Mid-Term Evaluation
CRWRC Child Survival Project
Bangladesh: Dhaka, Netrokona, Panchagor
(July 2007)

Christian Reformed
World Relief Committee (CRWRC)

Date of Submission: October 31, 2007

Cooperative Agreement No. GHS-A-00-04-00010-00
September 30, 2004 – September 30, 2009

Midterm Evaluation Team

Dr. Frank Baer, Team Leader, Independent Consultant
Dr. Kishan Chakraborty, Activity Manager, SMNC, USAID/Bangladesh
Ms. Nancy TenBroek, Child Survival Program Manager, CRWRC/Bangladesh
Ms. Kohima Daring, Child Survival M&E Specialist, CRWRC/Bangladesh
Mr. Will Story, Child Survival and Health Technical Advisor, CRWRC/US
Mr. Faisal Ahmed Khan, Program Officer, CRWRC/Bangladesh
Dr. Shahnaz Parveen, Project Manager, CCM OR CRWRC/Bangladesh
Mr. Doyal Chandra Paul, Executive Director, SUPOTH
Mr. Rezaul Karim, Health Coordinator, SUPOTH
Mr. Apurbo Ghagra, Executive Director, SATHI
Ms. Catherine Reina Guda, Assistant Director, SATHI
Ms. Shireen Akhtar, Health Coordinator, SATHI
Mr. Sanjay Ranjon Kor, Capacity Developer, SATHI
Mr. Gabriel Rozario, Executive Director, PARI
Mr. Profullo Chandra Hajong, Health Coordinator, PARI
Ms. Niki Vander Meulen, Student Intern, U. of Michigan

Back: Nancy TenBroek, Kishan Chakraborty, Doyal Chandra Paul, Will Story, Frank Baer, Faisal Ahmed Khan
Front: Rezaul Karim, Kohima Daring, Profullo Chandra Hajong, Shireen Akhtar, Apurbo Ghagra,
Sanjay Ranjon Kor, Niki Vander Meulen, Catherine Reina Guda, Shahnaz Parveen, Gabriel Rozario

Table of Contents

[1] All other attachments referred to in the 2006 MTE Guidelines are included in the narrative of this report.

Executive Summary

A. Introduction

The Mid-Term Evaluation (MTE) took place July 14-25, 2007. A participatory approach encouraged problem analysis and solution development by project staff as full members of the evaluation team. The team of 16 persons included an external consultant team leader, a representative from USAID/Bangladesh, staff of CRWRC/Bangladesh and CRWRC/US, and representatives from the three implementing partners (PARI, SATHI and SUPOTH).

The evaluation process strived to answer five questions:

1) Is there satisfactory progress in project implementation?
2) Is the project achieving its objectives?
3) Are the interventions sufficient to reach desired outcomes?
4) What barriers exist to achieve objectives?
5) What recommendations might help improve the project?

The evaluation team split into two teams (and four sub-teams) to complete field visits in the three project areas (see map). More than two dozen group interviews were conducted with District and Sub-district Authorities, staff of Union and NGO Service Delivery Program (NSDP) health facilities, training institutions, Peoples' Institutions (PIs), primary groups, community health volunteers (CHVs), trained traditional birth attendants (TTBAs), village doctors, and women of reproductive age. Following the field visits, observations and findings were discussed, and a consensus emerged for ten major recommendations. The evaluation results were presented to a meeting for stakeholders on July 25.

B. Project description and objectives

The CRWRC Child Survival Project (CSP) works in selected unions of two rural districts (Panchagor and Netrokona) and one urban district (Dhaka). The project is implemented through three partner organizations: PARI (Netrokona), SATHI (Dhaka) and SUPOTH (Panchagor). The six objectives include:

1) Improve maternal and neonatal care;
2) Prevent and properly treat diarrheal disease;
3) Detect ARI and make appropriate referrals;
4) Improve child nutrition;
5) Reduce mortality and morbidity from vaccine preventable diseases; and
6) Increase awareness about HIV/AIDS.

These objectives have been developed as part of the national strategy for Community-based Integrated Management of Childhood Illness (C-IMCI) to 1) improve links to health facilities, especially for referral; 2) increase community-based care by TTBAs; and 3) Promote key family practices by CHVs and primary groups.

C. Main accomplishments

CRWRC and its implementing partners are to be commended for creating a highly effective and efficient working relationship that has resulted in a smoothly implemented project. Their approaches should be documented as a case study in developing and managing local partnerships. The working relationship between implementing partners and their respective locally-based PIs and primary groups has also been very good.

CSP has made excellent progress in project implementation of its Detailed Implementation Plan and in achieving its stated objectives. The interventions adopted appear to be technically sufficient to reach the desired outcomes, yet efforts for further improvement are also being considered. The decision to use an integrated approach as part of the national C-IMCI strategy has provided a solid framework for project implementation and collaboration with the Ministry of Health (MOH).

D. Overall progress in achieving objectives

CSP has made excellent or very good progress in achieving midterm targets for the six interventions. Working through the national C-IMCI strategy has provided a solid and integrated basis for these interventions. The project has surpassed mid-term targets for 9 of 16 indicators and made good progress with three additional indicators. See Table 4 for an overview of results. The project emphasis on Behavior Change Communications by CHVs and TTBAs creates a demand for and is linked to service delivery at health facilities. Therefore, the success of CSP also represents a success of the MOH in the provision of essential health services.

E. Main constraints, problems and areas in need of further attention

The project has effectively and appropriately dealt with a number of barriers related to geography, infrastructure, communication, climate, institutions, tribal practices, gender bias and local beliefs. Access to health care and program sustainability in supporting CHVs and TTBAs are the primary remaining concerns (see recommendations below).

F. Capacity-building effects of the project.

CSP's approach to capacity building of implementing partners and PIs is very solid. The three implementing partners are not project-dependent. The fact that some PIs have existed for more than ten years and are being registered as Community Based Organizations (CBOs) is a positive indication of this capacity building.

G. Prospects for sustainability and phase-out planning

The primary concern shared by all is whether PIs and primary groups can sustain a network of CHVs and TTBAs. Much of the capacity building of CHVs and TTBAs is still dependent on project paid health animators. The project has begun to explore and test a variety of approaches to share the tasks of these paid animators with the PI health sub-teams, with primary groups, and with key personnel based at neighboring health facilities.

H. Conclusions and recommendations

The following ten recommendations are proposed to assist the project staff in improving the project during the next two years:

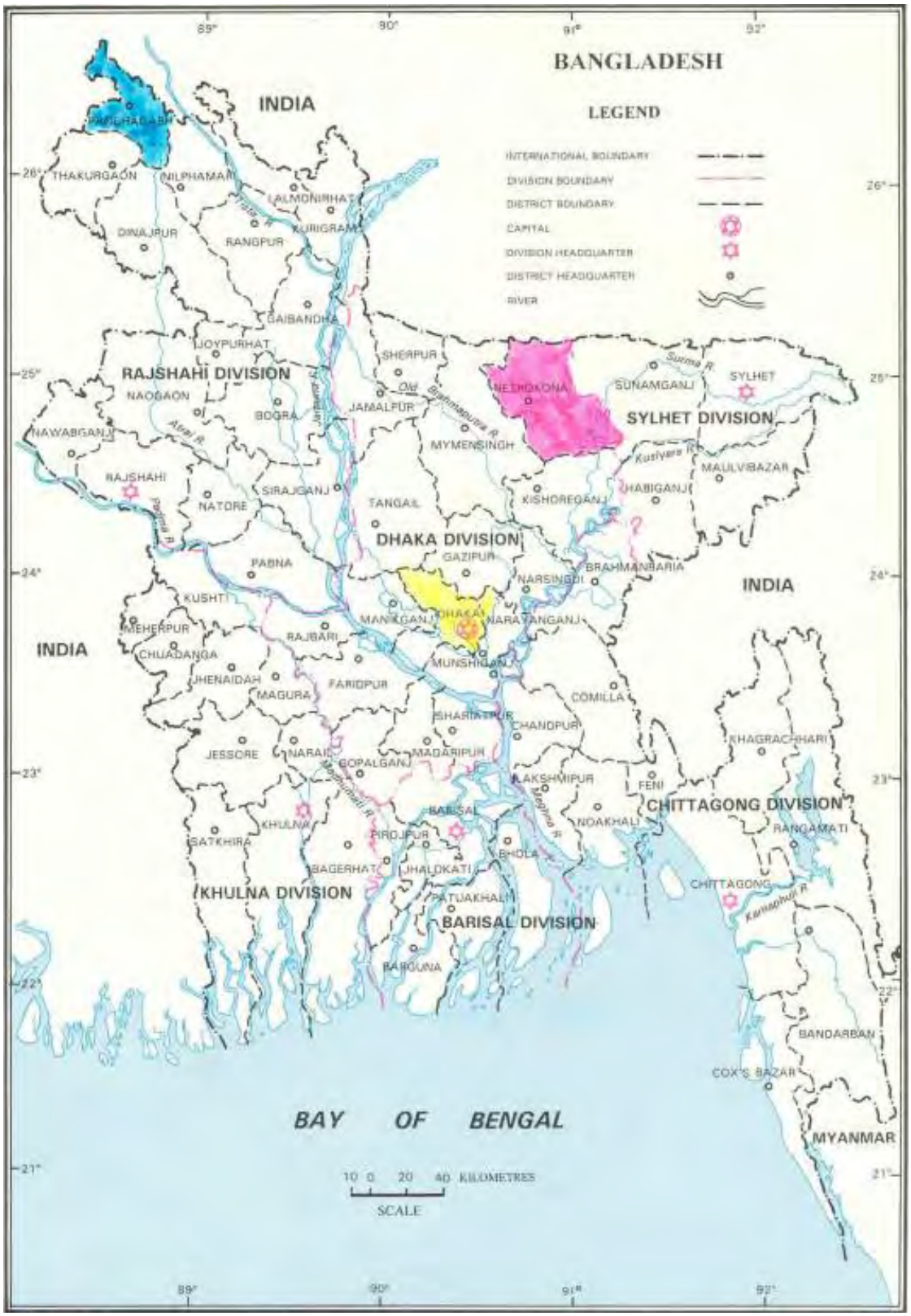
1) Explore and test approaches to reinforce supervision and support linkages between community-based workers and PI health sub-teams.
2) Explore and test approaches to reinforce supervision and support linkages with health facilities and key health workers, e.g., health assistants and skilled birth attendants.
3) Identify capacity topics and indicators for continuing training of PIs, health sub-teams and primary groups for sustainability in long-term planning, networking, communication, advocacy, supportive supervision, and transitioning project paid health animators.
4) Implementing Partners should build on the local power base of PIs to reinforce relationships with local health authorities and facilities, including those supported by NSDP, to ensure the availability, access, affordability and quality of services.
5) Continue to explore options to improve access to urgent health care by improved management and expansion of emergency health funds.
6) Give special attention, using the BEHAVE framework, to technical interventions for which the mid-term targets were not met.
7) Continue to explore why some implementing partners have done particularly well in certain areas in order to document those achievements and share them with other partners as part of the Learning Circle.
8) CRWRC headquarters should document and share the CSP experience in Bangladesh as a case study in developing and managing local partnerships.

9) Examine options for support systems for community-based treatment in rural areas using evidence from the Community Case Management Operations Research in Panchagor.
10) Examine options for program consolidation and expansion in existing unions and eventually to neighboring unions.

I. Grantee's responses and action plan

The ten proposed recommendations were discussed, revised and agreed upon by the full evaluation team and project staff. The implementing partners have already begun drafting action plans for the implementation of these recommendations.

Project Map
(with the three targeted district highlighted)



List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guérin vaccine
BCM	Bengal Creative Media
CBO	Community Based Organization
CCI	Community Capacity Indicators
CCM	Community Case Management
CHA	Community Health Animator
CHV	Community Health Volunteer
C-IMCI	Community/Household Integrated Management of Childhood Illness
CRWRC	Christian Reformed World Relief Committee
CSP	(CRWRC) Child Survival Project
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support Plus Project
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, and Tetanus vaccine
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
GLP	Global Learning Partners
GOB	Government of Bangladesh
HBLSS	Home-Based Life Saving Skills
HFA	Health Facilities Assessment
HIV	Human Immunodeficiency Virus
ICDDR,B	International Center for Diarrheal Disease Research in Bangladesh
KPC	Knowledge, Practices, and Coverage survey
LAMB	Lutheran Aid to Medicine in Bangladesh
LNRA	Learning Needs Resource Assessment
LQAS	Lot Quality Assurance Sampling
MAMAN	Minimum Activities for Mothers and Newborns
MIS	Management Information System
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
NID	National Immunization Days
NSDP	NGO Service Delivery Program
OCI	Organizational Capacity Indicators
ORS	Oral Rehydration Solution
PD	Positive Deviance
PDI	Positive Deviance Inquiry
PI	Peoples' Institution
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TFD	Theatre for Development
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

I. INTRODUCTION

A. CRWRC in Bangladesh

The Christian Reformed World Relief Committee (CRWRC) was established in 1962 by the Christian Reformed Church in North America. CRWRC partners with 130 faith-based and non-governmental organizations in 30 countries throughout Africa, Asia, Eastern Europe, and the Americas. CRWRC began working in Bangladesh to provide relief and agricultural assistance in the early 1970's after the Liberation War. Today, CRWRC collaborates with 5 Bangladesh development agencies serving over 22,000 families. CRWRC focuses on strengthening national development organizations so that they are equipped for capacity building of their communities.

The CRWRC Child Survival Project (CSP) works with three local non-governmental development organizations (PARI, SATHI and SUPOTH) in selected unions and wards in the districts of Netrokona, Dhaka and Panchagor, respectively (see map). The total beneficiary population is around 170,000 with 5,072 children less than five years of age and 11,468 women of reproductive age.

Table 1: CSP Beneficiary Population

Partner NGO	Locations	Population	Beneficiaries	
			Children < 5	Women of Reproductive Age
PARI	**Netrokona:** Durgapur, Kullagora & Lengura Unions	**89,068**	**1,662**	**3,248**
SATHI	**Dhaka:** Wards/Slums of Lalbagh, Sutrapur, Maniknagar and Mirpur	**45,445**	**1,810**	**3,750**
SUPOTH	**Panchagor:** Chaklahat and Kamatkazaldighi Union	**35,290**	**1,600**	**4,470**
	Totals	**169,803**	**5,072**	**11,468**

B. Midterm Evaluation Methodology

The Mid-Term Evaluation (MTE) took place July 14-25, 2007. A participatory approach encouraged problem analysis and solution development by project staff as full members of the evaluation team of sixteen persons. This included an external consultant team leader, a representative from USAID/Bangladesh, staff of CRWRC/Bangladesh and CRWRC/US, and representatives from the three implementing partners (PARI, SATHI and SUPOTH).

The evaluation process strived to answer five questions:

1) Is there satisfactory progress in project implementation?
2) Is the project achieving its objectives?
3) Are the interventions sufficient to reach desired outcomes?
4) What barriers exist to achieve objectives?
5) What recommendations might help improve the project?

The evaluation team split into two teams (and four sub-teams) to complete field visits in the three project areas (see map). More than two dozen group interviews were conducted with District and Sub-district Authorities, staff of Union and NGO Service Delivery Program (NSDP) health facilities, training institutions, Peoples' Institutions (PIs), primary groups, community health volunteers (CHVs), trained traditional birth attendants (TTBAs), village doctors, and women of

reproductive age. Following the field visits, observations and findings were discussed, and a consensus emerged for ten major recommendations. The evaluation results were presented to a meeting of stakeholders on July 25.

C. Strategic Objectives

The strategic objectives of CSP are to:

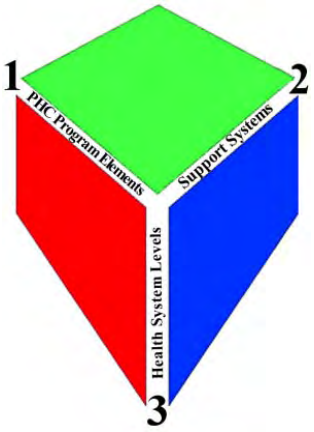
1) Improve maternal and neonatal care;
2) Prevent and properly treat diarrheal disease;
3) Detect ARI and make appropriate referrals;
4) Improve child nutrition;
5) Reduce mortality and morbidity from vaccine preventable diseases; and
6) Increase awareness about HIV/AIDS.

The project chose to implement these objectives as part of the national strategy for Community-based Integrated Management of Childhood Illness (C-IMCI). To this end the project embraced three strategic approaches:

1) Improve networking with health facilities in order to refer complicated pregnancies and severe childhood illnesses;
2) Increase the quality and availability of pre-natal, natal and post-natal care through training of TTBAs; and
3) Promote key family practices critical for child health and nutrition through training CHVs and forming primary groups.

D. Conceptual Framework

Figure 1.



Given the multi-level, capacity-building nature of this project, the evaluation team found it useful to examine the work of CSP and the MOH as part of an integrated health system (see Figure 1) where:

The <u>First Dimension</u> includes health interventions which, for the purposes of CSP, are C-IMCI and Behavior Change Communications;

The <u>Second Dimension</u> includes the support systems required to deliver and maintain the health interventions, e.g., planning, training, supervision, information and referral systems, which are provided by/through primary groups, PIs, and health facilities; and

The <u>Third Dimension</u> includes organizational levels ranging from the home/family to the health district. For CSP this dimension includes two parallel organizational systems, i.e., the community-based structures of PIs and the health system of the MOH.

The evaluation process examined in particular how CSP has/could develop first and second dimensional links between the two organizational systems that would contribute to the sustainability of activities (see Table 2).

Table 2. Linking the MOH and Peoples' Institutions

MOH Health System	Sustainability Links	Community-Based
▪ Home and Family ▪ Community Outreach ▪ Union Facilities ▪ Sub-district ▪ District/National	**BCC** **C-IMCI** **← Info Systems →** **Referral Systems** **Supportive Supervision**	▪ Home and Family ▪ CHVs and TTBAs ▪ Primary Groups ▪ Central Committees ▪ Peoples' Institution

II. PROGRESS IN ACHIEVING OBJECTIVES

A. Technical Approaches

1. Overview of Technical areas

CSP is on schedule to reach the mid-term targets for number of primary and adolescent groups formed, number of beneficiaries served, and number of TBAs and CHVs trained (see Table 3). CSP is reaching more children under five than expected. This is mainly due to the interest of mothers who are not in primary groups to have their children participate in growth monitoring and other CSP initiatives.

Table 3. Beneficiaries, Group Formation, and People Trained in the CSP Through June 2007

Particulars		Dhaka		Netrokona		Panchagor		TOTAL	
		Actual	Target	Actual	Target	Actual	Target	Actual	Target
Primary Groups		150	169	153	155	139	184	442	508
Primary Group Members		2719	2880	2353	2480	2725	3650	7797	9010
Adolescent Group	Girls	41	40	6	6	12	12	59	58
	Boys	21	20	3	4	12	10	36	34
Adolescent Group Member	Girls	450	460	118	115	292	300	860	875
	Boys	215	240	62	82	239	245	359	567
Peoples' Institutions		15	15	2	1	1	1	18	17
Number of children under 5		1471	1650	2212	1374	1484	1450	5167	4474
CHVs Trained		164	166	155	155	90	90	409	411
TBAs Trained		78	88	74	75	75	75	227	238

CSP has made very good to excellent progress in achieving its strategic objectives for its six technical areas and 16 principle indicators. CSP has met or surpassed the mid-term targets for nine indicators; made good progress towards three additional indicators; and encountered problems with four indicators. Table 4 shows the degree of progress for each indicator and implementing partner with a comparison of baseline KPC, mid-term target and mid-term KPC results. The results are color-coded to highlight the progress as being excellent, very good, good, not significant, and lack of progress/decreasing indicator (see legend). The project has, in fact, surpassed the End of Project (EOP) targets for several indicators, and should consider whether to increase EOP targets for selected indicators or to sustain the MTE achievements.

It was noted that the performance of implementing partners varies, and that sometimes one implementing partner performs significantly better for a particular intervention, e.g., Panchagor for Antenatal Care Rate as shown below. A number of reasons were suggested for this difference but nothing conclusive was decided during the MTE. This led to the recommendation to explore and share the work of high performing partners.

INTERVENTION AREA	INDICATOR	Part-ner	Base-line %	MT target %	MTE KPC %	Progress
Antenatal Care Rate	Percentage of mothers who had at least 4 prenatal visit prior to the birth of her youngest child less than 24 months of age	**P**	**31**	**43**	**78***	**+++**
		N	**6**	**14**	**9**	**+**
		D	**36**	**65**	**58***	**+**

- **<u>Recommendation:</u> Continue to explore why some implementing partners have done particularly well in certain areas in order to document those achievements and share them with other partners as part of the Learning Circle.**

CSP has already begun investigating why no significant progress was shown in four intervention areas:

- Mothers who received at least two tetanus toxoid injections;
- ORT use during diarrheal episode;
- Increased fluid and continued feeding during an illness; and
- ARI care seeking at health facilities.

With regards to Tetanus Toxoid for pregnant women it is suspected that the KPC survey did not adequately capture women who had been fully vaccinated during a previous pregnancy and only received one booster shot during their last pregnancy. CSP will test this hypothesis during their next round of surveys. For the other indicators that missed the mid-term target, e.g., increased fluid and continued feeding during an illness, the project has proposed to use the BEHAVE framework and focus group discussions to examine reasons for the lagging performance, i.e., is it a survey problem or a behavioral barrier. The evaluation team agreed, therefore, on the following recommendation:

- **<u>Recommendation:</u> Give special attention, using the BEHAVE framework, to technical interventions for which the mid-term targets were not met.**

Table 4: Progress in Achievement of Project Objectives

INTERVENTION AREA	INDICATOR **BOLD** = KPC Rapid CATCH Indicators	Partner	Base-line %	MT target %	MTE KPC %	Pro-gress
Strategic Objective I. Improve Maternal and Neonatal Care P=Panchagor N=Netrokona D=Dhaka						
Delivery by Skilled Health Personnel (including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel	P	18	42	61*	+++
		N	21	30	31*	++
		D	35	46	76*	+++
Antenatal Care Rate	Percentage of mothers who had at least 4 prenatal visit prior to the birth of her youngest child less than 24 months of age	P	31	43	78*	+++
		N	6	14	9	+
		D	36	65	58*	+
Tetanus Toxoid (TT)	**Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age**	**P**	**80**	**88**	**49***	-
		N	**62**	**72**	**61**	
		D	**59**	**75**	**66**	+
Knowledge on Maternal Danger Signs/Symptoms	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and postnatal period	P	33	43	66*	+++
		N	31	40	62*	+++
		D	37	62	71*	++
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease						
ORT Use During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	P	64	72	46	-
		N	56	65	54	
		D	55	70	67	+
Increased Fluid and Continued Feeding During an illness [1]	**Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food**	**P**	**57**	**NA**	**56**	
		N	**64**	**NA**	**75***	++
		D	**94**	**NA**	**95**	
Zinc Supplementation During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness	P	14	45	33	+
		N	11	50	48*	+
		D	9	50	41*	+
Availability of Soap for Hand Washing	**Percentage of mothers of children age 0-23 months that have soap readily available for hand washing.**	**P**	**53**	**60**	**98***	+++
		N	**15**	**27**	**90***	+++
		D	**37**	**NA**	**98***	+++
Strategic Objective III. Detect ARI and Make Appropriate Referrals						
ARI Care Seeking	Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility	P	29	42	14	-
		N	8	18	19	++
		D	63	75	61	
Maternal Knowledge of Child Danger Signs/Symptoms	**Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms**	**P**	**70**	**75**	**82***	+++
		N	**73**	**78**	**80**	++
		D	**62**	**78**	**91***	++
Strategic Objective IV. Improve Child Nutrition						
Underweight	**Percentage of children aged 0-23 mos who are more than 2 standard deviations (SD) below the median weight-for-age (WA) of WHO/NCHS reference population**	**P**	**38**	**30**	**26***	++
		N	**41**	**30**	**37**	+
		D	**39**	**30**	**27***	++
Exclusive Breastfeeding [2]	**Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours**	**P**	**61**	**90**	**74**	+
		N	**33**	**79**	**63***	+
		D	**50**	**80**	**67***	+
Appropriate Complementary Feeding Practice	**Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours**	**P**	**27**	**42**	**47**	++
		N	**14**	**70**	**75***	++
		D	**55**	**65**	**79**	+++
Vitamin A Coverage	Percentage children aged 6-23 months who received a Vitamin A dose in the past six months	P	62	75	74*	++
		N	61	67	84*	+++
		D	53	65	77*	+++
Strategic Objective V. Reduce Morbidity and Mortality from Vaccine						
Complete Immunization Coverage	**Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio**	**P**	**57**	**72**	**92***	+++
		N	**32**	**60**	**74***	++
		D	**28**	**50**	**82***	+++
Strategic Objective VI. Increase Awareness of HIV/AIDS						
Maternal Knowledge of HIV Risk Reduction	**Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV**	**P**	**12**	**50**	**59***	++
		N	**13**	**55**	**58***	++
		D	**51**	**65**	**84***	+++

[1] Baseline data not collected for this indicator. The data presented was collected during Sept.'05 Nutritional Surveillance.
[2] Baseline data not reliable for this indicator. The data presented was collected during Sept. '05 Nutritional Surveillance.
* = $p < 0.05$ for chi-square test between baseline and midterm proportions.

Legend: Degree of Progress in Meeting Mid-Term Targets			
+++	Excellent Progress in surpassing targets by large margin		No significant progress
++	Very Good Progress in meeting or surpassing targets	-	Lack of progress or decreasing indicator
+	Good Progress towards meeting the targets		

2. Progress report by intervention area

a) Maternal & Neonatal

Delivery by skilled health personnel (including TTBAs): The Dhaka and Panchagor domains have achieved much higher than the midterm targets (see Chart 1). The Netrokona region was also able to reach its midterm target. Because of the availability of trained TBAs (TTBAs) in the community, mothers prefer using TTBAs to attend their delivery. They seek help from a doctor or nurse only when they have complications at the time of birth; therefore delivery by skilled health personnel, not including TTBAs, remains low for all three working areas (see Chart 2).

Chart 1: Delivery by Skilled Health Personnel (including TTBAs)

Percentage of children aged 0-23 months whose births were attended by skilled health personnel.

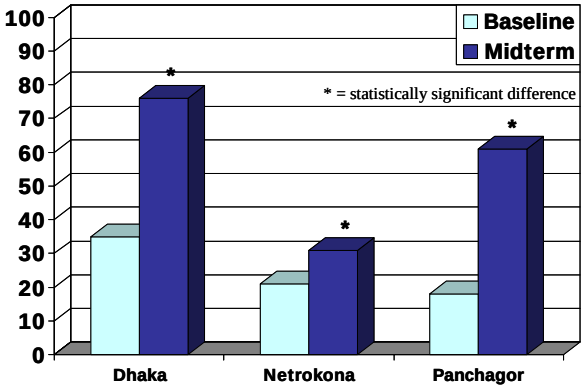
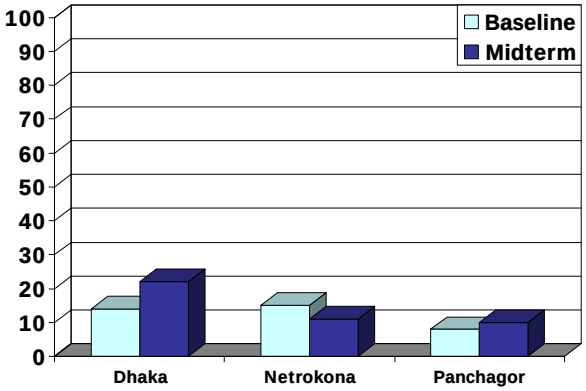


Chart 2: Delivery by Skilled Health Personnel (not including TTBAs)

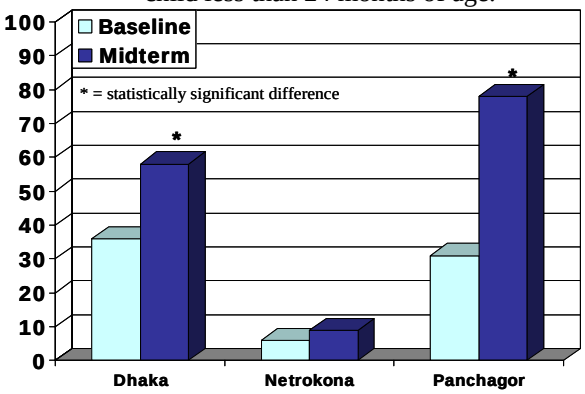
Percentage of children aged 0-23 months whose births were attended by skilled health personnel.



Antenatal Care Rate: Similar to the above indicator, the Dhaka and Panchagor domains exceeded the midterm target with a higher percentage of mothers attending four prenatal visits from a skilled attendant prior to their last birth (see Chart 3). Although Netrokona region could not reach the midterm target (14%), it has improved its performance on this indicator from 6% in the baseline to 9%.

Chart 3: Antenatal Care Rate

Percentage of mothers who had at least four prenatal visits prior to the birth of her youngest child less than 24 months of age.



It is interesting to note that the percentage of mothers attending one prenatal visit increased from the baseline in both Dhaka (85% to 91%) and Panchagor (60% to 95%); however, it decreased slightly in Netrokona (49% to 47%). The percentage of mothers attending one prenatal visit is an estimate of the number of women who have access to prenatal care; whereas, the percentage of mothers attending all four prenatal visits is an estimate of the health system performance. Therefore, it appears that access to prenatal care needs to be addressed in Netrokona.

Tetanus Toxoid (TT): The percentage of mothers who received two doses of TT before the birth of their youngest child increased slightly from baseline in Dhaka (59% to 66%) and remained the same in Netrokona (62% to 61%) (see Chart 4). However, it decreased significantly in Panchagor (80% to 49%). After discussion with the CSP Coordinators of all three areas it was revealed that TT coverage is actually very high in all the regions. Almost 100% pregnant women are being provided with TT. In collecting the data, when mothers had already received 5 doses of TT before their last pregnancy, community health animators recorded it as already immunized. However, when mothers had already received 2 doses of TT before the most recent pregnancy and received only 1 dose of TT during their last pregnancy, the staff recorded it as only one dose received by mothers. This issue will be further examined and addressed in the next nutritional surveillance[2].

Chart 4: Tetanus Toxoid during Pregnancy

Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age.

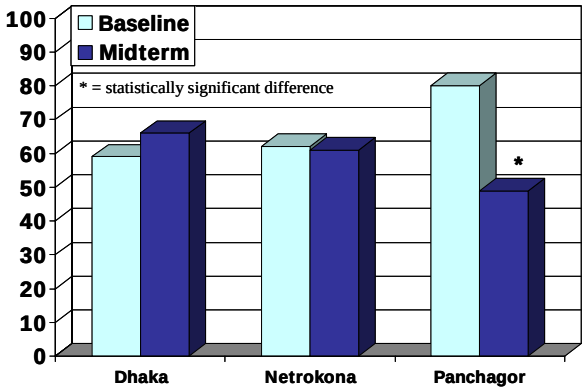
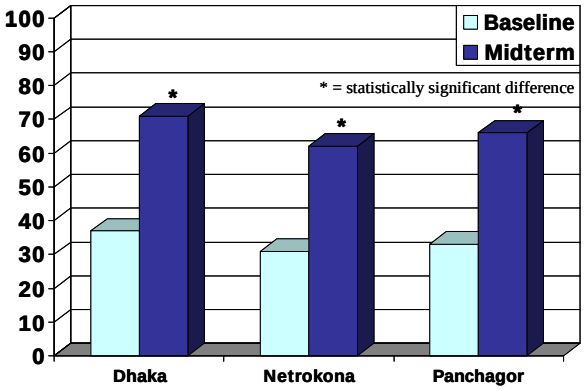


Chart 5: Knowledge of Maternal Danger Signs/Symptoms

Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs and symptoms during prenatal, natal and postnatal period.



Knowledge on maternal danger sings/symptoms: Mothers knowledge on at least two danger signs/symptoms during the prenatal, natal and postnatal period has improved significantly and all three regions achieved far above their midterm targets (see Chart 5).

b) Diarrheal Disease

ORT use during diarrheal episode: ORT use during diarrhea increased from 55% to 67% in Dhaka, decreased slightly from 56% to 54% in Netrokona, and decreased from 64% to 46% in Panchagor (see Chart 6). None of the three working areas reached the midterm targets (70%, 65% and 72% respectively). The decline in ORT use may be due to the recent emphasis placed on using zinc supplementation during a diarrheal episode. Mothers may have not understood the importance of using both ORT and zinc during a diarrheal episode. This issue will be further examined and addressed in the next nutritional surveillance[3].

[2] Nutrition Surveillance was conducted in August 2007 among primary group members. This survey revealed the percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age was 99% (Panchagor), 98% (Netrokona), and 84% (Dhaka).

[3] Nutrition Surveillance (August 2007) revealed the percentage of children aged 0-23 months with diarrhea in the last two weeks who received ORS and/or RHF was 100% (Panchagor), 95% (Netrokona), and 96% (Dhaka).

Increased fluid and continued feeding during an illness: The CSP did not have this indicator at the time of baseline due to the wording of the question at baseline. However, this indicator was collected in September 2005 during the nutritional surveillance and repeated during the Midterm KPC survey (see Chart 7). There was no change from September 2005 to midterm in Dhaka (94% to 95%) and Panchagor (57% to 56%). However, Netrokona showed a slight improvement from September 2005 to midterm (64% to 75%). This indicator has varied significantly in each working area throughout the program. This may be due to the way in which the question was asked during the KPC survey and nutrition surveillance surveys.

Chart 6: ORT Use During Diarrheal Episode

Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF).

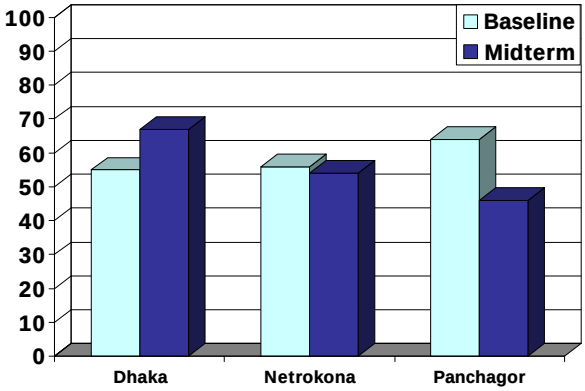
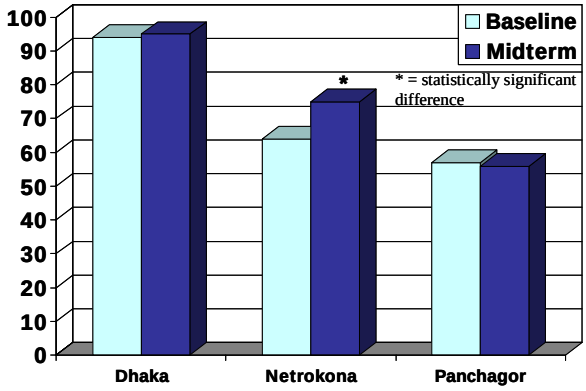


Chart 7: Increased Fluid and Continued Feeding During an Illness

Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food.



Zinc supplementation during diarrheal episode: All three working areas showed significant improvement from baseline (see Chart 8). All three regions did not reach their midterm targets, but they still achieved significant increases in zinc use during diarrhea (41%, 48%, and 33% for Dhaka, Netrokona, and Panchagor respectively).

Availability of soap for hand washing: All three working areas have done exceptionally well on this indicator (see Chart 9). Dhaka increased from 37% to 98%, Netrokona increased from 15% to 90%, and Panchagor increased from 53% to 98%. Given these results it has been decided to add a new indicator for the MTE and Final KPC surveys to more accurately measure hand washing behavior:

> *Percentage of mothers of children aged 0-23 months who live in a household with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the last 24 hours.*

Chart 8: Zinc Supplementation during Diarrheal Episode

Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness.

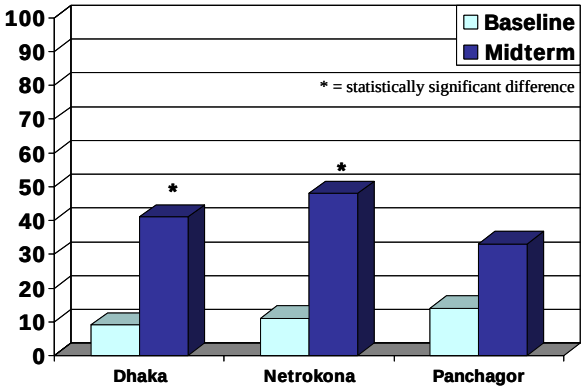
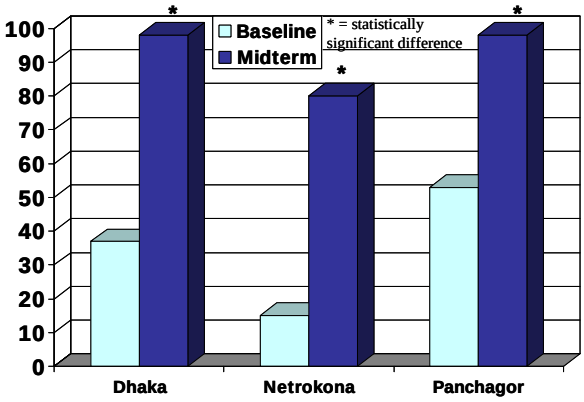


Chart 9: Availability of Soap for Hand Washing

Percentage of mothers of children age 0-23 months that have soap readily available for hand washing.



c) ARI

ARI care seeking: The percentage of mothers reporting that they took their child to a health facility when s/he had fast or difficult breathing increased from baseline in Netrokona from 8% to 19% (see Chart 10). However, the other two working areas performed a bit below the baseline benchmark. (Dhaka dropped from 63% to 61% and Panchagor dropped from 29% to 14%). One reason for the decline in Panchagor and Dhaka may be the distance to the health facilities and that antibiotics are not administered by the community health volunteers or the village doctors. The reason behind this decline is being sought and appropriate action will be taken.

CSP is also conducting Operations Research, with GOB approval, in training CHVs for Community Case Management (CCM) of ARI. CSP feels that the potential to expand CCM activities is greatly due to the GOB's commitment to C-IMCI. If CCM is successful in achieving higher treatment rates without compromising quality, then it is hoped that the GOB will include CCM in its on-going C-IMCI strategy and scale up the role of CHVs and TTBAs for CCM of diarrhea and pneumonia. Based on this ongoing research the following recommendation was made to examine additional options from CCM.

- **Recommendation: Examine options for support systems for community-based treatment in rural areas using evidence from the Community Case Management Operations Research in Panchagor.**

Maternal knowledge of child danger sings/symptoms: All three working areas achieved far above the baseline and the midterm target (see Chart 11). Mother's knowledge of child danger signs in Dhaka increased from 62% to 91%, from 73% to 80% in Netrokona, and from 70% to 82% in Panchagor.

Chart 10: ARI Care Seeking

Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility.

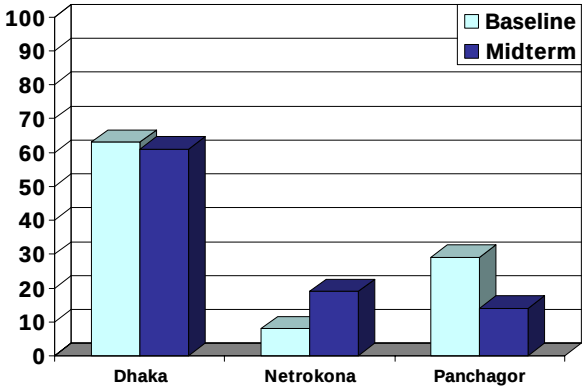
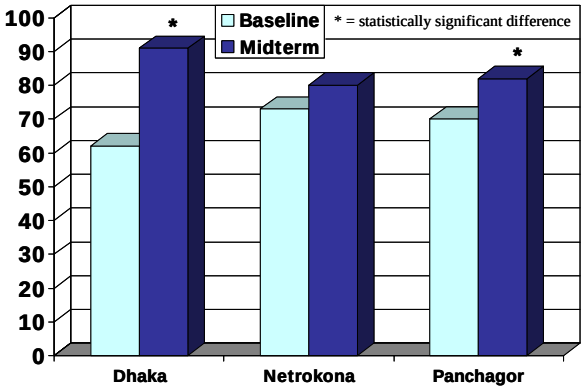


Chart 11: Maternal Knowledge of Child Danger Signs/Symptoms

Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms.



d) Nutrition & Micronutrients

Underweight (<-2 z-score): The percentage of children underweight declined remarkably in all three working areas (see Chart 12). The percentage of children underweight decreased from 39% to 27% in Dhaka, from 41% to 37% in Netrokona, and from 38% to 26% in Panchagor. With the exception of Netrokona, all working areas reached their midterm target.

Exclusive breastfeeding: Exclusive breastfeeding rates increased significantly from baseline in Dhaka (50% to 67%), Netrokona (33% to 63%), and Panchagor (61% to 74%). Despite the increased rates in all three working areas, none of the working areas reached their midterm targets (see Chart 13).

Chart 12: Underweight Children

Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median weight-for-age (WA) of the WHO/NCHS reference population.

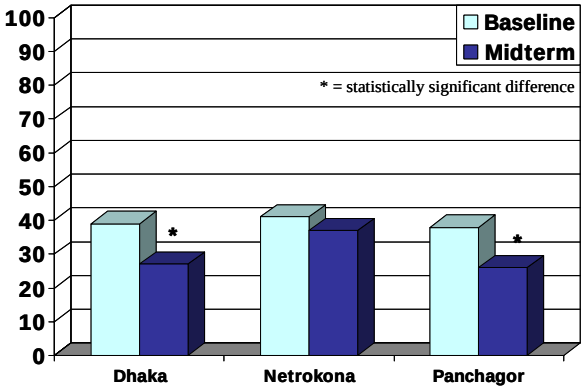
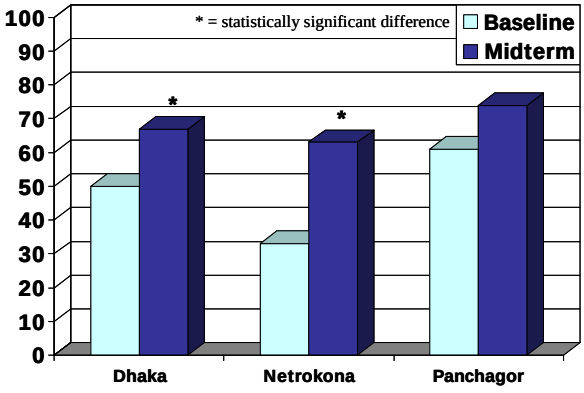


Chart 13: Exclusive Breastfeeding

Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours.



Appropriate complementary feeding practices: All three working areas exceeded midterm targets and reached far above the baseline. Appropriate complementary feeding increased in Dhaka from 55% to 79%, in Netrokona from 14% to 75% and in Panchagor from 27% to 47% (see Chart 14).

As part of this intervention area, CRWRC trained partner staff, health sub-team members and CHVs in Positive Deviance using the nine steps of the PD/Hearth process in all three program areas. Through identifying the positive deviants the project identified key positive behaviors and influenced feeding practices by caregivers. The 12 day Hearth sessions are conducted two to three times in a year. As caregivers and their community members learn about supplemental and energy rich foods, the Peoples' Institutions will work with them to ensure that this is sustainable and that nutritional practices in the communities will improve.

Vitamin A coverage: All three working areas exceeded their midterm target and reached far above the baseline. Vitamin A coverage increased in Dhaka from 53% to 77%, in Netrokona from 61% to 84%, and in Panchagor from 62% to 74% (see Chart 15).

Chart 14: Appropriate Complementary Feeding Practice

Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours.

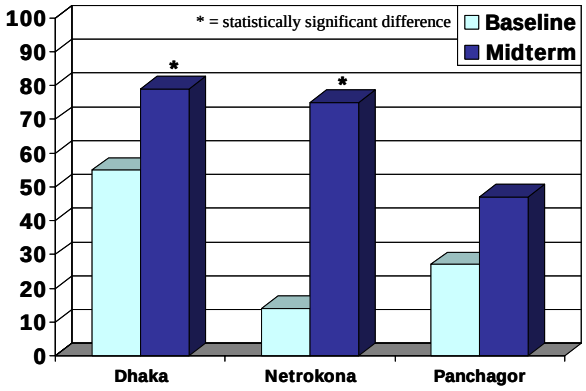
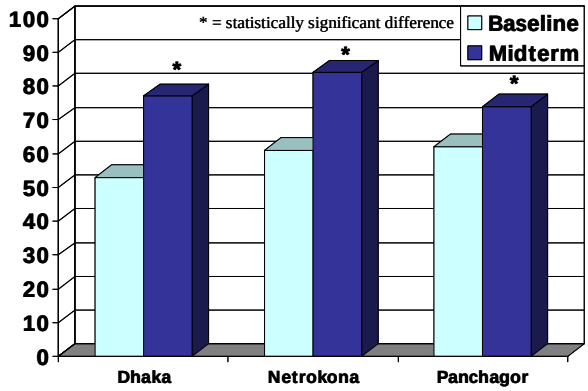


Chart 15: Vitamin A Coverage

Percentage children aged 6-23 months who received a Vitamin A dose in the past six months.



e) Vaccinations

Complete immunization coverage: All three areas achieved much higher complete immunization rates compared to the baseline and the midterm targets (see Chart 16).

f) HIV/AIDS

Maternal knowledge on HIV risk reduction: All three working areas exceeded their midterm targets and had dramatic increases from baseline in mother's knowledge of HIV prevention from baseline (see Chart 17).

Chart 16: Complete Immunization Coverage

Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio.

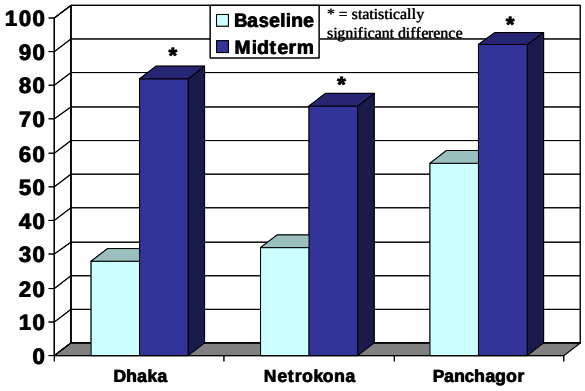
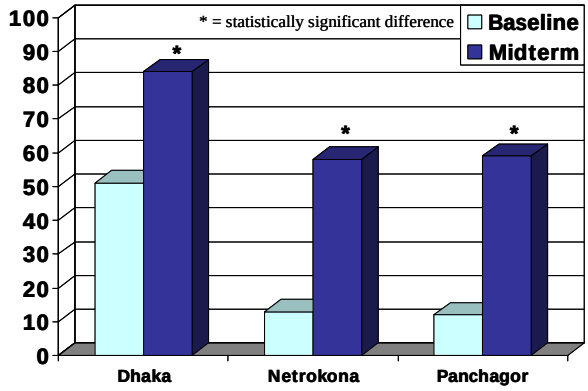


Chart 17: Maternal Knowledge of HIV Risk Reduction

Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV.



3. New tools or approaches

Baseline information from focus group discussions revealed that an important barrier to seeking care was access to the referral centers. Parents or women may be referred to a clinic or health care provider by a CHV or TTBA, but they often do not go due to lack of transportation and lack of funds.

Following discussions with the Peoples' Institutions in Netrokona, Panchagor and Dhaka, the PI members decided to develop Emergency Health Funds (EHF) to assist with the cost of medical treatment and transportation to health facilities, especially in rural areas. The PIs also developed the policies for fund use by primary groups and community members who deposit money on a monthly basis.

In addition to emergency transportation, these funds are also intended for other health related items, including antihelminthics and iron tablets, where they are not available from the Government. The Panchagor PI also made a long term decision to include savings to purchase a small ambulance. The PIs keep records of fund use and of small income earning activities to increase the fund size. Additional information about the Emergency Health Fund is provided in the *Results Highlight* section of this report.

The evaluation team noted a wide appreciation for the Emergency Health Funds at all levels. It was suggested that PIs explore keeping a percentage of the EHF with primary groups, in having written emergency plans, and in designating an emergency transportation vehicle. Based on these discussions the evaluation team proposed the following recommendation:

- **<u>Recommendation:</u> Continue to explore options to improve access to urgent health care by improved management and expansion of emergency health funds.**

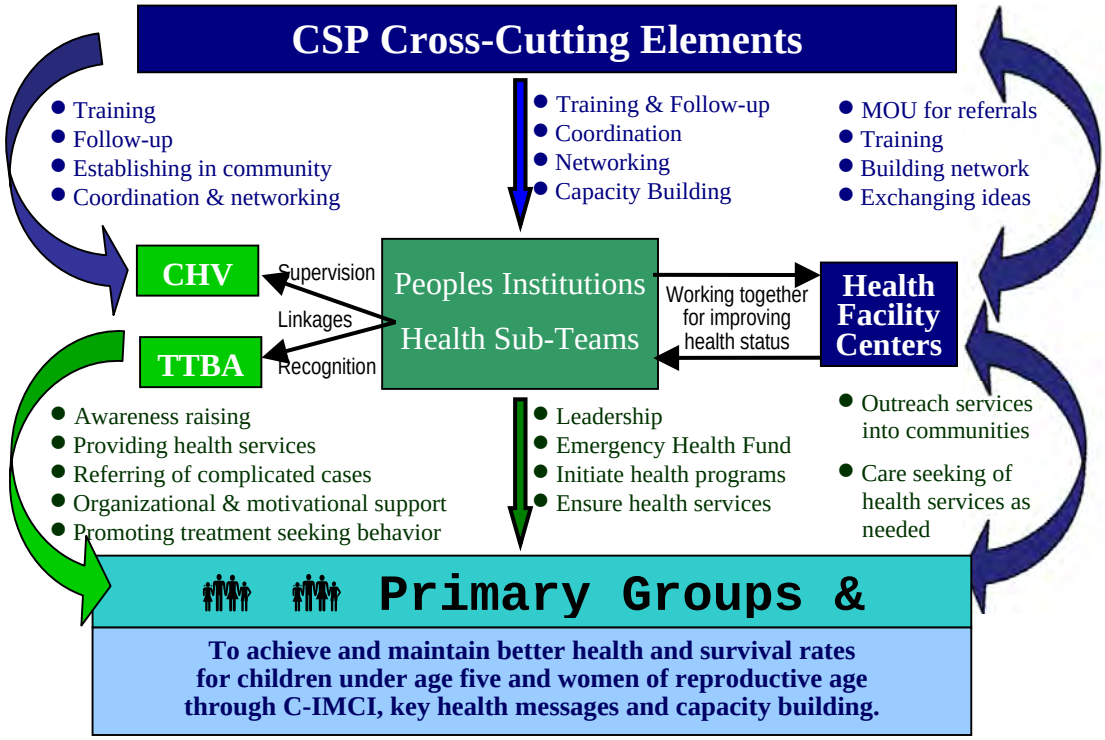
B. Cross-cutting approaches

CSP chose to implement its objectives as part of the national strategy for C-IMCI. To this end the project embraced three strategic approaches:

1) **Training and support of CHVs and TTBAs** for BCC, awareness raising; referring of complicated cases and promoting treatment seeking behavior in order to:
    a. Increase the quality and availability of pre-natal, natal and post-natal care through training of TBAs; and
    b. Promote key family practices critical for child health and nutrition through training CHVs and forming primary groups.
2) **Capacity building and networking of community institutions** to support CHVs and TTBAs through leadership in health planning and services provision, and management of the Emergency Health Fund; and
3) **Network building and coordination with the health facilities** for facility-based and outreach services for the project targeted communities by improving networking with health facilities and referring complicated pregnancies and severe illnesses.

These three approaches are cross-linked for networking, supervision, and sustainability purposes so that all three approaches are working together for improving health status (see Figure 2). The details of each cross-cutting component are discussed in the following sections.

Figure 2. CSP Cross-Cutting Approaches



1. C-IMCI

During the DIP review it was recommended that CRWRC examine the possibility of bundling the proposed Child Survival interventions within the framework of C-IMCI. CRWRC took the suggestion quite seriously and has firmly established the implementation of the project within that framework of the national IMCI and C-IMCI strategies.

The IMCI approach of the MOH includes the three components of technical training, systems strengthening and C-IMCI, which, in turn, also includes three elements -- 1) links to health facilities 2) community-based service delivery; and 3) behavior change communications.

IMCI & C-IMCI
I. Technical Training in IMCI
II. Health Systems Strengthening
III. Community IMCI
1) Links to Health Facilities
2) Community-Based Service Delivery
3) Behavior Change Communications

IMCI has, according to MOH, been partially implemented in 150 sub-districts, i.e., primarily the component of technical training. CSP has provided, therefore, several sub-districts where a C-IMCI component is also being implemented.

CRWRC has very effectively incorporated its strategic objectives into the three components of the Community/Household Integrated Management of Childhood Illness (C-IMCI) resulting in the following key intervention activities:

1) Improve networking with health facilities in order to refer complicated pregnancies and severe childhood illnesses;

2) Increase the quality and availability of pre-natal, natal and post-natal care through training of TBAs; and

3) Promote key family practices critical for child health and nutrition through training CHVs and forming primary groups.

Working through the national C-IMCI strategy has provided a solid, integrated basis for project interventions. CSP emphasis on BCC by CHVs and TTBAs creates a demand for services that must link to service delivery by health facilities. Therefore, the success of CSP also represents a success of the MOH in the provision of essential health services. The key to sustaining this success will be sustainable cross-cutting links for supervision and support of CHVs and TTBAs. Much of the current efforts in training CHVs and TTBAs are still dependent on project paid health animators.

In principle the responsibilities of the animators are to be taken over by PI health sub-teams. However, in order to ensure one-to-one support of CHVs and TTBAs, the project should consider additional ways to link between community-based workers and the PI health sub-teams. For example, some partners have identified CHV team leaders (“super CHVs”) who could play a key role in supervising CHVs and in meeting with health sub-teams. A similar approach might be explored for supporting TTBAs. These approaches may also vary by rural versus urban areas. It is recommended that the project identify the multiple tasks currently performed by health animators and designate (with redundancy) one or more groups/persons who might best provide that ongoing support. This might include, for example, animators supported by Implementing

Partners or by PIs, and/or increased responsibilities of health sub-teams, primary groups, super CHVs and government Health Assistants.

- **<u>Recommendation:</u> Explore and test approaches to reinforce supervision and support linkages between community-based workers and PI health sub-teams.**

CSP is to be commended for taking the initiative of sponsoring IMCI training for health assistants based at union facilities. CSP should build on that event to establish a working and reporting relationship between health sub-teams and their respective health facilities. Some examples of way in which health facilities could support CSP include: compiling and reporting on the work of CHVs, facilitating supervision contacts between Health Assistants (HAs) and CHVs, participating in health sub-team meetings with CHVs, involving HAs as resource persons for refresher training, and further improving referral and reporting forms that are tailored to the work and reporting of CHVs and TTBAs. A similar relationship and collaboration approach should be developed with Skilled Birth Attendants (SBAs). A consensus was established for the following action:

- **<u>Recommendation:</u> Explore and test approaches to reinforce supervision and support linkages with health facilities and key health workers, e.g., health assistants and skilled birth attendants.**

A number of the Peoples' Institutions, health facility staff, and local health authorities asked about the possibility of expanding the work of the project to cover the entire population within the union where CSP is currently working, and about expanding the project to cover neighboring unions within the sub-district. One option, if the project is able to create alternative supervision support for CHVs and TTBAs, would be to move existing project paid health animators to begin working in neighboring areas. Additional options should be considered with PIs and health authorities based on the following recommendation.

- **<u>Recommendation:</u> Examine options for program consolidation and expansion in existing unions and eventually to neighboring unions.**

2. Communication for Behavior Change

CSP uses the BEHAVE framework (from CS Technical Reference Materials of USAID/GH/HIDN, 2004) to identify the most important key family practices for each program area of C-IMCI, and to targeted BCC to the following groups:

<u>Community Health Volunteers (CHVs) and Trained Traditional Birth Attendant (TTBAs)</u>. CHVs and TTBAs are the key resource persons for BCC and referrals. As of June 2007, 409 CHVs and 227 TBAs have been trained for all three working areas.

> "After being trained we can assess the critical cases. For example, I had one mother who acquired diabetes during her pregnancy. I knew that this put her and her child at risk so I was able to refer her to the hospital right away."
> - reported by project-trained TTBA

Local Women's Groups. Key family practice messages are communicated to women of reproductive age in a variety of ways. Local Groups for women have been created in each program area as part of the Peoples' Institution.

Local Men's Groups. Participatory Rural Assessment focus group discussions indicated that the family decision maker is seldom the woman herself. Husbands and in-laws are considered the "family guardians" and make the decisions on issues such as when and where health care will be received. For this reason, Men's Groups (husbands in particular) are an important intervention group for counseling and group discussion on issues such as the importance of prenatal care for women, safe pregnancy practices, and safe and hygienic delivery.

Outreach to People of Influence. Along with the local women's and men's groups, CRWRC has reached out to traditional healers, imams, teachers, and village doctors to communicate key family practice messages, e.g., to established and practicing Village Docs.

Drama. Drama is widely appreciated and enjoyed in Bangladeshi culture, especially for communicating preventive and promotional health messages and services. Rather than remain dependent on an outside drama team to deliver these health messages, Bengal Creative Media was contracted to conduct "Theatre for Development" and "Music for Development" training. Sixty individuals have been trained in each working area. These local theater groups are now able to carry on independently in communicating health messages through drama.

3. Capacity Building

a) CRWRC

CRWRC has been using indicators to measure its own organizational development in the areas of financial and human resource management, along with several other capacities. CRWRC added two more indicators that will specifically measure improvements in the organization's capacity to do results-based programming and to increase its technical capacity to backstop community health programs in the field. The four strategic objectives that CRWRC has been tracking as part of the CSP are shown in the Table 5 below.

Table 5. CRWRC Capacity Building Objectives and Status

1) CRWRC maintains a positive financial position.	During the past two years CRWRC's annual revenue has exceeded its annual budget. In addition, in fiscal years 2006 and 2007, CRWRC increased its grants revenue by 43% and 14%, respectively. In July 2007, CRWRC also hired a Chief Financial Officer to help manage CRWRC's financial systems and ensure compliance with USAID regulations for management of grant funds and reporting of expenses. In the past year, CRWRC has received three awards from USAID, including a PEPFAR-funded New Partners Initiative grant, a Malaria Communities Program grant, and a second (standard category) Child Survival grant.
2) CRWRC increases clarity about lines of accountability and performances expectations for all its personnel.	CRWRC continues to use the Main-Team Self-Assessment Survey (MTSAS) on an annual basis to evaluate inter- and intra-team collaboration. All CRWRC personnel have position descriptions and receive an annual performance evaluation from their supervisor. The Directors recently revised CRWRC's "Boundaries Document," which clarifies decision making authority and lines of accountability in CRWRC.

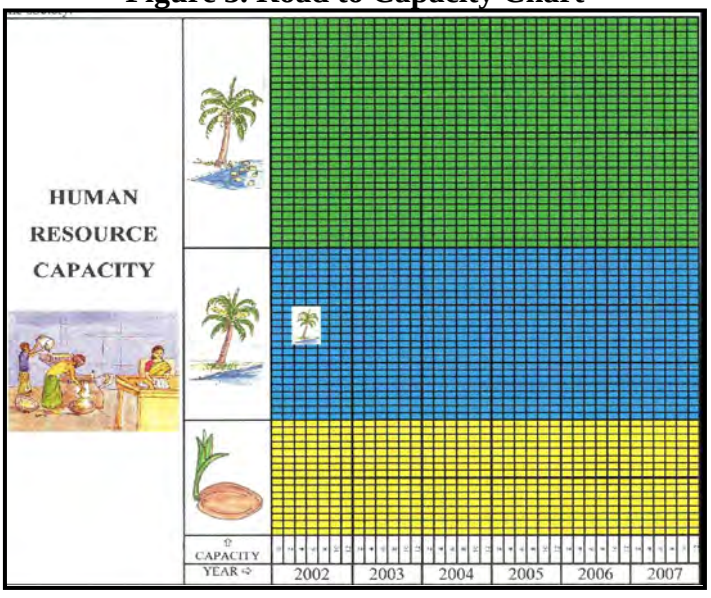
3) CRWRC knows the specific results that its programs are achieving and can identify programs that need to be strengthened.	In 2004, CRWRC initiated a contract with Newdea – a results-based management system that empowers nonprofits to be more efficient, simplify grant compliance, eliminate multiple reporting steps, conduct regular monitoring and evaluation and improve communication to all supporters. CRWRC has worked with Newdea to provide meaningful communication to donors using robust, customized reporting tools that pulls information from the everyday management of projects. Over the past two years, results-based management has been mainstreamed throughout CRWRC and its partners for long-term planning and reporting.
4) CRWRC increases its capacity to provide high quality consultation to its local partners on sustainable health programming.	CRWRC Bangladesh has hosted two learning exchanges with other CRWRC staff and partner organizations interested in maternal and child health programs. Two learning exchanges included three CRWRC staff from Ecuador, Uganda, and Laos and 7 partner organization staff from Laos and Cambodia. As a result, Laos is beginning to adapt the Peoples' Institution model for their village development committees, the Regional Health Advisor for Asia is providing consultancy to Cambodian health programs, and a five-day BEHAVE workshop was conducted for the Latin America Ministry Team. The BEHAVE workshop was facilitated by the Child Survival and Health Technical Advisor and the Regional Health Advisor for Asia in Nicaragua in May 2007. All six CRWRC staff and 26 partner organization staff from seven countries in Latin America participated in this workshop.

In February 2006, CRWRC became a member of the Child Survival Collaborations and Resources (CORE) Group. The Child Survival and Health Technical Advisor serves on the Board of Directors and is co-chair of the Social and Behavioral Change Working Group for the CORE Group. The Child Survival and Health Technical Advisor has worked through the Regional Health Advisors for CRWRC to disseminate the best practices and innovative ideas ascertained from the CORE Group.

b) Local partners

CRWRC has been partnering with PARI, SATHI, and SUPOTH for the past 15 to 20 years. CRWRC has established two-year renewable partnership agreements with each partner. These partnership agreements are used to identify and prioritize the areas in which each partner needs assistance. Capacity building activities by CRWRC include field visits accompanied by feedback regarding areas of improvement for each of its partners, establishing connections with donors to diversify their partner's funding, assisting in the establishment a board of directors for each partner and developing each partner's capacity measurement system.

Figure 3. Road to Capacity Chart



The system of measurement, Organizational Capacity Indicators (OCI), was developed by CRWRC during the course of a USAID grant on capacity development in the mid 1990s. In Bangladesh, measurement is done using a "Road to Capacity" system that was developed by CRWRC partners in 1998. Each partner develops a goal statement for seven capacity areas: Vision, Mission, Values; Human Resources; Management Systems; Networking; Stewardship; Gender Participation; and Financial Sustainability. Then, each partner develops its own indicators to assess progress for each capacity area. The partners follow an appreciative inquiry method of sharing stories to verify that indicators are being achieved. Afterward, they agree together on a numerical score and post it on the "Road to Capacity" chart (see Figure 3). Following this, the partner decides on a target number that it hopes to achieve within the next six months. They then develop a simple work plan of actions to be taken to achieve the goal in each capacity area. (Each partner's progress towards capacity using OCIs can be seen in Sustainability Strategy – Section B.4.a.)

c) Peoples' Institutions

CRWRC uses the Peoples' Institution (PI) to create a sustainable system for building community capacity in maternal and child health. This model was first designed by CRWRC in 1990 for its rural-based programs, and later adapted for urban-based programs. A PI is a community-based organization composed of several smaller primary groups. The goal for the PI, and the associated primary groups, is to become an independent, self-sustaining organization that has a lasting impact on their members and on the broader community. Primary groups are the entry point for individuals into the PI system and members have the opportunity to participate in activities and teaching regarding savings-based credit, health promotion, literacy and agriculture.

CRWRC and its partners believe that all organizations need to monitor their growth in capacity in order to understand where they are in comparison with where they hope to be in the future. Therefore, each PI and primary group also does a short self-assessment every 6 months. This is made easier by using an organizational development monitoring tool that is appropriate to the culture and context of the organization. CRWRC and its partners ensure that each organization develops its own tool for talking about and monitoring its development. The process for monitoring capacity is the same as described for the local partners. However, the PIs and the primary groups have slightly different capacity areas from which they choose indicators to measure capacity and sustainability. The capacity areas for PIs include human resource development; leadership and management; legal identity; finance; gender; and networking. The primary groups capacity areas include: management; finance; technical; community governance; and networking. As each organization or group grows in their capacity, they eventually reach a point at which they "graduate." Graduation criteria differs among the different organizations. Essentially, the organization or group must reach a predetermined level of capacity in each area before they can graduate and operate independently from the NGO or the PI.

d) Health Facilities

Although CRWRC does not do any direct capacity building of the health facilities in its working areas, there is still a direct linkage between the child survival program and the government and NGO health facilities. At the beginning of the program CRWRC conducted a health facilities assessment (HFA) in all three working areas. Through the HFA, collaborative relationships were initiated with government health facilities, NGO providers and private clinics. Based on the

results of the HFA, a referral system was developed to improve relationships between health facilities and the community. These linkages continue to grow stronger and are a critical element for the sustainability of the child survival program (See the recommendation in C-IMCI – Section B.1.). In the past year, CRWRC has worked with the National IMCI Working Group in Bangladesh to support IMCI training for government health personnel in all three working areas. This type of collaboration will help ensure the sustainability of IMCI in CRWRC's working areas.

e) Health Worker Performance

After TBAs and CHVs receive training, the Community Health Animators (CHAs) hold monthly sessions with them to review cases, make recommendations and assess appropriateness of referrals. During semi-annual meetings between the health sub-teams and the health facility staff, the referrals are discussed and recommendations are made to increase the effectiveness and the appropriateness of referrals. In addition, CHAs in all three working areas were trained by LAMB Hospital in supportive supervision which includes one-on-one observation of CHVs and TTBAs using a quality improvement checklist. This provides a good balance of group meeting for cross-learning as well as one-on-one supervision.

f) Training

CRWRC has sub-contracted training of CHVs and TTBAs to indigenous training institutions. CRWRC has also had the opportunity to increase the training capacity of each of the training institutions through training in Adult Dialogue Education and in using similar curricula. Each training institution has revised its TTBA curriculum to make it more participatory and a better overall learning experience. LAMB Hospital has recently received approval for their 21 day Community Birth Attendant curriculum from the government.

By working through existing training facilities rather than developing its own training system, CRWRC has achieved an impressively low cost per TTBA and CHV (see Table 6) and contributed to capacity building of local institutions.

Table 6. Training cost by type of Trainee (in USD)

Training Institution	TTBA	CHV
Radda Barnen	105	22
Joyramkura	90	23
LAMB Hospital	100	53

The training has been very effective. It has been clear that the TTBAs have safer practices from observational follow-up as well as quantitative knowledge- and skills-based follow-up (see Table 7). According to one TTBA, "We also did not understand the importance of keeping track of due dates. Now we know to carefully monitor the dates and to seek medical attention for overdue women."

Table 7. Pre-Test, Post-Test and Follow-up Scores for TTBAs

Training Institution	Pre-Test	Post-Test	6 mo. Follow-Up
Radda Barnen	51%	98%	91%
Joyramkura	30%	79%	NA
LAMB Hospital	19%	78%	75%

4. Sustainability Strategy

CRWRC is well known for its experience and approaches to capacity building. These have been put to good use in the CSP project in capacity building and sustainability building of community-based organizations, including implementing partners, Peoples' Institutions and Primary Groups. The progress of each organization towards sustainability is monitored using the Child Survival Sustainability Assessment (CSSA) framework. CRWRC worked with each partner organization to select the most appropriate indicators for each of the six components. Each partner organization works with the PIs in their working area to report on their progress towards sustainability every six months.

a) Local Partners

As mentioned earlier, each partner develops a goal statement for seven capacity areas: Vision, Mission, Values; Human Resources; Management Systems; Networking; Stewardship; Gender Participation; and Financial Sustainability. Then, each partner develops its own indicators to assess progress for each capacity area. Table 8 summarizes the past, current and targeted benchmarks for each capacity area.

Table 8. Capacity Progress and Projected Targets for Implementing Partners

Org. Capacity Areas	SUPOTH					PARI					SATHI				
	05	06	07	08	09	05	06	07	08	09	05	06	07	08	09
Vision, Mission, Values	4.0	4.0	--	--	--	AE	AE	AE	ME	ME	AE	NC	AE	AE	AE
Human Resources	4.0	4.0	--	--	--	AE	AE	AE	AE	ME	AE	AE	AE	AE	AE
Management Systems	3.0	3.5	--	--	--	AE	AE	AE	AE	ME	AE	AE	AE	AE	AE
Networking	4.0	4.0	--	--	--	AE	AE	AE	ME	ME	ME	AE	ME	AE	AE
Stewardship	3.5	4.0	--	--	--	AE	AE	AE	AE	ME	AE	NC	AE	AE	AE
Gender Participation	3.5	3.8	--	--	--	AE	AE	AE	ME	ME	AE	AE	AE	AE	AE
Financial Sustainability	3.0	3.0	--	--	--	AE	AE	AE	AE	ME	AE	NC	NC	AE	AE

NOTE: SUPOTH uses a 1.0 – 5.0 scale and was not able to provide OCI projections. PARI and SATHI use the following scale: More than expected (ME); As Expected (AE); No change (NC); Less than expected (LE).

b) Peoples' Institutions

The CSSA (see Figure 4) is used by each partner in collaboration with the Peoples' Institutions in their working area to make program decisions concerning strategic focus areas for sustainability for the next six months. The PI capacity indicators mentioned earlier are incorporated into the Organizational Capacity and Organizational Viability components of the CSSA. Through assessing the six components, CRWRC hopes that the positive health outcomes achieved by the CSP will be sustainable within each community. A tabular summary of the CSSA dashboards for the PIs in the three working areas is shown in Table 9 below showing past developments and projected yearly targets for continued development by EOP.

Figure 4. CSSA Monitoring for Netrokona

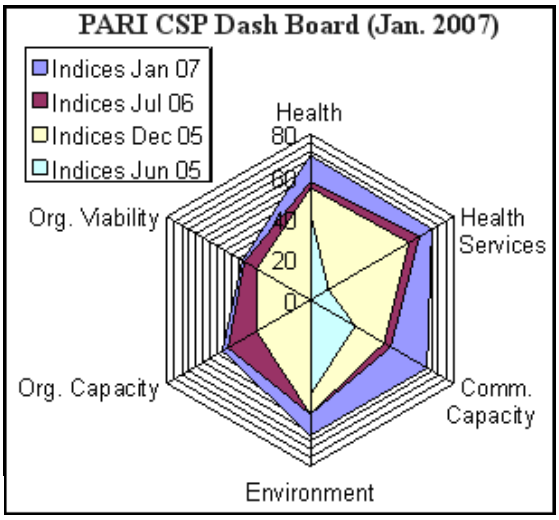


Table 9. CSSA Progress and Projected EOP Targets in Panchagor, Netrokona and Dhaka (Composite Percentage for all Indicators in Each Component)

Peoples' Institution's CSSA Benchmarks	Panchagor			Netrokona			Dhaka		
	2005	2007	2009	2005	2007	2009	2005	2007	2009
Health	49	65	80	42	62	90	41	72	78
Health Services	20	81	90	16	67	100	23	70	85
Community Capacity	64	56	80	25	61	90	56	78	80
Environment	61	68	85	46	65	90	41	72	88
Organizational Capacity	66	94	95	0	49	90	36	62	85
Organizational Viability	22	85	90	0	38	80	35	65	84

c) Primary Groups

The capacity development of Primary Groups is also individually monitored by their respective PIs with respect to five levels of maturity (1 through 5). The capacity indicators for primary groups are included in the Community Capacity component of the CSSA framework mentioned above. CSP activities are targeted towards the members of the primary groups with the hope that the primary groups will have a greater impact on the broader community. Table 10 summarizes the developmental progress of Primary Groups for each implementing partner, including baseline, MTE status, and projected EOP targets.

Table 10. Capacity Progress and Projected Targets for Primary Groups

Primary Group Capacity Indicators	Panchagor					Netrokona					Dhaka				
	05	06	07	08	09	05	06	07	08	09	05	06	07	08	09
Management	4.00	4.00	4.25	4.50	4.90	1.0	1.8	2.4	3.0	4.0	3.63	3.57	3.66	4.06	4.08
Finance	4.00	4.00	4.25	4.50	4.75	.50	1.5	2.0	3.0	4.0	3.25	3.10	3.28	3.77	3.86
Networking	4.00	4.00	4.25	4.50	5.00	N/A	N/A	N/A	N/A	N/A	3.46	3.54	3.56	3.97	4.02
Technical Areas	3.50	4.00	4.25	4.50	4.75	1.0	1.8	2.6	3.5	4.0	2.93	3.05	3.10	3.66	3.86
Community Governance	4.00	4.00	4.25	4.50	4.90	1.0	1.8	2.6	3.5	4.0	3.55	3.62	3.65	4.02	4.07

The capacity building process initiated by CRWRC through its implementing partners, Peoples' Institutions and Primary Groups is well developed and monitored. There are, however, a number of additional capacity areas where groups have identified the need for further training or development. The evaluation team has proposed, therefore, the following recommendation:

- **<u>Recommendation:</u> Identify capacity topics and indicators for continuing training of PIs, health sub-teams and primary groups for sustainability in long-term planning, networking, communication, advocacy, supportive supervision, and transitioning project paid health animators.**

The Peoples' Institutions have, in particular, a special role to play in advocacy and lobbying the support of local governmental authorities, MOH authorities, and health facility personnel to ensure links between key health workers, PI health sub-teams and volunteers; advocate for services needed, e.g., maternity waiting room; plan/expand satellite clinics; and obtain subsidized payment levels for referred cases. To build on this power base, the following is recommended:

- **<u>Recommendation:</u> Implementing Partners should build on the local power base of PIs to reinforce relationships with local health authorities and facilities, including those supported by NSDP, to ensure the availability, access, affordability and quality of services.**

III. PROJECT MANAGEMENT

A. Planning

CSP has created a highly effective and efficient working relationship and a smoothly implemented project with its three implementing partner organizations. The working relationship between implementing partners and locally-based Peoples' Institutions and Primary Groups has also been very good.

The Project Directors and Health Coordinators in each of the organizations work with CRWRC in all the planning activities. Each of the three partners is responsible for working with their own organization's staff in beginning "bottom up" planning for the interventions. The evaluation team felt that the planning and management of these partnerships merits documentation as a case study, and included this as one of the recommendation for CRWRC headquarters:

- **CRWRC headquarters should document and share the CSP experience in Bangladesh as a case study in developing and managing local partnerships.**

Once the initial detailed implementation plan (DIP) was completed, it was translated into Bangla and distributed to and reviewed by the project coordinators with their all staff. The CSP staff in each project use the DIP for planning and carrying out activities. All staff are able to articulate the objectives of the project. PI leaders are also able to articulate the objectives of the project. Job descriptions are based on the DIP activities. Monthly staff meetings include a DIP review. The Peoples' Institutions in the community have also reviewed the DIP and have made a calendar of activities.

During the midterm evaluation, it was found that DIP work plan activities are on target. The Community Case Management timeframe has been adjusted based on a late start of the project due to change in operations research content. Upon completion of six monthly nutrition surveillance surveys, CSSA dashboards, KPC and capacity assessments the DIP was reviewed and adjustments were made to ensure fulfillment of target. During the KPC review at midterm, plans were made to conduct Doer/Non-Doer analyses and develop BEHAVE frameworks for intervention areas that are below the midterm target.

B. Staff Training

CRWRC CSP staff attend workshops when they are available. All CSP staff received an initial two-week orientation to the specific project in which they were working. They also received a one-week orientation on the Child Survival Project and extensive training in specific health-related topics, e.g., baseline survey implementation, nutrition surveillance, values and health,

dialogue education (basic, advanced, curriculum design and facilitation), BEHAVE framework, PD Hearth, CSSA, and supportive supervision of CHVs and TBAs. Additional training is now being added for Kangaroo Care. Mini-workshops on health-related topics are held during the monthly staff meetings at each project. KPC or nutrition surveillance refresher training is also held for all staff prior to each survey/surveillance. CSP staff and Learning Circle representatives are also to receive training in August 2007 on growth monitoring from the National Nutrition Council of Bangladesh. Special training on community case management has also been held for the Health Coordinator and Community Animators in Panchagor.

C. Supervision of Project Staff

Each of the three partner organizations has its own management system and structure with CSP as a specific program under that project. The CRWRC Dhaka-based CSP staff are supervised by the CSP Program Manager. She is supervised by the CRWRC Bangladesh/India country team leader. Each staff has weekly meetings with their supervisor. The CRWRC CSP Program Manager, Program Officer and Monitoring Consultant visit the fields at least quarterly.

The Health Coordinators are supervised by the Partner Directors of each project. They are part of the Project Management Teams and also meet individually with the Directors on a biweekly basis. All supervisors have had training in supervisory leadership. Supervision involves a lot of two way feedback and dialogue. CRWRC uses an appreciative inquiry approach as opposed to problem solving and seeks to build on the strengths of each staff person. The current staffing arrangement appears adequate. The CRWRC CSP office coordinates activities, but direct staff supervision takes place within the three individual projects.

Each staff is evaluated on a yearly basis. There is an evaluation review half yearly to assess progress with the staff person. Individual training plans are developed yearly and reviewed on a semi annual basis.

D. Human Resources and Staff Management

CRWRC has a detailed policy manual which is reviewed by the CRWRC Office Management Team on a yearly basis. Each of the three partner organizations has a policy manual which is reviewed and approved by their respective boards on a yearly basis.

CRWRC International hired the two CRWRC Consultants involved in the project. CRWRC Bangladesh/India has been responsible for the direct hiring and contract management of the local staff Secretary, Accountant, Program Officer and Operations Research Project Manager. Each project has one Health Coordinator and four to seven Community Health Animators.

All CSP positions have detailed job descriptions written in both Bangla and English. These are reviewed with staff on a yearly basis. All positions are currently filled. Morale is monitored on a quarterly basis and appears to be very good. There has been some turnover in the SATHI project, which is located in Dhaka. Some staff (particularly nurses) have left for more permanent Government employment. SATHI is now training some of its field staff for child survival positions. These staff will then likely go back to regular program activities in SATHI at the end of the child survival grant.

As there are three different partners working under CSP, field staff (CHAs) were hired by the specific implementing partners, with input from the CSP Program Manager. The three coordinators were hired by each project, with interviews conducted by the project directors and the CSP Program Manager. Job descriptions for these positions were prepared jointly by the three partners with input and final approval from the CSP Program Manager. There are currently 16 CHAs: four in SATHI, six in SUPOTH and six in PARI. Each organization also has a Health Coordinator. All of the CHAs have previous experience working in health related programs. The three Health Coordinators all have field experience in health programs as well as managerial experience.

Each of the three partner projects is currently preparing plans for staffing at the end of the project. In some cases, staff will be offered positions on other project areas. Each partner project will also give experience certificates to staff to assist them in gaining new employment.

E. Financial Management

The NGO Affairs Bureau in Bangladesh approved the five year budget for the Child Survival Project of CRWRC. The project has a full time Finance Officer who is based at the CRWRC office in Dhaka. A quarterly expense reporting template was set up by the CRWRC International Finance Manager in the U.S., which is completed by CRWRC staff in Bangladesh by the 10th of the month following the end of each quarter. Each of the three partner organizations maintains separate bank accounts for the CSP. CRWRC receives payments for the CSP from its U.S. office. It then sub-grants funding to the partners and sub-contracting organizations per the agreement with USAID and according to the regulations of the GOB. All vouchers and receipts related to the project are kept in the CRWRC Dhaka office.

In the second year of the CSP, the Finance Officer conducted quarterly visits to each of the three partner organizations to do an internal audit of the financial activities. Written reports of these audits are then shared with each organization and necessary strengthening of the financial systems, if needed, are made. The CSP Program Manager is responsible for the overall financial system and reviews and approves all financial reports. As part of the end of the first fiscal year, an external financial audit and financial management review took place in October, 2006 by a GOB approved firm, Azad Zamir and Company. This audit included a total review of CSP expenditures at the CRWRC Bangladesh and partner level. This company will also conduct the third year audit in October 2007.

F. Logistics

There are no major equipment needs for the CSP. All supplies such as flip charts, growth monitoring charts, CHV and TTBA record books, mother cards and growth monitoring scales have been readily available. CRWRC is currently planning to use the new Government approved weight scales, and expect the supply of these to be available from August 2007. The project does not anticipate any difficulty with other logistics procurement as printing of the flip charts, cards and record books is done in-house.

G. Information Management

CSP has a comprehensive Management Information System (MIS) with monthly reporting system of activities per the DIP. The project also conducts semi-annual nutrition surveillance using the LQAS. The project has conducted a baseline and midterm KPC and plans a final KPC at the end of the project. In addition to this, CRWRC completes a quarterly report of data which is submitted to CRWRC headquarters via a web-based information system for internal review. Focus group discussions for qualitative data have also been conducted at baseline and midterm. Community capacity, organizational capacity and CSSA dashboard assessments are done with each organization and Peoples' Institution on a semi-annual basis. All data is collected, entered and analyzed in a systematic way. Dissemination meetings are held in the community following each nutrition surveillance and dashboard collection. All nutrition surveillance and KPC results are shared with the district health authorities (Civil Surgeons) in each of the project sites. CRWRC also uses data generated by the Ministry of Health, UNICEF, ICDDR,B, Mitra, USAID, Save the Children and NSDP to assist in program planning.

CRWRC has also developed an extensive organizational capacity indicator (OCI) system that is measured semi-annually by each project board, staff and stakeholders. Each community also uses a community capacity indicator (CCI) system to measure their progress. The three partner organizations incorporated the OCI and CCI systems into the CSSA dashboard with semi-annual assessments.

H. Technical and Administrative Support

CRWRC received USAID and GOB permission to conduct operations research in Community Case Management for diarrhea and pneumonia using community health volunteers in Panchagor. CRWRC has contacted Dr. Shams El Arifeen and Dr. Emdad at ICDDR,B and USAID Bangladesh for technical assistance support in this research. CRWRC also hopes to have ongoing technical assistance during year four and is currently contacting potential international consultants, based at LAMB Hospital, for this role.

Administratively, the CSP Program Manager meets with the three Health Coordinators, the Monitoring Officer and the Program Officer monthly to discuss monthly reports by each project and review variances. Mini-trainings on management and specific CSP-related topics are included in these two-day meetings. Project Directors attend the Coordinators meeting each quarter. The minutes from the monthly meetings are shared with the technical backstop in the CRWRC headquarters.

CRWRC Dhaka-based CSP staff visit each project on a quarterly basis. Each of the three projects also has its own internal management system. Health Coordinators are members of the project management team and also meet with the CHAs on a monthly basis. These meetings include activity updates, variance reports, planning and mini-workshops. The Health Coordinators are included in the CRWRC Learning Circle forums and participate in team building and management workshops in this forum.

I. Mission Collaboration

CRWRC Bangladesh has maintained regular contact with the local mission via Ms. Carrie Rasmussen in the Health and Population Division. Ms. Rasmussen met all CSP coordinators, visited the SATHI CSP program, and met quarterly with the CSP Program Manager for program updates. She helped CRWRC develop the procedures for the procurement of zinc. Following her departure from USAID, Mr. Kishan Chakraborty took over those responsibilities, and participated as a full member of the midterm evaluation team, including a four-day field visit to Panchagor.

CRWRC has a very positive relationship with USAID, which has helped to improve the quality of the Child Survival Project. The USAID Mission and CRWRC are in frequent communication. USAID keeps CRWRC informed of mission activities and workshops and seeks CRWRC's input. CSP staff have attended USAID partner's workshops as well as meetings on branding and VAT procedures.

CRWRC work supports the USAID Mission objectives related to maternal and child health, especially in providing health care to the rural communities. Upon USAID's suggestion, CRWRC has targeted indigenous communities in Netrokona and Panchagor, and to a lesser extent in Dhaka. CRWRC collaborates closely with the USAID-funded NSDP clinics (especially in Dhaka and Netrokona) and link with them for referrals.

IV. CONCLUSIONS AND RECOMMENDATIONS

Following the field visits the evaluation team prepared a consolidated list of findings and preliminary recommendations by each of the three implementing partners (see Table 11):

Table 11: List of Preliminary Recommendations by Implementing Partners

Recommendations for SATHI:
1) Further training for PI sub-teams in the area of sustainability
2) Work on linkages/relationships with health facilities so that PI members can get subsidized treatment
3) Work towards clarifying the long-term plan with PIs
4) Revisit selection criteria for CHV and TTBA
5) Arrange meetings with husbands to discuss the role of the CHVs and TTBAs
6) More collaboration with stakeholders to achieve the KPC targets, ARI care seeking and breastfeeding.
7) Conduct Doer/Non-Doer for exclusive breastfeeding and use the BEHAVE framework
8) Explore why SATHI has done well in certain areas in order to continue the achievements
9) Health Animators may be overburdened. These responsibilities will be handed over to PI sub-teams.
10) PI needs to know what the capacity areas are to sustain the CSP (and how to monitor them)
Recommendations for PARI:
1) All CSP-related staff need to understand integrated community development.
2) Primary groups need more knowledge about the PI so that they understand the sustainability process.
3) The CSP staff need to identify the areas of capacity needed for sustainability with the PIs.
4) Focus on indicators that are still low at midterm and try to address them in a sustainable way.
5) Build the relationship/understanding between the health sub-team and the CHVs and TTBAs.
6) Build relationship between the Gov. health centers and the health sub-team along with CHVs and TTBAs.
7) Build the relationship between NSDP and the health sub-team along with CHVs and TTBAs.
8) Reach out to family members of influence (husbands, in-laws) to raise awareness about CHVs and TTBAs.
9) Create men's primary groups in order to share the health message with all.
10) Explore the idea of creating two PIs in Durgapur.
11) Discuss who can be trained using the GLP TOT course in order to ensure training capacity.
12) Discuss the use of the emergency fund with PIs and primary groups so that the use of the fund is clear.
13) Explore the idea of keeping a percentage of the emergency fund with the primary group.
14) Work with the CCC to arrange for transportation that is owned by the CCC.
15) Create an emergency plan for use of transport in case of an emergency.
Recommendations for SUPOTH:
1) Training PIs on capacity building, networking and communication.
2) More training for PI health sub-team, including supportive supervision.
3) Motivational work for CHV's husbands and in-law relatives.
4) CHV refresher training.
5) More emphasis on proper record keeping.
6) Effective referral service by keeping relationship between CHVs and local health facility.
7) Ensure even more participation of community people in developing health fund.
8) Expand program to other unions in future.
9) Emphasis on understanding objectives of CSP to TTBA, CHV and PI.
10) Supportive supervision needed for CHV and TTBA.
11) Maintain the relationship with district and sub-district as well as local health facility.

Following a discussion of findings, conclusions and preliminary recommendations a list of approximately 15 draft recommendations was prepared and discussed. From a discussion of that list emerged a consensus for the following ten major recommendations to assist the project staff in improving the project during the next two years:

1) Explore and test approaches to reinforce supervision and support linkages between community-based workers and PI health sub-teams.

2) Explore and test approaches to reinforce supervision and support linkages with health facilities and key health workers, e.g., health assistants and skilled birth attendants.

3) Identify capacity topics and indicators for continuing training of PIs, health sub-teams and primary groups for sustainability in long-term planning, networking, communication, advocacy, supportive supervision, and transitioning project paid health animators.

4) Implementing Partners should build on the local power base of PIs to reinforce relationships with local health authorities and facilities, including those supported by NSDP, to ensure the availability, access, affordability and quality of services.

5) Continue to explore options to improve access to urgent health care by improved management and expansion of emergency health funds.

6) Give special attention, using the BEHAVE framework, to technical interventions for which the mid-term targets were not met.

7) Continue to explore why some implementing partners have done particularly well in certain areas in order to document those achievements and share them with other partners as part of the Learning Circle.

8) CRWRC headquarters should document and share the CSP experience in Bangladesh as a case study in developing and managing local partnerships.

9) Examine options for support systems for community-based treatment in rural areas using evidence from the Community Case Management Operations Research in Panchagor.

10) Examine options for program consolidation and expansion in existing unions and eventually to neighboring unions.

V. RESULTS HIGHLIGHT – THE EMERGENCY HEALTH FUND

Lack of transportation is a major barrier to health care, especially in rural areas. The distance to health facilities, the lack of available vehicles, the high cost of transportation and the lack of funds during an emergency contribute to this problem. Borrowing from local money lenders can result in debts, large interest rates, and could eventually result in families of losing land and property.

The Peoples' Institutions (PI) of the CRWRC project in Netrokona, Panchagor and Dhaka districts developed Emergency Health Funds (EHF) to assist medical treatment and transportation costs. EHF bi-laws encourage community primary group members to collect a small amount each month in a PI managed bank account. Primary group members, TTBAs and CHVs can apply for emergency health funds on a 24/7 basis for group and non-group members. The beneficiary population eligible for assistance includes, therefore, not only the 7,000 current primary group members but also the general population of more than 100,000.

There are also provisions on a case-by-case basis for the extremely poor to receive assistance without a commitment to repay funds. The existing funds and the number of emergency referrals made to date are shown at right.

Table 1. Emergency Health Funds Used and Referrals Made During the Last 6-months

District	EHF funds	Referrals
Netrokona (PARI)	15500 taka	21
Panchagor (SUPOPTH)	700 taka	2
Dhaka (SATHI)	5300 taka	3

In order to show the impact of the EHF on health care seeking behavior in Netrokona, knowledge, practices and coverage (KPC) survey data was analyzed at baseline (January 2005) and at midterm (January 2007) to assess health care seeking behavior of mother of children under five who had pneumonia or diarrhea.

Results of the KPC survey showed striking increases in health care seeking behavior for pneumonia and diarrhea in the primary groups *and* in the general population of Netrokona. Among the primary groups, the percentage of children aged 0-23 months whose mother sought advice/treatment for pneumonia increased from 8% to 48% ($p<0.05$) and for diarrhea increased from 78% to 94% ($p<0.05$). Among the general population, the percentage of children aged 0-23 months whose mother sought advice/treatment for pneumonia increased from 8% to 19% ($p>0.05$) and for diarrhea increased from 78% to 94% ($p<0.05$).

A good example of how the generous use of the Emergency Health Fund saved the lives of a young mother and her first born come from the story of Sibani and Ritali who lived in a remote village in Durgapur near the Indian border.

Sibani is a Traditional Birth Attendant with 19 years of experience. Sibani participated in a 13-day skills-based CRWRC project sponsored TBA training at Joyramkura hospital that included diagnosing at-risk pregnancies and providing ante-natal care. According to Sibani, "I am now practicing all of these things in my community. I also used them to help Ritali."

Ritali Hajong is a sixteen year-old small, quiet young woman. From the beginning of her pregnancy, Sibani cared for Ritali. This included sending her to the doctor for regular check ups. Sibani knew that Ritali was very weak and was having a hard time eating.

When Ritali's labor pains came, Sibani was there to coach her, and concluded that Ritali just didn't have the strength to deliver her child. She immediately sent Ritali to the nearest health facility, a fourteen kilometre trip, in a two-wheeled cart pulled by community members. The

health facility nurse concurred with Sibani's diagnosis and decided that Ritali would require a caesarean section at Mymensingh hospital, a costly procedure that the Ritali's poor family could not afford.

The PARI field trainer heard about the situation, went to see the family at the health facility, and activated the EHF of the Ginok Peoples' Institution whose goal is that no mother or child in their community would die. The Ginok EHF provided Ritali's family with 2000 taka. This amount was supplemented by 4000 taka from the PARI field manager. Ritali's family was overjoyed at this generosity. The unconscious Ritali was immediately sent Mymensingh for a caesarean procedure that resulted in the joyous birth of Sunali Hajong.

A month and a half later, sitting under a shade tree with Sunali, Ritali says, "I feel well and am very thankful to the Peoples' Institution and PARI for their generosity. I know that if they were not there to help me that Sunali and I would probably have died." I am also thankful to Sibani for taking good care of me. Even though my delivery was very hard, I was confident in the care that she provided me."

The community-led initiative to create an EHF has led to a dramatic increase in health care seeking behaviors among members of the community groups. Allowing individuals from outside of the community groups to access these funds has led to a modest increase in health seeking behavior in the general population as well. The EHF is an innovative method for reducing the barriers to seeking health care that was created by and can be sustained by the community.

VI. THE ACTION PLANS

SUPOTH

Action Plan According to Midterm Evaluation

Subject	Activities/ Intervention	Responsibilities	Time Frame
Linkage between community-based workers and PI health sub-team (HST), i.e., CHVs & TTBAs	1) Arrange orientation program about responsibilities/ roles of CHVs and TTBAs for sustaining work post-CSP.	HC/CHA/ PI-HST	Nov-07
	2) Arrange a meeting with PI, CHVs and TTBAs on linkage between PI and community-based workers.	HC/CHA/ PI-HST	Quarterly
	3) Continuing monthly meeting between CHVs/TTBA and 2 leaders of PI. PI to arrange meetings, syllabus, etc.	CHA/PI-HST	Monthly
Linkage with health facilities and key health workers.	1) Identify/select super CHVs	CHA/PI-HST	Oct-07
	2) Arrange a meeting with super CHVs, TTBAs and PI health sub-team on linkage their roles and responsibilities.	HC/CHA/ PI-HST	Nov-07
	3) Arrange a meeting with Government health personnel and super CHVs, TTBAs about linkage and networking.	HC/CHA/ PI-HST	Quarterly
	4) Arrange a meeting with Government health authority and PI about health service availability. Develop MOU between Government Health authority and PI.	HC/CHA/ PI-HST	Jan-08
Identify capacity areas for continuing training for PI health sub-team and primary groups.	1) Arrange a meeting with PI and HST for identifying their capacity areas lacking for sustainability.	HC/CHA/ PI-HST	Nov-07
	2) Plan with PI and HST according to their selected growth area.	HC/CHA/ PI-HST	Nov-07
	3) Arrange orientation with PI and HST on Supportive Supervision of CHV/TTBA	HC/CHA/ PI-HST	Nov-07
	4) Continue meeting with PI and HST to increase the capacity area about sustainability.	HC/CHA/ PI-HST	Quarterly
	5) Prepare work plan with PI about Sustainability and Seed fund uses.	HC/ PI leaders	Quarterly
	6) Develop and sign an MOU with PI about how to run program, continuing CHV and TTBA works.	HC/PI Leaders	Feb-08
	1) Arrange meeting to introduce PI to the local health facilities.	FS/CHT	Nov/Dec-07

To build and reinforce relationships with PIs and local health authorities and facilities (including NSDP)	1) Arrange meeting to introduce PI to the local health facilities.	FS/CHT	Nov/Dec-07
	2) Emphasize or reinforce the quarterly meeting with PI, HST and local health facilities 3) Supervise CHV on identify cases and refer to the appropriate place.	CHT FS/CHT	Quarterly Monthly
	4) PI-HST communicates with local facilities for ensuring service availability. MOU to outline guidelines for responsibility.	CHT/PI	continuing
Management of the emergency funds with PIs and primary group.	1) Arrange meeting with PI leaders, HST and CCC/primary group leaders about emergency fund management and its utilities.	HC/FS	Dec/Jan-07/08
	2) Meeting with PI and community about raising more emergency funds.	HC /PI leaders, Elite persons	Bi-Six monthly
	3) Dissemination meeting with local elite person about emergency funds.	HC/CHA/PI	Feb-08
	4) Arrange workshop with PI leaders, HST and CCC/group leaders on emergency fund utilities. Output is a cooperation agreement between the communities and the PIs.	HC/PI/CCC leaders	Semi-annually
	1) Conduct Doer/Non-doer survey on selected issues.	HC/CHA	Oct-07
	2) Prepare BEHAVE Framework on issues according to survey reports.	HC/CHA	Oct-07
	3) Start work according to framework at the field level.	CHA/CHV	Jan-08

NOTE: CCC = Community Central Committee; CHA = Community Health Animator; CHT = Community Health Trainer; CHV = Community Health Volunteer; FS = Field Supervisor; HC = Health Coordinator; HST = Health Sub-Team; PI = Peoples' Institution

PARI

Action Plan According to Midterm Evaluation

Subject	Activities/ Intervention	Responsibilities	Time Frame
Linkage between community-based workers and PI health sub-team (HST), i.e., CHVs & TTBAs	1) Arrange orientation program about responsibilities/ roles of CHV and TTBA for sustaining.	HC/FS/CHT/FT	Oct-07
	2) Arrange a meeting with PI, CHV and TTBA on linkage between PI and community based workers.	HC/FS/CHT/FT	Quarterly
	3) Continue monthly meeting between CHVs/TTBAs and 2 leaders of PI	CHT/FT	Monthly
Linkage with health facilities and key health workers.	1) Identify/select of super CHVs	CHT/FT	Sept-07
	2) Arrange a meeting with super CHVs, TTBAs and PI health sub-team on linkage and their roles and responsibilities.	FS/CHT/FT	Nov-07
	3) Arrange a meeting with Government health personal and super CHV, TTBA about linkage and networking Develop MOU between PI and Government facilities.	HC/FS/CHT	Quarterly
	4) Arrange a meeting with Government Health authority and PI about Health service availability. Develop plan of action for their work together.	UH&FPO/HC	Jan-08
Identify capacity areas for continuing training for PI health sub-team and primary groups.	1) Arrange a meeting with PI and HST to identify their capacity areas needs for sustainability.	HC/FS/CHT	Nov-07
	2) Plan with PI and HST according to their growth areas identified as above.	HC/FS/CHT	Nov-07
	3) Arrange orientation with PI and HST on Supportive Skill Supervision	HC/FS/CHT	Nov-07
	4) Continue meeting with PI and HST to increase the capacity area about sustainability.	HC/FS/CHT	Quarterly
	5) Prepare work plan with PI about Sustainability and Seed fund uses.	HC/ PI leaders	Quarterly
	6) Conduct MOU with PI about how to run program, continuing CHV and TTBA work.	HC/PI Leaders	Feb-08

To build and reinforce relationships with PIs and local health authorities and facilities (including NSDP)	1) Arrange a meeting to introduce PI and local health facilities and develop plan for ongoing communication (MOU as above) for their ongoing work together.	FS/CHT	Nov/Dec-07
	2) Emphasize or reinforce the quarterly meeting with PI, HST and local health facilities	FS/CHT	Quarterly
	3) Super CHVs identify cases and refer to the appropriate.	CHV	Monthly
	4) As per their needs (PI/ HST) they have communicated with local facilities for ensuring service availability.	CHT/PI	Continuing
Management of the emergency funds with PIs and primary group.	1) Arrange a meeting with PI leaders, HST and CCC/primary group leaders about emergency fund management and its utilities.	HC/FS	Dec/Jan-07/08
	2) Meeting with PI and community about raising more emergency funds.	HC /PI leaders, Elite persons	Semi-annually
	3) Dissemination meeting with local elite persons about emergency funds.	HC/CHT/PI	Feb-08
	4) Arrange workshop with PI leaders, HST and CCC/group leaders on emergency fund utility and develop MOU between community and PIs.	HC/PI/CCC leaders	Semi-annually
BEHAVE framework	1) Conduct Doer/Non-Doer survey on selected issues – per mid term KPC results.	HC/FS/CHT	Sept-07
	2) Prepare BEHAVE Framework on issues according to survey reports.	CHT/FT/PI	Oct-07
	3) Start work according to framework at the field level	CHT/FT/PI	Jan-08

NOTE: CCC = Community Central Committee; CHA = Community Health Animator; CHT = Community Health Trainer; CHV = Community Health Volunteer; FS = Field Supervisor; FT = Field Trainer; HC = Health Coordinator; HST = Health Sub-Team; PI = Peoples' Institution

SATHI

Action Plan According to Midterm Evaluation

Subject	Activities/ Intervention	Responsibilities	Time Frame
Linkage between community-based workers and PI health sub-team (HST), i.e., CHVs & TTBAs	1) Arrange orientation program about responsibilities/ roles of CHVs and TTBAs for sustainability.	HC/CHA/ PI-HST	Nov-07
	2) Arrange a meeting with PI, CHVs and TTBAs on linkage between PI and community base workers.	HC/CHA/ PI-HST	Quarterly
	3) Continue monthly meeting between CHVs/TTBAs and 2 leaders of PI	CHA/PI-HST	Monthly
Linkage with health facilities and key health workers.	1) Identify/select super CHVs	CHA/PI-HST	Oct-07
	2) Arrange a meeting with super CHVs, TTBAs and PI health sub-team on linkage their roles and responsibilities.	HC/CHA/ PI-HST	Nov-07
	3) Arrange a meeting with Government health personal and super CHVs, TTBAs about linkage and networking.	HC/CHA/ PI-HST	Quarterly
	4) Arrange a meeting with Government Health authority and PI about Health service availability.	HC/CHA/ PI-HST	Jan-08
Identify capacity areas for continuing training for PI health sub-team and primary groups.	1) Arrange a meeting with PI and HST to identify their capacity area needs for sustainability.	HC/CHA/ PI-HST	Nov-07
	2) Plan with PI and HST and develop actions for weak areas.	HC/CHA/ PI-HST	Nov-07
	3) Arrange orientation with PI and HST on Supportive Supervision of CHVs/TTBAs	HC/CHA/ PI-HST	Nov-07
	4) Continue meeting with PI and HST to increase the capacity area about sustainability	HC/CHA/ PI-HST	Quarterly
	5) Prepare work plan with PI about Sustainability and Seed fund uses.	HC/ PI leaders	Quarterly
	6) Develop and sign MOU with PI about how to run program, continuing CHV and TTBA work.	HC/PI Leaders	Feb-08
To build and reinforce relationships with PIs and local health authorities and facilities	1) Arrange meeting to introduce PI to local health facilities	FS/HST	Nov/Dec-07
	2) Emphasize or reinforce the quarterly meeting with PI, HST and local health facilities	FS/HST	Quarterly
	3) Super CHVs identify cases and refer to the appropriate place	CHV	Monthly

(including NSDP)	4) (PI/ HST) communicate with local facilities to ensure service availability.	HST/PI	Continuing
Management of the emergency funds with PIs and primary group.	1) Arrange meeting with PI leaders, HST and CCC/primary group leaders about emergency fund management and its utilities.	HC/FS	Dec/Jan-07/08
	2) Meeting with PI and community about raising more emergency fund.	HC /PI leaders, Elite persons	Semi-annually
	3) Dissemination meeting with local elite person about emergency fund.	HC/CHA/PI	Feb-08
	4) Arrange workshop with PI leaders, HST and CCC/group leaders on emergency fund utilities.	HC/PI/CCC leaders	Semi-annually
BEHAVE framework	1) Conduct Doer/Non-Doer survey on selected issues – per mid term KPC results.	HC/CHA	Oct-07
	2) Prepare BEHAVE Framework on issues according to survey reports.	HC/CHA	Oct-07
	3) Start work according to framework at the field level	CHA/CHV	Jan-08

NOTE: CCC = Community Central Committee; CHA = Community Health Animator; CHT = Community Health Trainer; CHV = Community Health Volunteer; FS = Field Supervisor; HC = Health Coordinator; HST = Health Sub-Team; PI = Peoples' Institution