both the Bangladesh and Rwanda programs will benefit.

CSTS provided technical assistance to Concern Headquarters by conducting the Institutional Strengths Assessment. Concern staff state the findings were very helpful and led to discussions and a follow-up action plan. The headquarters backstop and program manager traveled to Washington D.C. in 2000 to discuss the DIP with nine technical reviewers and USAID. While Concern staff appreciated the intensive technical suggestions, the scope and volume of the recommendations were too extensive to be incorporated into the program in their entirety during the first half of the program. Some recommendations have not been implemented yet, (i.e. training private providers), but will be addressed in years 3 and 4.

As mentioned earlier, Concern is very adept at identifying qualified CS consultants within Bangladesh and has used a variety of individual consultants and technical assistance organizations for different program elements. Early in the project, there was discussion of plans for a CSTS staff member to visit the project. This visit is scheduled for 2003.

The CSP can benefit from external technical assistance in the following areas during the remainder of the program:

- Quality of Care (QOC) training, including health care facility assessments, to compare facility compliance with national, and international standards (assuming facility agreement to participate.) Continuous Quality Improvement (CQI) or other approaches can apply to all aspects of CSP implementation.

- Strengthening the CSP Monitoring and Evaluation system to:

Design and implement monitoring systems to track progress and demonstrate effectiveness in all program intervention areas (these may include LQAS, verbal autopsies, "doer/non-doer analysis" or others). This will require strengthening the HMIS.

Possible orientation to Results Framework program planning and evaluation, as appropriate. (Results Frameworks are rapidly replacing Logframe Analysis in many donor programs, including USAID.)

- Consensus-building advocacy techniques to forge agreement amongst the key players in health delivery about the major causes of infant, child and maternal mortality in the project area and the determinants of key behavioral measures necessary to address them. (Concern Bangladesh already has considerable skill in advocacy, but there may be specialized assistance in how to approach multiple government agencies or constituencies simultaneously.)

- Technical updates on all C-IMCI and Maternal/newborn care program implementation issues.

- Refresher EPI supervisory training for CSP management staff. with a focus on partner management capacity building. (Classes are available in Bangladesh) This is particularly important since national polio eradication campaign days (SNIDs) are scheduled to end and adjustments to the EPI program will be necessary.

- Participation in CORE South Asia regional technical workshops in BCC and C-IMCI workshops scheduled for 2003.

D. OTHER ISSUES IDENTIFIED BY THE TEAM

The Midterm Evaluation Core Team stated that they wanted the evaluators and USAID to know that the intensive investment in building the municipal health system was necessary to build support for all interventions. Implementation of any intervention was impossible until the municipal authorities were "brought on board" with the program. Delayed initiation of certain parts of the program (IMCI) were planned from the beginning, not inadvertently left out or forgotten. The slow national IMCI implementation gave further justification to wait until other services were established before undertaking IMCI.

E. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Concern Worldwide's CSP is consistent with the organizational values and goals as expressed in their recent 2002-2005 strategic plan.

The project has achieved, or made significant progress towards, meeting all five project objectives listed below:

1. A developed Municipality Health Planning and Management System
2. Insitutionalized and well managed activities (EPI and Vitamin A)
3. A sustainable community health promotion (CHP) system
4. Competent and independent Municipality staff and supervisors
5. Improved Child Survival Program planning and management.

Because the project specified objective capacity indicators at the beginning of the program, confirmation of progress is easier for outputs 1-3, than for outputs 4 and 5. . The MTE core team drew conclusions about outputs 4 and 5 from qualitative assessments.

The CSP has already succeeded in establishing a municipal health system in Saidpur and Parbatipur by motivating municipalities to implement the 1995 GOB circular requiring formation of municipal and ward level health committees. This is a remarkable accomplishment. The municipality has developed a community support system where families at the community have direct linkage to all levels of municipal decision-making in health matters.

The CSP succeeded in persuading the local municipalities to include health in their agenda (where it was not previously). Consequently, health has higher priority in annual planning and budgets. Through this process, the municipal and ward elected officials have been brought closer, and made more visible, to their constituents. With this program strategy, Concern Worldwide joins the over 70% of Child Survival grantees now engaged in supporting strengthening of decentralized health services.

The CSP gives support to anecdotal evidence cited by CSTS that the Child Survival Grants may have spill-over effects on civil society development by helping to build problem-solving skills at the community level, developing community-based development associations, and enhancing community response to conflict or disaster.

Concern's strategy for developing these municipal health structures has the potential to become a model for facilitating urban health development throughout Bangladesh and should be shared widely in both public health and civil society development settings.

The MHCs and the WHCs established by the CSP have demonstrated considerable ability to bring together disparate groups to address identified health priorities in communities. The CSP uses participatory methods to facilitate programming input from all sectors of the community. At the field level, the CSP is an integrated partnership at every implementation level with full participation of project stakeholders.

Program elements under the responsibility and control of the municipalities have demonstrated a marked increase in quality because of the CSP. The activities included in these interventions and program outputs, however, represent less than half of the overall program effort. There were, however, insufficient program outputs and verifiable indicators devoted to measuring impact of the Maternal and Newborn Care and IMCI components articulated in the original DIP. Implementation of the IMCI component was not scheduled to begin until the second half of the program; therefore, the CSP still has time to develop end of program targets to measure impact in this program element.

Recommendations

1. To have further impact on decreasing maternal and child mortality, the CSP needs to shift focus away from EPI and Vitamin A services, which have been largely successful, and significantly increase emphasis on maternal/newborn care and community integrated management of childhood illness (C-IMCI).

Specialized training for both staff and partners in Community/Household IMCI, Safe Motherhood and Saving Newborn Lives will be necessary to assure project impact on mortality and morbidity at the household level. Cross-visitation with other CSP projects addressing Community IMCI and Safe Motherhood should be pursued for the Project Managers, and possibly the Field Trainers (depending on cost.)

Concern should seek opportunities to collaborate with partners of the new USAID NGO Service Delivery Program (NSDP) to look for ways to strengthen the Community IMCI and Safe Motherhood aspects of the project. New information from the Saving Newborn Lives program implemented by Save the Children (US) in Bangladesh can also be a valuable source of information to help address perinatal mortality.

Implementing the IMCI component in the second half of the CSP

Since IMCI case management is unlikely to be implemented on a national scale in Bangladesh within the next year to 18 months, and the absorptive capacity of the municipal health staff to use the training is therefore very limited, the log frame indicator "all municipal health staff and 96 PPs trained on IMCI case management…." should be dropped, and replaced by adding an indicator to the M&E plan that measures program activities in community/household IMCI. This change will help to demonstrate the direct effect of CSP efforts. .

2. The CSP will need to engage in networking, coordination and advocacy with all major health care providers in the project area to address the main causes of maternal and child mortality in the municipalities.

The municipalities need to be proactive in networking with the health providers within their municipality and strongly advocate for joint efforts to address the major causes of infant, child and newborn deaths. These efforts include advocating for staff recruitment at the municipal level, sharing epidemiological information, coordination of health service referrals and finding ways of ensuring access to health care for the poorest sectors of the population.

The CSP will also need to devote significant attention to quality of care issues at all levels, including referral centers for danger signs of IMCI-related illnesses and maternal complications. If the facilities agree, health facility self-assessments can be conducted with Concern's assistance to establish what needs to be done to improve the quality of care. These assessments compare service delivery against national and international standards for case management. The municipalities and the facilities will then be better prepared when IMCI is implemented at the national level.

3. The CSP can move towards sustainability through concerted efforts to develop an exit strategy for WHCs, CHVs and Municipality HMIS.

EPI/Vitamin A

The CSP should plan to begin exiting from significant involvement in EPI and Vitamin A activities early in FY 2003. The project should begin by assessing the quality of services provided and develop plans for turning over the stronger centers to municipality management.

WHCs

The ability of the CSP to graduate WHCs from significant external involvement and ensure their sustainability requires the transfer of skills in facilitation, team building and motivational skills and financial management from CSP staff to the WHC members. WHCs will have to develop transparent management of the funds they have collected to support CSP activities. Concern can apply lessons learned from the Rural Development Project to assist in these efforts.

CHV's

The CSP and municipalities will have to address the issue of CHV turnover and incentives to encourage sustainability of these activities. The CSP should also consider selecting additional volunteers from other sectors of the population who will remain in the community.

Concern and the Municipality should involve the parents of CHVs by informing parents of the nature and importance of the work the CHVs do.

Municipal health staff should assume responsibility for training and refresher training of CHVs beginning in FY2003. To address the inevitable turnover of CHVs, plans should be developed for selecting, training and motivating new CHVs from the community over time.

TBAs

TBAs have a continuing need for clinical updates on safe delivery, postpartum, and newborn care. Experienced professionals with extensive delivery experience should provide this training. To provide for sustainable TBA clinical refresher training, the CSP should network with local health providers, such as LAMB Hospital and the MCWC Maternity Hospital in Saidpur, to provide continuing education in safe delivery for TBAs.

The CSP should commit to keep safe delivery, postpartum care, and care of the newborn as the primary activities of the TBAs. Introducing new mothers to ways of providing for the health of their infants, such as vaccinations, use of ORS and watching for danger signs as part of the postpartum check can be appropriate as long as the other quality elements of TBA performance are maintained.

The Monitoring and Evaluation System, including the HMIS

Stakeholders place a high value on improved monitoring progress and effectiveness of program activities. Concern can consider introducing some of the newer, less costly and time consuming monitoring measures, such as Lot Quality Assurance Sampling (LQAS), or "doer-non-doer" analysis to the program.

The HMIS should be expanded to include additional indicators to measure the IMCI and Safe Motherhood interventions of the program. The M&E system should refine objective indicators to measure progress in outputs 4 and 5. Recommendations from the BCC strategy to add additional impact indicators should be followed.

Additional attention needs to be paid to targeting and tracking Vitamin A supplements to postpartum women and children who have completed their immunizations by including this information in the HMIS and the M&E plan.

The CSP should closely monitor the volume of clients seeking formal health care at referral health facilities in response to recognition of danger signs as promoted through the community health promotion/BCC activities. The census-based information system developed by the CSP, in principle, can track all maternal and child deaths. Verbal autopsies, a methodology used in the CSP BCC audience

analysis, is one way the project can monitor the effectiveness of this program strategy in averting preventable maternal and child deaths.

The project should continue to monitor TBA performance, and develop ways of monitoring and strengthening individual performance as a follow-on to the TBA study. Duties can be deleted, or added, based on this monitoring to maintain the quality of care.

To encourage use of data for decision-making and sustainability of data collection, the CSP should provide a means for the municipalities to generate HMIS reports for themselves and turn this responsibility over to them as soon as possible. Concern can provide the training and has already arranged to provide the equipment. This is an important step in the turnover of the HMIS, and sustainability of the EPI and Vitamin A component depends on it.

Supervisors should make greater use of the HMIS to monitor program effectiveness and select areas for increased supervisory attention and training. This will require additional training for the supervisors.

4. To impact on the majority of life-threatening child illnesses, the project must find ways to promote safe practices by private practitioners (PPs).

As recommended by the DIP review and baseline survey consultants, these practitioners will need to be directly involved in designing activities to ensure their participation. This will be a major challenge for the CSP in the next two years.

PPs should be encouraged to be venues for health education on appropriate behaviors (such as child feeding, exclusive breastfeeding, immunizations, antenatal care) and referral of children with danger signs of life-threatening illness to the appropriate health facilities.

Homeopaths, particularly, should be targeted for inclusion in the CSP because they treat newborns and very young infants, who are known to be at the highest risk of death from preventable causes. These infants are often the hardest to reach of all targets groups in child survival.

5. The CSP should find ways to promote greater community-level male involvement in CSP activities.

Although the program has involved men throughout the program, the CSP must make stronger efforts to involve men in the project activities to obtain their support. Along with mothers-in-law, they are the most important decision-makers in household health care-seeking behaviors. Imams may be able to contribute to greater male involvement because they play a strong role in influencing male behavior.

6. Plans for Sharing Lessons Learned

Concern and the other CSP partners should share lessons learned in the CSP development process with other health NGOs and GOB offices as part of the national level advocacy efforts.

Concern should encourage and facilitate opportunities for the municipal chairmen and commissioners involved in the CSP to share the story of the CSP with their colleagues throughout Bangladesh.

Concern might consider contacting other CORE members in Bangladesh with the intention of starting a local version of CORE in Bangladesh. Several CORE PVOs participated in the PVO Polio Eradication Initiative project scheduled to end in 2002. Discussions are underway for future CORE PVO collaborations in Bangladesh and Concern can be a part of them.

F. RESULTS HIGHLIGHT

Community Participation Promotes Swift Community-Based Action

Presented by Dr. Shahnewaz A Khan, Assistant Country Director, Concern Bangladesh at the Global Health Council, May 2002

Promoting health in urban settings presents many challenges for engaging residents in health promotion. In Bangladesh, locally elected bodies form municipal governments. While charged with coordinating health promotion and services, municipalities are plagued by complex, bureaucratic decision-making procedures. Municipalities are also responsible for multiple social and economic sectors, limiting their ability to concentrate efforts on health. Further, the marginalized extreme poor have little clout and their needs are rarely reach the local political agenda.

Since 1998, Concern Bangladesh and the municipal governments of Parbatipur and Saidpur have jointly implemented a Child Survival program. In an effort to foster the active participation of all segments of the community, the program facilitated the establishment of Ward Health Committees. Members of the committee are diverse and represent broad segments of the community including minority sub-population, women's groups, teachers, NGO workers, formal and informal health workers, as well as members of the Municipality Cabinet. Community members participate in decision-making, some contribute financially and others volunteer their time.

This committee meets regularly to identify and discuss a broad spectrum of local issues and generate community remedial action. These committees are the first stop in managing community health needs, allowing local action by bypassing the municipality's complex system.

An informal but sustainable community participation mechanism for local actions has emerged under the leadership of this Ward Health Committee. Results of decisions made by these groups have been clear and rapid. For example, several committees have established emergency transportation plans, medical funds for indigents, recognition programs for volunteer health promoters, and special campaigns for vaccination of children from difficult to reach households. In response to this swift and decisive action, many committee members, including elected representatives have gained popularity within the community.

In conclusion, the child survival program has developed a model for sustained urban community participation in health promotion. This model builds on basic principles of community empowerment through development of leadership and coordination skills.

G. ACTION PLAN NOTES

In a workshop from 24-25th August 2002, Concern Worldwide and Concern Bangladesh met with CSP stakeholders used the key findings and recommendations to develop the Action Plan for the remainder of the project. Recommendations were grouped into five core areas for action. Each core area and discussion points are described below.

The overall purpose of the workshop was the participatory development of a preliminary CSP workplan for years 3 & 4 through distillation of MTE Recommendations, DIP, BCC strategic plan, and HICAP action plan.

Specific objectives of the meeting were to:

- discuss key evaluation recommendations to develop mutual understanding of their intent
- identify optimal strategic directions that the CSP partnership should take to effectively address each of the recommendations
- develop preliminary action steps to achieve directions set from the MTE
- review multiple plans into consolidated and preliminary workplan for years 3 and 4

Summary of Recommendations and Strategic Steps Proposed by the Team

Core Area #1: Shifting emphasis from EPI/Vitamin A which have been largely successful to newer areas of maternal/newborn care and integrated management of childhood illness (diarrhea, ARI/pneumonia, and nutrition)

As described in the MTE report, there are several issues raised about the need to make a strategic shift of effort and resources towards the IMCI and Safe Motherhood components. CSP team fully agrees and supports this recommendation. Some specific points to be considered in the action plan include:

EPI/Vitamin A

While we are reducing the CSP effort, focus on improving the quality of EPI program, particularly the cold chain operations remains critical. CSP will largely hand over mobilization/tracking responsibilities to the WHCs and the CHVs but will need to provide guidance to MHS in making this transition WHCs will maintain EPI as a regular agenda item. CSP Coordinator will collaborate with UHFPO, IOCH for ensuring cold chain and supplies during quarterly supervision. Concern will build skills of MHS to advocate for better supplies, increase number of supervisors and permanent health staff in both municipalities. Concern will continue to build supervisors skills in EPI management as well as other critical areas of facilitation, team building, and motivation.

Safe Motherhood

This has largely been included as major focus of BCC strategy. Effort will include awareness raising on ANC, EmOC/normal delivery, postpartum and newborn care

service promotion. CSP will organize household group meetings for birth preparedness (including men, in-laws and other influential family members).
Education materials will be provided for TBAs, MHS, WHC, and CHVs to promote SMI.
Further training in SMI and newborn care to be provided to MHS, WHC, CHVs as well as Concern staff.
Professional staff from MCWC, LAMB, and the Saidpur 50-bed hospital will conduct refresher training for TBAs. Practical trainings at these sites will be arranged.
A TBA referral system will be developed building on information from monthly meetings and Safe Motherhood events.

Community IMCI

Objectives will be added to BCC strategy to include pneumonia, diarrhea and malnutrition elements with an aim to raise awareness among community mothers/caretakers about danger signs, early referral, and home care. Significant strategic planning and training for Concern and MHS staff including cross-visits to C-IMCI programs will be needed to advance understanding of the concept. C-IMCI training for private providers, WHCs, CHVs and TBAs and education materials to be adapted for the program.

Core Area #2: Moving towards sustainability through concerted efforts of an exit strategy for WHCs, CHVs and Municipality HMIS

The CSP team needs more support in capacity building planning and organization development in order respond to this recommendation area better. A participatory training and planning exercise is planned for February 2003 in which CSTS support has been requested. An interim plan from the stakeholders is as follows:

a) Ward Health Committees strengthened to be independent and sustainable to work with municipality health committee (most in Parbatipur are at nascent stage while at nursing stage in Saidpur)

- Strategy (guidance, motivation, develop skill, leadership, team building and financial management
- The work:
  - Develop more skills to the WHC Chairmen and Secretaries for developing leadership
  - Training on facilitation, financial management, capacity building
  - Support to establish better financial management systems
  - Cross-visit/mentoring between WHCs

b) Developing partnership between CHVs for different activities

- Strategy (identify and explain the roles and responsibilities of CHVs, documentation, and seeking the ways how to implement)
- The work:

- Organize gathering for parents of volunteers to explain CHV roles and responsibilities
- Review volunteer selection process and select new volunteers (as necessary)
- Award high performing volunteers
- Develop skill of MHS to train new CHVs
- Develop mechanism to supervise CHVs through WHCs

c) Develop a sustainable monitoring system meeting municipality health information system requirements

- Strategy: Match the government HMIS with CSP system
- The work:
    - Orient supervisors on HMIS
    - Identify gaps in current HMIS
    - Provide training to municipality staff on data analysis, use, and dissemination

Core Area #3: Networking, coordination, and advocacy to address main causes of maternal and child mortality in the Municipalities

The CSP team embraces this recommendation but also realizes that it will not be easy as so many of the issues are outside of the direct control of the MHS. The following are initial thoughts on working towards the recommendation.

Increased coordination

- Strengthen MHC to organize regular meetings
- Ensure members attendance/participation
- Ensure municipality presence in district and sub-district level health meetings
- Organize coordination meetings between field staff of service providers
- Link to plans in BCC strategy to address quality of services and strategic partnership

Advocacy to recruit municipality staff as per organogram

- Meeting with municipality cabinet – motivate them to recruit health staff (internal lobbying)
- Municipality initiative to advocate on staff issues with support from other partners

National level advocacy

- Organize national level workshop to disseminate lessons learned
- Share with other municipality leaders through Chairmen's' Association
- Organization national level workshop

Core Area #4: Promote safe practices of key Private Practitioners (PPs)

The CSP team fully supports this recommendation and has long recognized their importance in improving child survival. Over the first two years, the team has been

learning about the extent of private practitioners in the area including types, clients, quality/practices, training, and factors for high use of their services.

Necessary Steps:

- Identify PPs (RMPs, Drug sellers (trained/untrained), homeopathic) that see the most cases of ARI, diarrheal diseases, and newborn complications
- Training of selected PPs (curriculum drafted based on findings from CSP assessments) will be separate for homeopaths
- Annual seminars for private practitioners only (continuing education)
- WHC Coordination meetings twice per year with TBAs, PPs, Homeopaths, Herbalists
- Annual coordination meetings with formal health service providers with PPs
- Ensure attendance of PP representatives in monthly WHCs (but how will they
- Promotion of drug selling licensing to hold accountable to municipality (may require circular from MOHFW/MOLGRD
- Recognition/reward for private providers
- Advocacy to formulate MOHFW/MOLGRD circular for PPs to support municipality health programs

Core Area #5 Greater community-level male involvement: effective reach to decision-makers

The CSP team has long recognized the role of men in household care-seeking decision-making. They also realized the role of Imams in changing attitudes and social norms. These aspects have already been incorporated in the recently developed BCC strategy. Some additional thoughts from the team include:

- Provide training guardians of female TBAs, CHVs, and WHC to be sensitized on core interventions
- Identify 60 men in each ward and provide training on core interventions so as to spread information to other families
- Meetings of men's groups on different health interventions
- Information dissemination through mobile projection unit (need to check suitability of existing films)
- Involve men in observation of health events
- Work with Imams to create and disseminate messages