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ACCESS: SAFE MOTHERHOOD AND NEWBORN CARE (SMNC)

PROJECT ASSESSMENT

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LIST OF ACRONYMS

AC	ACCESS Counselor
ADB	Asian Development Bank
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
CAC	Community Action Cycle
CAG	Community Action Group
C-KMC	Community kangaroo mother care
CM	Community Mobilizer
CRP	Community Resource Person
CSM	Community Supervisor Mobilizer
DFID	Department for International Development, United Kingdom
DHS	Demographic and Health Survey
FGD	Focus group discussions
FIVDB	Friends in Village Development Bangladesh
FSO	Field Support Office
FWA	Family Welfare Assistant
FWC	Family Welfare Center
ICDDR, B	International Centre for Diarrheal Disease Research, Bangladesh
KMC	Kangaroo mother care
KPC	Knowledge, practice, and coverage
LAM	Lactational Amenorrhea Method
M&E	Monitoring and evaluation
MIS	Management information system
MNC2	Maternal and newborn care (2nd visit)
MNH	Maternal and neonatal health
NGO	Nongovernmental organization
SBA	Skilled birth attendant
SC	Save the Children
SMC	Social Marketing Company
SMNC	Safe Motherhood and Newborn Care
SNL	Saving Newborn Lives
SSFP	Smiling Sun Franchise Program
TBA	Traditional birth attendant
TFR	Total fertility rate
TOT	Training of trainers
TT	Tetanus toxoid
UHC	Upazilla Health Complex
UN	United Nations
UNFPA	UN Fund for Population Activities
UNICEF	UN Children's Fund
UTL	Upazilla Team Leader
WHO	World Health Organization

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ANNEXES

EXECUTIVE SUMMARY

An external team assessed USAID's Safe Motherhood and Newborn Care (SMNC) program to document progress to date, identify challenges, and advise on any adjustments needed to the current project and on whether to continue the activity when the current three-year period ends. SMNC is part of USAID's global ACCESS program, managed in Bangladesh by Save the Children (SC) in partnership with two Sylhet-based nongovernmental organizations (NGOs), Shimantik and Friends in Village Development Bangladesh (FIVDB). The assessment team in March 2008 interviewed stakeholders, reviewed documents, and visited Sylhet to observe activities and talk with project staff and clients.

The project has made commendable progress in a brief period and is already beginning to show results. Careful and extensive stakeholder preparation and involvement before implementation facilitated successful program entry into remote rural communities in the seven Upazillas (subdistricts) where SMNC works. Community mapping and other preparatory activities also facilitated rapid and systematic roll out. An excellent program management system, adapted from the Projahnmo project, also contributed to early successes. There are already signs of behavior change in caring for newborns due to the counseling and teaching provided by ACCESS counselors (ACs) and solid community support emerging as the result of the Community Action Groups (CAGs)—a vital part of the SMNC community mobilization strategy.

The assessment team did find areas where changes would lead to a more useful and replicable maternal and newborn health (MNH) model for Bangladesh. It also has specific suggestions to help increase institutional sustainability and scale up the program SMNC is supporting. It is crucial to refine the current MNH model to better integrate the community mobilization and household behavior change elements; encourage more flexible and variable application of the model to local conditions; and improve its cost-effectiveness by reducing the intensity and oversight of external entities. The team also offers recommendations on how to improve ownership of the project by the partner NGOs, improve their ability to contribute to strategic decision making, and enhance the sustainability of the project so that the program is not endangered by the eventual end of USAID support.

Finally, the team recommends forcefully that USAID continue support for this program until September 2011 to allow time to refine the model and give it a chance to demonstrate its impact on communities in a poor and remote region of the country. The program is off to a very promising start; it now needs time to make adjustments to ensure that Bangladesh gets the full benefit of a thoroughly tested, replicable, and sustainable model for improving MNH in poor rural areas.

I. INTRODUCTION AND BACKGROUND

While maternal mortality has been reduced over the past 15 years, at 320 per 100,000 live births Bangladesh still has one of the highest rates in Asia. The principal causes of maternal deaths are hemorrhage, eclampsia, infection, obstructed labor, and complications due to unsafe abortions. According to the last Demographic and Health Survey (DHS), over the past five years neonatal deaths have been the primary cause of infant mortality (71%) and constitute over half of all under-5 mortality (57%).[1] Neonatal mortality has declined more slowly than maternal mortality. Concerns about the neonatal death rate have caused the government and development partners to jointly launch new programs and advocate for addressing newborn health issues in Bangladesh.

Nationally, addressing maternal and neonatal mortality is challenging because 85 percent of births still occur at home, and only 18 percent of them are attended by trained medical providers (doctors, nurses, or community skilled birth attendants). Unfortunately, when complications occur, women are not taken to more sophisticated facilities, either because the dangers are not understood or because there is no reliably equipped and staffed referral facility nearby. Similarly, newborns that experience life-threatening conditions, such as asphyxia or sepsis, are treated locally by untrained village doctors who may not have the knowledge or the drugs to deal with their problems. The challenges are thus from both the demand side (lack of community and family knowledge and ability to react appropriately) and the supply side (availability of providers who are adequately trained and equipped to provide life-saving interventions). About half of all neonatal deaths occur in the first three days of life due to birth asphyxia, infection, neonatal tetanus, and complications of premature birth. The lack of household information about MNH contributes to low demand for essential services. Experience from other countries and from projects such as Projahnmo, which was funded by USAID, and Save the Children's Saving Newborn Lives (SNL) in Bangladesh, demonstrate that community mobilization, household behavior change interventions, and providing workers in the community with the skills and tools to look after newborns, can reduce mortality significantly.

Sylhet District is a particularly disadvantaged part of Bangladesh; most health indicators there are worse than national averages (see Table 1)[2]:

TABLE 1. KEY INDICATORS–BANGLADESH DHS 2007

Indicators	National	Sylhet
Neonatal mortality rate	37/1,000 live births 41/1,000 live births	63/1,000 live births
Total fertility rate	2.7	3.7
Contraceptive prevalence rate	56%	32%
Unmet need for family planning	18%	26%
At least one ANC visit with trained provider	52%	47%
Place of delivery	Home: 85%	Home: 91%
Skilled attendance at birth	18%	11%

Source: Bangladesh DHS, 2004.

[1] Bangladesh Demographic and Health Survey, 2007, Preliminary Report.
[2] Table taken from SMNC power point presentation dated March 8, 2008

II. DESCRIPTION OF ASSESSMENT

Rationale and Objectives: The Safe Motherhood and Newborn Care Program in Bangladesh (SMNC) was initiated in 2006 by USAID/Bangladesh using a field support mechanism to the ACCESS Leader with Associate Award cooperative agreement, managed by the Health, Infectious Disease and Nutrition Office (HIDN) of the Global Health Bureau at USAID/ Washington. It was envisioned to be a five-year program (three years with two optional one-year extensions) in seven Upazillas in Sylhet, covering a population of roughly 1.6 million. Save the Children (SC), a partner of the global ACCESS project, is the lead implementing organization in Bangladesh. This is especially appropriate because SC is already viewed as a leader in newborn health there. It has been carrying out the SNL program in Bangladesh since April 2001, supported by the Bill and Melinda Gates Foundation. Local implementing partners of the SMNC project are Shimantik and Friends in Village Development Bangladesh (FIVDB), both of which are Sylhet-based NGOs, and the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B), which is responsible for certain monitoring and evaluation activities.

USAID believes that the SMNC Program, which is based on lessons learned from the Projahnmo research project,[3] is essential for testing the feasibility of scaling up from a research model to one that can be applied to a large geographic area. The intent was to use a programmatic level of intensity that could be scaled up nationally if successful.

Although the project began in February 2006, full-scale field implementation did not begin until about April 2007, for reasons described below. Despite its relatively short time in the field, USAID felt that assessment by an external team would be advantageous to determine how much progress has been made, analyze constraints and challenges, and suggest adjustments to improve implementation. USAID also asked for strategic recommendations for the future and for ways USAID may continue this type of work.

Two explicit objectives were outlined in the scope of work[4]:

- Assess progress and achievements in relation to the expected results of the project.
- Recommend changes, if any, in the project approach or interventions for improving and strengthening the project (including assessing opportunities for scaling up in a follow-on project).

The consultant team was required to assess all dimensions of the project, from technical strategy and specific interventions to supervision and monitoring and institutional issues with collaborating partners. It was also required to identify best practices, lessons learned, and challenges, which will all be important for considering future activities. This report is organized to address these issues.

Methodology: The team consisted of a maternal and newborn health specialist from Bangladesh, the newborn technical advisor from USAID/Washington's Bureau for Global Health, the USAID ACCESS activity manager, and a team leader with broad public health policy and program skills. An administrative officer helped arrange logistics.

Most of the assessment was conducted March 9–31, 2008; it consisted of interviews with stakeholders (ACCESS and USAID staff; NGOs; SNL staff from SC, UN agencies, and other

[3] See Annex 4 for a brief description of Projahnmo.
[4] See Annex 1 for the scope of work.

development partners; and headquarters staff of the two major SMNC NGO partners). The team reviewed project-related documents and reports,[5] and visited Sylhet for four days, March 15–18. A field question guide was drafted to ensure that informants in the field were all asked about the issues relevant to the assessment. The team then produced a PowerPoint presentation and this assessment report.

[5] These are listed in Annex 2.

III. SUMMARY PROJECT DESCRIPTION

The SMNC program was planned as a three-year activity (February 2006–March 2009) with a possible extension for two years if funds are available. Although the global ACCESS project (a "leader with associate" award to JHPIEGO) ends in July 2009, USAID/Bangladesh can extend its activity by issuing an associate award with JHPIEGO and its partners that, if issued before July 2009, can last for five years without regard to the ACCESS leader award end-date. The total budget for SMNC is estimated at $15 million for five years, with an average yearly budget of $3 million; so far $5.661 million has been obligated.

The strategic approach of the SMNC program has been to scale up both the Projahnmo research project and SC's current SNL program with modifications, and apply lessons learned from those projects. The model used in Projahnmo was modified because the interventions were moving from an intensive research mode to a model that would enable scaling up. The original SMNC program did not anticipate becoming involved in maternal or newborn service delivery or helping to reinforce the service delivery system. In 2007, however, USAID supported the idea of adding certain activities related to building capacity in newborn health for health facility staff and training informal providers, such as traditional birth attendants (TBAs) and village doctors.

The expected results of the SMNC program are that increased numbers of mothers in the project will:

- Have four antenatal care (ANC) visits and two tetanus toxoid (TT) immunizations during pregnancy.
- Have birth plans and clean deliveries.
- Recognize signs of complications and seek care.
- Practice immediate wrapping and drying of the newborn.
- Initiate immediate and exclusive breastfeeding.
- Delay bathing the newborn.
- Practice dry and clean cord care.
- Practice skin-to-skin community kangaroo mother care (C-KMC) for all newborns.

While increasing skilled attendance at births was among the desired results listed in the original project description, no SMNC activities currently contribute to that objective.

Progress and achievements in the project are monitored using data collected at the community and facility level and by baseline and end-of-project surveys for which ICDDR,B is responsible (see Section IV C for details).

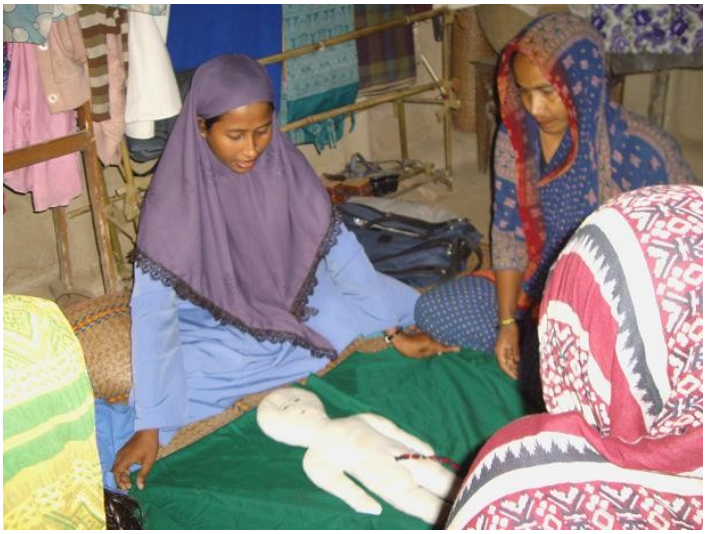
IV. ASSESSMENT OF PROJECT PROGRESS AND ACCOMPLISHMENTS

STRATEGIC APPROACH

The SMNC program uses household visits and community mobilization to change home-based maternal and newborn care practices and increase care-seeking and utilization of services. It does not provide health services. The two-pronged strategy is articulated in Objectives 1, 2, and 4. Objective 3 addresses reinforcement of health systems and Objective 5 deals with increasing leadership and advocacy. Building the capacity of the two main NGO partners is also a major goal.

MEASURING AND MEETING TARGETS

Objective 1: To increase knowledge, skills, and practices of healthy maternal and newborn behaviors in the home



Objective 2: To increase appropriate and timely utilization of home- and facility-based essential MNH services

Objectives 1 and 2 are achieved primarily through trained community health workers, ACCESS counselors (AC), who conduct surveillance visits every three months to identify pregnant women and conduct two ANC and two postnatal home visits, the first within 24 hours after birth and the second within five to seven days.

The two pregnancy visits aim to achieve

- an increased use of four ANC visits and TT immunization at the Union Health and Family Welfare Center (FWC) or satellite clinics;
- development of birth and newborn care preparedness plans (including preparation of birthing materials, such as a clean delivery kit; identifying a birth attendant and a person to care for the newborn; arranging for or saving emergency funds; and arranging emergency transport);
- recognition of danger signs during pregnancy and delivery, and prompt care-seeking;
- adequate nutrition (iron-folate supplements and improved dietary intake);
- clean delivery;
- immediate drying and wrapping of the newborn;

- immediate and exclusive breastfeeding; and
- delayed bathing of the newborn.

The two postnatal visits aim to achieve

- recognition of newborn complications and referral;
- keeping the baby warm (wrapping);
- clean cord care (avoiding application of any substance to the cord stump); and
- exclusive breastfeeding.

The project has mapped service delivery points and outlets, assessed facilities, and developed a list of referral facilities by location. This referral information has been incorporated into both the AC home visit and community mobilization activities.

Findings

The project has recruited 286 ACs to conduct home visits to identify pregnancies and counsel pregnant women and newly delivered mothers. Each AC covers 5,000–6,000 people (800 households in six villages). According to data from the SMNC management information system (MIS), during April 2007 and January 2008 the ACs identified 224,717 married women of reproductive age, of whom 60,379 were pregnant. From the last quarter of 2007 to the first quarter of 2008, postnatal visits by ACs within the first week of life doubled from 37 to 74 percent. In the first quarter of 2008, the ACs visited 11,552 newborns (55%) within 24 hours and 14,429 newborns (82%) `five to seven days later.

It appears from the MIS data that the uptake of many desirable home-based essential maternal and newborn care practices has been dramatic. Between April 2007 and January 2008, 46 percent of mothers prepared birth plans, 75 percent had a person to care for the newborn, and 58 percent of newborns received essential care—a composite indicator that incorporates three practices: clean cord cutting instrument *plus* drying and wrapping *plus* breastfeeding within one hour. Individually, each practice was even higher: at 92 percent use of a clean cord instrument was almost universal, drying and wrapping reached 83 percent, and breastfeeding reached 84 percent. Moreover, bathing of 75 percent of newborns was delayed (3 days), and for 83 percent nothing was applied on the cord stump. Except for the prevalence of a clean cord-cutting instrument, these behaviors are a marked change from the previous norm. Preliminary analysis of the baseline survey data indicates there was very low prevalence of these desired practices in Sylhet (e.g., only 17 percent dried the newborn, and a large majority, 66 percent, applied a substance to the cord, usually turmeric, ginger juice, mustard oil, chewed rice, or clay from the earth burner).

Service providers at the Upazilla Health Complex (UHC) and Family Welfare Centers (FWCs) confirmed that the SMNC program has increased utilization in their facilities, especially for ANC. Shimantik's Smiling Sun Franchise Program (SSFP) clinic services have also increased due to household demand generated by the SMNC program; according to Shimantik SSFP service statistics, ANC services increased by 18 percent and postnatal services by 45 percent, leading to an increase in cost recovery from 16 to 23 percent.

While MNH practices have has improved, the figures are still low for the recommended four antenatal visits (15%), skilled birth attendance (15%), and postnatal care by skilled providers (15%).

Most of the ACs are confident, empowered, and treated with respect in the community. There are clear signs of early community acceptance of project interventions; ACs are welcomed on the doorstep and at community meetings. Uptake of messages and compliance is good, as indicated by the MIS data and the team's field observations. In general, AC counseling, interpersonal skills, and use of job aids are effective.

SMNC has recently introduced community kangaroo mother care (C-KMC) into the program. While the intervention is aimed at low-birthweight newborns, messages about skin-to-skin care and hypothermia will be conveyed to mothers of all newborns regardless of weight, because ACs are not equipped to weigh newborns. The project has begun training master trainers and TBA coordinators in C-KMC. As part of the training of trainers (TOT), each group of master trainers demonstrated their C-KMC proficiency by training a group of ACs immediately after completing their own C-KMC TOT. ACs will also be trained on C-KMC in refresher training being organized for the coming months.

Interventions to prevent postpartum hemorrhage, active management of the third stage of labor (AMTSL), and use of misoprostol to prevent postpartum hemorrhage are not available in Sylhet. Supported by EngenderHealth, the national Taskforce for AMTSL has developed a national rollout plan to scale up AMTSL in every district, including Sylhet, and the Government of Bangladesh is likely to soon approve roll-out of a community-based misoprostol program. When it does, SMNC plans to apply this intervention in Sylhet.

Since the large majority of women prefer to use TBAs for deliveries, the SMNC program has recently begun training more active TBAs on clean delivery practices, avoidance of harmful practices, and essential newborn care. C-KMC has also been integrated into TBA training. Semiannual cluster meetings are used to establish a link between TBAs and ACs.

The project also plans to orient village doctors on MNH issues to reduce harmful practices, ensure clean delivery, identify danger signs, increase timely and appropriate referral, and increase knowledge and practice of emergency obstetric and newborn first aid.

Challenges

While the quality of technical messages is good and based on the latest evidence-based information, the team noted some technical deficiencies. For instance, some ACs considered jaundice to be a major cause of maternal death. Technical knowledge about major causes of mortality would help community mobilizers (CMs) and ACs to guide community discussions on hemorrhage rather than jaundice as a major cause of maternal death. ACs were also observed saying that if a mother is given TT, she will not have convulsions.

Supervisors and ACs expressed the need for more technical updates so they can respond to questions from the community. AC counseling skills can be further enhanced by adding negotiation skills for customizing messages to client needs.

After almost a year of program implementation, it is now time for the SMNC project to review and strengthen the sick-newborn component of the program. ACCESS had initially considered including clinic-based training and a more detailed newborn assessment tool to enable ACs to assess and refer sick newborns. However, after discussing this with USAID, ACCESS decided to limit the training to pictures and video to counsel the mother about newborn danger signs. It also decided to monitor referrals from households and compare them with the findings of the Projahnmo project, in which community workers are being trained to assess and identify sick newborns. If the comparison between the two projects indicates that ACs perform more effectively when they are trained in clinical assessment, ACCESS would propose that USAID add this to the program. MIS estimates, in fact, do show that the SMNC ACs identified danger signs in about 3.6 percent of newborns they attended and these were referred. This rate is much lower than in Projahnmo, where about 17 percent (unpublished data presented in forums in Dhaka, Delhi, and Bangkok) of newborns assessed had danger signs for severe and possible very severe disease. This indicates that AC clinical skills are inadequate to identify danger signs, and they are missing severe cases needing referral care. Rather than trying to replicate the hospital-based training provided by the Projahnmo project, the assessment team recommends that the ACs, as part of their refresher training, be encouraged to do more direct examination of the newborn to identify danger signs and symptoms of infection rather than simply passing the information along during counseling. The videos and pictures used in the original training may suffice.

Overwhelming demand for family planning and birth spacing messages and supplies was expressed at all levels. Women surreptitiously pull ACs aside to ask them if they have contraceptives; SMNC project staff expressed a need to include family planning in their program; service providers at the UHC and UH/FWC noted that this was a great need; and the Deputy Director for Family Planning and Civil Surgeon also advised the team to incorporate family planning into the program.

Recommendations

- Because there is a high fertility rate and a large unmet need, messages on birth spacing should be enhanced to incorporate the lactation amenorrhea method (LAM), transition to fertility, and specific postpartum methods. Facilitating a network of family welfare assistants (FWAs), depot holders, and SMC's Healthy Timing and Spacing Program would make more methods available at the community level. A plan for a supply/commodity network customized to the village level should be developed immediately.

- Because there is high newborn mortality due to infections, messages about recognition of danger signs should be buttressed by enhancing the technical capacity of ACs to assess, identify, and refer for infections.

- All levels of staff including ACs, community supervisor mobilizers (CSMs), CMs, Upazilla team leaders, and partner NGO technical leaders need better basic skills training (e.g., on counseling skills) and regular technical refresher training so that they can better respond to the frequent questions from the communities. One-to-one coaching is required for ACs whose counseling skills are poor—something that should be a priority.

- SMNC should coordinate with EngenderHealth to ensure that Sylhet is given priority in the national rollout of AMTSL and misoprostol for postpartum hemorrhage prevention.

Objective 3: To improve key systems for effective service delivery, community mobilization, and advocacy

A review of the project proposal makes it clear that the definition of "key systems" has two aspects: (1) building NGO systems and capacity to manage the SMNC project, and (2) linking the project with the health care system itself to ensure that once women and newborns are referred for care, they have a better chance of obtaining the services they need. After the project began, activities related to improving the health system were added (e.g., training of Upazilla Health Center staff, TBAs, and village doctors). This review examines progress on both.

Findings [6]

NGO systems: The project has a truly commendable system for rolling out and managing the core program implemented by the two partner NGOs. These include processes for initial community consultations and advocacy, mapping of households, identification of community resources and of married women of reproductive age and pregnant women, birth notification, tracking service use, and so on. Partner NGOs were involved in intervention design workshops held when the project began. A monthly activity calendar helps to organize the work and ensure that staff are following the strategic approach developed. SC provides both technical oversight and capacity development for the partner NGOs in financial and administrative management.

Most of the activities are carried out by staff hired by Shimantik and FIVDB with technical support from the SC ACCESS office in Sylhet. Implementation teams for Upazillas led by Upazilla team leaders (UTL) report to focal points located in Sylhet. Technical and programmatic oversight and liaison with USAID and other partners are handled by the SC ACCESS office in Dhaka.

A large number of staff—286 ACs, 73 CSMs, 40 CMs, 23 Field Support Offices (FSOs), and 7 UTLs—have been hired and trained in MNH counseling and community mobilization. Shimantik already had experience with implementing household-level maternal and newborn care activities; FIVDB, though not originally a health NGO, has some experience implementing immunization, TBA training, and safe motherhood. However, the community action cycle (CAC) for community mobilization is a new approach for both organizations. The capacity of staff to mobilize communities to improve MNH can potentially be applied to community action in other programs.

The SMNC project is using many systems as they were developed in the Projahnmo research project rather than modifying them in ways that will facilitate replicability and expansion. While this was a logical way to get started, the evaluation team considers it important that the project begin evolving those systems to make them less complex and more sustainable. For example, as the project proposal stated, pregnancy identification should have involved multiple sources, but in practice only the Projahnmo pregnancy surveillance system is being used. In some villages, CAGs locate pregnancies on village maps. This approach can be a sustainable substitute for costly, time-consuming quarterly pregnancy surveillance. Secondly, now that a huge number of TBAs are being trained, the project should consider using the TBA network to identify pregnancies—a female CAG linked to the TBA network should be able to keep track of all pregnancies. A more flexible and cost-effective approach is important for a program model that intends to be scalable where 100 percent precision is not the goal.

Health care system: Since the project does not provide referral services, pregnant women and newborns are to be referred to government and NGO static and outreach facilities in or near project areas. Having mapped health care options in the area, the project has customized referral advice to minimize delay in a patient reaching a facility where the desired care should be

[6] Monitoring and supervision system issues are dealt with separately in Section IV C.

available. Though a referral slip provided by an AC is seen as an endorsement by a trained worker, client experience of the availability of services and the quality of care they received from service providers has been mixed. Service providers both at the FWCs and UHCs seem to welcome women and newborns referred by ACs, but often the services needed are simply not available. There are still too few NGO clinics in rural areas to offer an alternative to government facilities. Through the component added to the project recently, SMNC will provide some training on newborn care to staff in government facilities, but it cannot address the high rate of vacancies, limited hours, and other quality problems. More training and orientation of TBAs and village doctors is also seen as a way to make care more available in villages using practitioners already heavily used by the people.

Challenges

Partner NGOs have some concerns about their degree and type of involvement in program design, management, and modifications. Senior managers have become somewhat disengaged over time due to a perception that their organizational expertise has not been optimally used. The many SMNC staff hired for the project do not have much experience with the partner NGOs. Shimantik, FIVDB, and SC each have comparative advantages, but there have been no opportunities for cross-learning. This issue will become increasingly critical in thinking about sustainability and what will happen after USAID support ends.

The SMNC partnership is envisaged to promote capacity building among partner NGOs. Training a field staff and installing project-wide operating systems are only part of the picture. Since there was no needs assessment, ambiguity about the definition of capacity building and measurable indicators is a problem.

As mentioned several times in the project proposal, the intervention design should be adjusted based on services available and local conditions. While it is still relatively new, the program has yet to show much variability shaped by such factors. For example, messages about seeking routine postnatal services and how to deal with the need for emergency care for mother or newborn should vary depending on proximity to such services, travel distances, and so on. Variability can also be introduced for worker/population ratios, CAG planning, and arranging for alternative service delivery approaches. Much information is now available on a Union level from the baseline survey. From a program like SMNC where proven interventions are being implemented in a larger programmatic set-up, diversity and flexibility in approach would offer lessons the world would like to learn.

On the service delivery side, the tables of the baseline survey show that half the pregnant women did not receive any antenatal checkups and about one-third did not receive any TT injection. (The range is also quite wide between Upazillas.) These grim figures of routine maternal care are attributable to nonavailability of services from UHCs, FWCs or satellite clinics. While maternal and newborn complications are referred either to UHCs or to Sylhet, it is routine care that tends to suffer most. The project's initiative to train service providers at UHCs and FWCs will address only part of the larger problem.

Recommendations

- The MNH program model needs further refinement to better integrate the household and community mobilization components. For each output or set of outputs, intervention strategies and intensity should be worked out to minimize duplication. Where resources are tight, reinforcement of one component by the other is essential.
- Senior leaders from SC, FIVDB, and Shimantik and staff from USAID should meet regularly to discuss progress and issues. Staff at different levels need to be sensitive of

partner strengths and take initiative to work out strategies to ensure participation and engagement. FIVDB and Shimantik, even at this early stage, need to be planning for what happens to their SMNC program and staff once support ends.

- Clear and specific negotiation should take place between the SMNC partner NGOs to draft a capacity building plan. A time-bound, output-oriented capacity building plan with a transition plan for SC should be considered. Each organization should designate point persons for this.
- Given the widespread gap in Government of Bangladesh human resources in UHCs, FWCs, Union, and below, USAID and SNMC should discuss with the Director General for Health Services and Director General for Family Planning a priority recruitment plan for Sylhet. Alternative service delivery involving NGOs and projects should be explored as a stop-gap arrangement. While these discussions may not have immediate results, perseverance is important, given the growing pressure on the Ministry of Health to find solutions to these major problems.

Objective 4: To mobilize community action, support, and demand for the practice of healthy MNH behaviors

The project has introduced a rigorous and systematic model of community mobilization, the CAC, which has dramatically reduced maternal and newborn mortality in Bolivia and Nepal. The model is based on the following steps: organizing community action groups, identifying and prioritizing problems, action planning, evaluation, mobilizing, and scaling up.

Findings

The CAC approach is participatory, vibrant, and empowering for communities. The project has used the Participatory Rural Appraisal method for social mapping in 286 village clusters covering 1,799 villages, identifying all households and resources (including community resource persons [CRPs]) in the villages. In 222 villages 458 CAGs have met to prioritize MNH problems using body mapping as a tool. The groups have usually identified convulsions, excessive bleeding, edema, prolonged labor, and abdominal pain as priority maternal problems. For newborns, they identified as priorities pneumonia, umbilical infection, and asphyxia.

Community mobilization seems to have effectively catalyzed the formation of male and female action groups. The groups have developed action plans to address problems; these include reopening three satellite clinics and one EPI center, notifying ACs of pregnancies and births, influencing religious leaders to include MNH messages in their Friday prayers, initiating savings funds, organizing emergency transport for obstetric complications, and building small bridges. Volunteers and natural leaders are emerging from the meetings as community resource persons who say that they will continue the CAC process even after the cycle ends.

Challenges

Experts involved in designing the detailed steps in the CAC should again review whether body mapping is the only way to identify problems or whether other techniques could be introduced. There is no disagreement that it has been effective in helping identify maternal and newborn danger signs, but other areas where the community can play a role, such as transport, finance, service availability, and the like, are societal rather than physiological. The partner NGOs may be able to help identify additional methods for identifying problems and action steps that would better engage participants.

While the CAC approach has been effective in mobilizing communities and most of the staff are positive about it, there is general agreement that it is a new concept that involves a long-drawn-out, complex, and intensive process that should be simplified for Sylhet. There is a sense among partner NGO managers who know the communities well that the process being used is foreign and is a cookie-cutter approach. The full cycle has taken 13 to 14 meetings over 12 months, resulting in very slow spread and coverage; the first cycle of community mobilization activities have been introduced in only 13 percent of villages (out of 1,827 total).

The meetings have produced a roll-out plan for CACs, but it will fall short of full coverage by the end of the project period—by June 2011, SMNC community mobilization will cover only 1,554 villages out of a total of 1,799. This scale-up plan is based on the assumption that the project will support each village for two years, the first year giving more intensive CM and CSM support and the second year focusing on coaching and mentoring, with only periodic advice given in the third year. The plan also suggests that more mature neighboring villages can coach newer villages and that existing structures, such as local government, should be tapped for budget support to sustain program activities. The SMNC staff are considering ways to accelerate the process by reducing the intensity and number of meetings. They have suggested, among other things, doubling the number of villages per CM from 6 to 12, reducing the number of meetings, using CRPs more actively, creating a plan for using "champion" villages for cross-learning between villages, and identifying benchmarks so that SMNC and the community would know when to leave a village.

The rolling out of this component needs careful planning to ensure adequate coverage in all villages within the project time frame. SMNC staff now have a considerable amount of experience on the feasibility of the approach within the sociocultural context of Sylhet. The experience from this and other programs in Bangladesh should be fed into a thorough review of the CAC process by SMNC staff and should involve facilitators and community participants. Involvement of staff and community will be critical to allow for local adaptations to foster more ownership so the process is not viewed as "foreign." This should lead to the design of a less intensive approach that is more user-friendly for both providers and community. The roll-out plan should also incorporate a targeting system that would be based on information from the baseline survey and other project data.

While natural leaders have emerged and are enthusiastic about continuing CAG meetings on their own, this is unlikely to happen unless there is a thoughtful and deliberate plan to ensure sustainability.

Recommendations

- Adapt the CAC approach so that it is less intensive, more user-friendly, and scalable. Develop the modified approach in consultation with partner NGOs and the community.
- Develop an exit and sustainability plan so the CAGs continue to function after project facilitators leave. Project staff have ideas on how to sustain the groups. One is to bring together community resource persons from several villages to organize satellite clinics

with funds raised and managed by the community. Such ideas should be shared at a strategic meeting among partner NGOs to discuss sustainability options and to develop a joint plan for implementation.

Objective 5: To increase stakeholder leadership, commitment, and action for these maternal and neonatal health approaches

The project has an advocacy component to achieve this objective that, according to the project proposal, has three functional areas: (a) get stakeholder support and commitment to community-based MNH activities; (b) facilitate Government of Bangladesh actions to resolve operational issues so that the project functions smoothly; and (c) sustain the project initiative and scale up the best practices to other areas.

Findings

The project implements advocacy activities at the community, district, and national levels. Male CMs organize advocacy meetings with representatives of elected local government. The first round of meetings was organized solely to orient the representatives on project goals and objectives. Since the project started the CMs have conducted such meetings at 51 of the 56 Unions covered by the project. These meetings were attended by the Union Parishad Chairmen and male and female members.

CMs also attend monthly meetings organized by the Chairman at the Union Parishad. In these meetings, CMs brief the representatives on major MNH problems that the CAGs have identified—problems faced by project staff working in the community—and seek their support and intervention in resolving the issues. During the field visit, the assessment team interviewed one Chairman who is not only well aware of project objectives and activities but also appreciative of SMNC community-based activities in his area, where government services are almost nonexistent. He confirmed that as he learns about health issues from the CM, he raises the issues for discussion at the monthly Upazilla Coordination Committee meeting.

At the Upazilla and district levels, the advocacy initiative started with orientation meetings attended by government health and administrative officials, religious leaders, and local elites. These meetings helped build awareness about project goals and objectives and establish linkages with health facilities and communities. Project staff attend Upazilla Coordination Meetings at the UHC every month. Participation in these meetings helps staff discuss operational issues and explore common ground for improving collaboration with the government health program.

The SMNC project does not have a structure of its own for national advocacy but works with other committees and working groups to build consensus on MNH issues and best practices and mobilize support for policy changes. The project has sponsored and organized visits for representatives from government, international organizations, and donors to showcase project activities as one approach to improving MNH. Project staff also organize periodic meetings with policy planners and national health officials to update them on SMNC activities and operational problems.

Advocacy with local government has benefited the project in several ways. Local government entities have given project staff a firm foot-hold from which to penetrate rural communities and continue their work without problems, including efforts to ensure a safe environment for female staff. Their support also indirectly helped improve acceptance of ACs and CSMs in the community. In many places Union Parishad facilities are used for TBA training and fortnightly meetings of the project staff. This is a good example of support for, and recognition of, project activities by elected representatives.

The advocacy work has also helped build an effective working relationship with government health workers at both Upazilla and Union levels. This has improved the referral linkage with government facilities. Government health workers attribute increased use of government facilities for MNH services to community-based demand generated by the project.

Challenges

The project proposal and work plan called for SMNC to create an integrated advocacy strategy and action plan. Because that was not done, the project could not implement advocacy activities in a systematic way. Although advocacy produced some good results, there seems to be no strategic link to coordinate activities implemented at the community, district, and national levels. Such a strategy is also essential for sustaining the initiative and scaling up best practices.

The major systemic problems with the government health system are shortage of manpower, lack of essential supplies, and poor quality of services. These problems are more acute in SMNC project areas. There are no UHCs and FWCs in 50 percent of the Unions covered by SMNC. The project has highlighted these issues in its advocacy meeting with government representatives at different levels. But these are large and complex issues, and it is unlikely that advocacy only at the local level will lead to improvement in this situation.

Recommendations

- The project should develop an integrated advocacy strategy and work plan. The strategy can be integrated into existing work plan documents rather than separate, but it should identify specific, realistic advocacy objectives for the project to achieve through community, district, and national advocacy.
- It should establish a District Coordination Committee based at Sylhet with representatives from government, NGOs, USAID, local government, and other local stakeholders. This committee would provide technical and operational guidance to SMNC activities.
- SMNC might consider supporting each Union Parishad in drawing up health plans, in discussion with the Chairman and Members. To encourage more involvement by elected officials and a closer relationship with the SMNC program, such plans can identify health objectives for the Union and how they will be achieved.

PROJECT MONITORING, SUPERVISION AND EVALUATION SYSTEMS

Project Monitoring System

The structured project monitoring system does a good job of tracking the details of intervention components. ACs keep separate registers to record married women of reproductive age and pregnancies; both are updated during quarterly surveillance visits to households. Basic

information related to antenatal and postnatal visits is recorded in separate formats and submitted regularly for data entry.

ACs also monitor coverage for selected elements daily for submission every two weeks. The CSM compiles these counts of AC performance manually, and then they go up the hierarchy of supervisory and data management systems.

The major and most interactive use of field data takes place during collection and compilation for the fortnightly meeting. Managers at the Upazilla and Sylhet levels also make limited use of reports. Items related to coverage and immediate compliance by the families (like delayed bathing) are often used to support decisions about, for instance, low-performing units and intensifying supervision inputs to help improve performance.

There are numerous indicators grouped by strategic objective and intermediate results. The main data sources for these are the household surveys and the MIS, which provides considerable information on households. The indicators used to monitor community mobilization seem manageable and focused.

Challenges

From the perspective of scalability, the project monitoring system seems cumbersome. It is obvious that not much effort has gone into tailoring the Projahnmo systems to create cost-effective, user-friendly, scalable project MIS. Every activity has a cost implication.

At the onset the SMNC program did have to adapt from the Projahnmo project systems that had proven to be effective. However, at this juncture, in order to design monitoring systems that can be scaled up, the team suggests that SMNC managers become more discriminating, collecting only the information needed for decision making at each level and simplifying the system as much as possible. There is a critical management trade-off between the cost of collecting and processing information and the benefit to the program from use of the information. In what follows, the team offers detailed suggestions that we hope will be useful to SMNC and USAID in future discussions.

The rationale behind accumulating a wide range of information for both AC and CM components needs careful review. Information processing is not tailored to actual use of, or need for, information for each level. For example, the detailed information collected through the Community Mobilization Meeting Record Form is of questionable value for anyone other than the community group itself. How does the Upazilla or Sylhet level process and use this huge amount of information? Is there adequate staffing for this purpose? Does the painstaking process of transferring records up the management chain help in managing the program? If the purpose is research to understand the dynamics of community mobilization, definitely the information would be valuable—but that is probably beyond the scope and capacity of the project.

Duplicate information is collected. For example, the indicator “pregnant women who had an antenatal check-up” is being collected by (i) the AC (during MNC2); (ii) the CAGs; (iii) the CSM during random visits; and (iv) the survey. If the objective of this piece of information is to facilitate and improve antenatal care-seeking, CAGs are using it to direct action in real time. The other three—ACs, CSMs, and survey—are collecting post facto information that can only be used for understanding coverage and that could be minimized and replaced by information provided by the CAGs.

Regular monitoring of outcome indicators like mortality does not always help managers, particularly at the Upazilla and lower levels. Overemphasis on neonatal or maternal mortality sometimes hinders field workers’ natural engagement with families and the quality of

intervention. Information on neonatal death in the MNC2 form and the review of every death seems redundant. The project proposal mentions monitoring a small number of meaningful indicators and urges that outcome indicators be collected through population-based surveys. SMNC management needs to work more toward that. Monitoring of ACs and CSMs should be concerned only with factors where ACs and CSMs have control of quantity, quality, and timing.

The monitoring indicators deal with coverage and immediate compliance, not quality of inputs. Supervision as currently designed is mainly concerned with the quality of AC counseling, which could very well be reflected in the indicators.

Recommendations

- The monitoring system should be reviewed for ways to make it less intensive. Even if current workers seem to be accustomed to the system, adding more program components would add further load. The time saved from redundant record keeping could be better used to improve human interactions.

  Ways to reduce intensity:

  - Eliminate FSOs as a layer for compilation and decision making if they are compiling information. Get all CSM reports directly to UTL and have all processing and stratification done there. Since the systems are automated, periodic reports can be generated for FSOs.

  - Eliminate the whole range of compliance information (items F to O in the MNC2 form) except the details USAID/Bangladesh needs for mandatory reporting to USAID/Washington. A detailed form can be filled in by a CSM during random visits. If information on two newborn families per AC is collected monthly and averaged, that would provide a solid estimate for the monitoring and evaluation (M&E) manager to monitor how the project is performing in terms of family compliance with messages delivered by ACs.

  - To serve the result indicators related to CAGs, substitute a simple register (kept and maintained preferably by a CRP) for the detailed meeting record form. Instead of transmitting the whole form, the CSM or CM concerned can pass on a simple slip containing the pieces of information required for the indicator.

  - Reduce the AC fortnightly reporting form to coverage indicators only (drop the entire J section). Let CSMs and ACs mainly deal with coverage and quality of inputs. This will save SC much of the manual processing of fortnightly reports. Having CSMs collect compliance information from a sample of households would be more independent.

  - If MNC forms are entered into the computer, explore replacing fortnightly reporting forms with automated reports generated by ACs and supplied to the CSMs—recognizing that such reports may indicate performance from a few weeks previous.

- Consider defining input and process indicators for each level of monitoring. Specifying indicators by level will help minimize the burden at each level.

- Establish systems for prospective tracking of performance by worker. Using a combination of coverage data from the fortnightly meetings and data on quality of intervention from supervisors should allow for continuous assessment of AC performance.

- Integrate information on quality of interventions collected through on-site observation with fortnightly reporting of coverage so that a worker is assessed on both quality and coverage. Currently two distinct information streams are running in parallel.
- Adjust program components, strategies, and their arrangement in recognition of the fact that that is the only way most of the recommendations in this section can be implemented. These recommendations should be seen in relation to those cited earlier in order to make organization of the program more efficient.

Supervision

CSMs and other supervisors observe a substantial proportion of AC visits; these are scored and on-site feedback is provided to the ACs. Supervisors also make independent visits to households to evaluate the effectiveness of AC counseling by checking client knowledge retention and immediate compliance. CSMs use structured checklists custom-designed for each AC component (there are about 10 different checklists). Summaries of these are shared during the fortnightly interactions between the CSM and ACs.

Challenges

Checklists definitely help supervisors to more meticulously monitor the interaction of ACs with families, but recording scores for every item during every visit may not be necessary. There is not much use of the scores at any level. Written comments at the bottom of the checklists do not necessarily require scoring and recording. The quality ratings at the end of scoring could be made based on the CSM's subjective assessment.

Paper-heavy supervision over time tends to be insensitive to variations in quality of work. At some point CSMs may start being normative in rating and protective of those they supervise. Managers should be alert to determine whether the quality rating matches other performance indicators.

Recommendations

- Transform the process immediately to a monthly cycle; fortnightly meetings are too intensive for this program.
- Reduce the number and size of supervisory checklists, taking out item-wise scoring.
- Use checklists only for a sample of visits.
- Use quality ratings at the level of FSO or UTL to track individual performances and target refresher training or orientation. Build capacity at the CSM, FSO and UTL levels to categorize staff by quality of work and respond as needed. Quality ratings should be matched with other performance indicators.

Evaluation

Evaluation of the project in terms of MNH outcomes and impacts is designed to be a pre/post method based on household surveys. While the surveys will be designed to provide neonatal mortality rates for the entire project area, estimates for knowledge, practice, and coverage (KPC) would be available at the Union level. Inclusion of a comparison area at the baseline allows for concurrent comparison accounting for trends in Bangladesh. There is a plan for a mid-term mini-survey in the project proposal.

Challenges

Completion of the baseline survey, scheduled in the work plan for January 2007, was delayed by more than 12 months because of indecision at different levels about the legal implications[7] of involving ICDDR,B in project evaluation; changes in the scope and methodology of the survey; and delay in acquiring ethical clearances. Flood and two Eid holidays further stretched the data collection period. To some extent project interventions were also delayed waiting for the baseline survey. The survey was completed in January 2008, but as of mid-March only a few draft KPC tables (Upazilla and area level) were available to the team, and mortality estimates have yet to be shared officially. As a result, the project team had to develop implementation plans without area-specific information. Targeting the underserved and low performers and adopting a variable approach as planned would have been possible had the baseline results been available on time.

There are concerns among project managers about ICDDR,B's adherence to the agreed schedule for deliverables and accomplishments and for updating progress. On several occasions, concerted efforts had to be made to gather information or to receive technical assistance.

The baseline survey seems to be showing a much lower rate of neonatal mortality in both project and control sites than would be expected based on preliminary DHS and Projahnmo data shared informally. The team strongly recommends that the project ask ICDDR,B to conduct a thorough analysis of the mortality data by possible covariates, confounders, and effect modifiers; and completely verify data quality and consistency at field and entry level.

Recommendations

- The baseline findings should be thoroughly analyzed immediately. Union KPC estimates should be used to prioritize areas for community mobilization. Levels of community practices and behavior should be taken into consideration using a tailored approach to intervention strategy and intensity.
- In choosing the first group of 222 villages to start community mobilization activities, four criteria were used: availability of health facilities, communication to health facilities, existing NGO or community groups, and notional feeling about service utilization. Villages were grouped into "champion" and "disadvantaged" villages. Now that the baseline estimates are available and can provide information for the Union level, information on background characteristics and community practices should be extensively used to prioritize choices for the second-phase roll-out.
- A review of the baseline survey results on neonatal mortality should be requested to determine whether there were methodological or data quality problems that explain the extremely low rate reported.
- The project team needs to revisit the decision about a mid-term mini-survey. Intervention components at the Union level can be adjusted based on the KPC estimates from baseline survey. If an end-of-project survey is done in the last six months of 2011, a mid-term survey in during 2009 to provide overall or Upazilla-level estimates may not be helpful.
- As survey data are collected in future, it would be helpful to arrange for ICDDR,B to periodically brief SC and the USAID mission on the progress of implementation and on summary findings from the built-in continuous independent data quality assurance system.

[7] Because ICDDR,B declined to sign the Mexico City policy, legal opinions were sought about proceeding with the contract.

EMERGING BEST PRACTICES

This section is entitled "emerging" best practices because it is too early in the project to be categorical about best practices, especially if an evidence-based approach is taken to identify those practices. Nevertheless, several areas are showing real promise of eventually becoming demonstrable best practices.

1. **Community Action Groups (CAGs):** The experience with the CAGs in this project has been very promising. They seem to represent a powerful model to stimulate collective action and support for MNH programs. Some have even been able to mobilize community resources to finance emergency transportation for complicated deliveries or other needs. The men's groups have been surprisingly engaged and interested. Natural leaders are emerging who are being targeted to lead future efforts with less intensive participation by project staff.

2. **ACCESS Counselors (ACs**): SMNC has been able to demonstrate that young, minimally skilled, community counselors can be effective in bringing about behavior change in newborn care at home and increasing demand for MNH services. It might be expected that young, often single, women would not have much credibility and might have difficulty working with mothers and TBAs. ACs, however, are clearly accepted, their messages are received eagerly, and behaviors are clearly beginning to change. The tool kit of teaching aids and professional material may add to their credibility and stature.

3. **Advocacy model:** SMNC's extensive consultations with stakeholders before initiating the program has reaped clear benefits in rapid uptake of the program. Communities, local elected leaders, and health officials have shown no resistance; welcomed field workers; and otherwise demonstrated considerable support for the work. Within a relatively short time, work has got well underway in seven Upazillas with a population of about 1.6 million people. That is quite an achievement.

4. **Program management system**: The systems established for this project are truly remarkable. There have been a regimented series of steps followed, many of them based on experience from Projahnmo, for organizing and carrying out the work. The extensive exercises for mapping households and community resources gave field workers the framework for organizing and distributing the workload among SMNC field staff. Acquiring detailed knowledge of communities before undertaking any program interventions was highly beneficial. Procedures are being followed to organize the work day by day (e.g., the monthly calendar of activities) as a way of holding field workers accountable for their time. Supervision systems have been worked out to oversee activities and assess which field workers and communities need special attention. Data collection is more like a research project than a typical program.

V. ASSESSMENT OF INSTITUTIONAL AND MANAGEMENT ISSUES

Most of the emphasis in this assessment of the SMNC project has been on technical and strategic issues, but the team also looked at institutional relationships. Because the SMNC and the Global ACCESS programs both involve a consortium of organizations, the team looked at whether any aspects of the institutional relationships affected project implementation. The team also examined working relationships between the project and both national and local government, given the importance of SMNC as a pilot activity within a substantial national effort to improve newborn health involving many players. The team also examined USAID's relationship with the project.

JHPIEGO, SC/BANGLADESH, AND NGOS IN SYLHET

Findings

In general, the relationship between the Washington-based ACCESS project and the SMNC program in Bangladesh seems to be productive. SC and its local NGO partners are the primary implementing organizations, with mainly technical support coming from JHPIEGO and SC. Inputs from both were said to be timely and of high quality.

The team did, however, encounter issues that need attention related to how SC works with its two NGO partners in Sylhet. While on the surface working relationships seem cordial, problems arise from a perception that SC is too directive the about strategies and methodologies employed by the project. NGO partners do not always feel that the considerable expertise they bring to community work in the district is adequately valued or used. They also feel that there is not much genuine consultation on project strategies.

Such problems are exacerbated by the fact that SC, Shimantik, and FIVDB all have separate offices at the Sylhet district level. It might improve communications if all three partners were co-located, though that also introduces some risks:

- If staff from FIVDB and Shimantik are pulled out of their normal environment to work in an SC office set up only for project management purposes, it might create an artificial environment and interfere with enhancement of partner NGO capacity.
- It is not reasonable to suggest that SC have no office in Sylhet, since most of the project staff and operations are located there. It would not be wise to try to manage from Dhaka, especially because enhancing the technical capacity of the partner NGOs in newborn health is a large part of the mandate.
- Because for USAID this project is designed to test the feasibility of scaling up an intervention, the amount of M&E required is such that SC, as the organization USAID holds directly responsible, must be highly engaged in field activities.

Recommendations

Clearly SC needs to concern itself more with how to ensure partner ownership of project activities, for two reasons:

- The NGOs are local entities that can continue newborn health programs in the future. It is important that SC build and support their capacity technically and managerially; as a partner in the global ACCESS project, SC has substantial capacity and technical expertise. SC staff need to view themselves as technical and managerial back-up to the

NGOs as front-line implementers and over time lessen the degree of management intervention. Explaining the project in these terms to external visitors and giving the NGOs credit publicly would be one manifestation of this approach.

- The NGOs do in fact have community development expertise that SC lacks and that the project could benefit from. Though they took part in the workshop held to design program strategy, they do not feel as engaged as they should be on day-to-day strategic decisions. SC staff need to explore how that expertise can be used to respond the challenge of accelerating the CAC and ensuring that the pace of community mobilization picks up. Explicit consultations on this subject would be beneficial, particularly through the meetings of senior SC and NGO staff recommended earlier in this report.

NATIONAL MOH/FW, SYLHET LOCAL GOVERNMENT, OTHER PARTNERS

Findings

SMNC staff, and SC staff in general, seem to have a productive working relationship with national Ministry of Health Family Welfare officials on MNH matters. SMNC staff sit on the National Newborn Strategy Development Committee and its five subcommittees to provide advice and help draft government policy advisory documents. At the Sylhet district and Upazilla levels, staff from both SC and especially the two implementing partner NGOs are well received and collaboration is productive, although limited by the fact that the project does not provide much in the way of improvements in service delivery at the facility level. SMNC staff also interact regularly and productively with a range of other stakeholders, including technical staff from other donors (UNICEF, UNFPA, WHO, and DFID) and other NGO partners, such as BRAC.

USAID/BANGLADESH

Findings

Working relationships between USAID and the project appear to be excellent. Because the current SMNC project is funded through field support, its management and administration are simplified for USAID/Bangladesh. However, as part of the global ACCESS project, SMNC reports to USAID through JHPIEGO headquarters and reporting is therefore less frequent and timely than would be the case with a bilateral project. If future work is organized as an associate award, arrangements need to be made to ensure that USAID receives regular and timely reports.

Recommendation

- USAID would benefit from receiving quarterly reports, particularly reports on the indicators they need for their own monitoring and oversight responsibilities.

VI. SUSTAINABILITY AND SCALE-UP

FINDINGS AND CHALLENGES

Sustainability: In its original program description,[8] USAID called for the recipient organization to draft a sustainability plan for the project. While this has yet to be done, SMNC staff are thinking about the issue and making plans for further discussion with partner NGOs.

Looking at issues of sustainability implies action at several levels.

Community

The community mobilization component offers the best platform for sustaining efforts at changing household behavior related to caring for the newborn. Action cycles run by the CAGs, with facilitation from the project, are likely to empower communities so that they can work together to improve MNH. These CAGs may, however, evolve over time. Here are some points to consider:

- CAGs may not need to meet regularly but could be activated over the long term when stimulated by a problem situation. They can also be used for community work beyond MNH, addressing other development problems, or be attached to other programs, such as microcredit, which is common in Bangladesh.
- CAGs that have generated their own funds may have better group bonding and ownership. The funds might be used to address problems beyond MNH or to hire community health or outreach workers.
- The involvement of Union Parishads in drawing up health plans and setting objectives would also help elicit support from elected officials for CAGs and their work in each community.
- Partner NGOs might continue to give minimum support to the CAGs, such as (i) providing technical updates from national programs; (ii) acting as liaisons with the government and other NGOs and projects; and (iii) functioning as a hub for networking between CAGs to facilitate cross-learning.
- ACs are currently an important community resource. These young women over time could acquire multipurpose skills to survive in the rural health care market, equipping them for recruitment as Government of Bangladesh providers like the FWA, community SBA, HA, or FWV; NGO paramedics; or SBA or private practitioner as village doctors (both providing health care and selling drugs and commodities). Partner NGOs might consider an organizational role in such a process by (i) providing market-oriented training; (ii) providing small business loans, and (iii) facilitating employment through their own networks and linkages.

[8] *Safe Motherhood and Newborn Care Activity: Draft Description of Program.*

NGOs

Both Shimantik and FIVDB have already given some thought to what will happen to their current MNH program once USAID funding is no longer available. Shimantik is planning to create a paramedic training program in Sylhet and may try to encourage ACs and other competent staff currently working on SMNC activities to acquire skills that could enable them to continue similar work in the community on a fee-for-service basis. As an experienced health NGO implementing the USAID SSFP project and the ADB-funded Urban Health Project, Shimantik is well-positioned to compete for funding through the joint UN MNH program. FIVDB also has support from a number of donors and has thought about how elements of the SMNC program, particularly those related to community mobilization, could be incorporated into its microcredit and livelihood programs.

Because both NGOs are running the SMNC program largely with staff hired for that purpose, they will both need to think carefully and strategically about whether MNH activities should continue on as a core part of their mandate, and plan accordingly.

National Scale-Up and Synergy with Other Programs

One of the most critical challenges confronting the project at this stage is to demonstrate that it is functioning as a cost-effective and feasible model for scaling up newborn programs in Bangladesh. The environment is ready. There now appears to be widespread recognition by government leaders and development partners of the importance of newborn health and how it affects the country's high neonatal mortality rate. Substantial resources are available for both government and NGO programs to expand in this area. The SMNC project is poised to provide practical, programmatic lessons on how to expand MNH programs and achieve results without the intensive inputs typical of research or pilot projects.

The SMNC program is currently implementing a hybrid version of Projahnmo and the Nepal/Bolivia programs in a larger population. Preparing communities and rolling out the project was very well done. The program was introduced in the entire area using a pre-determined approach with almost no variations. Two possible weaknesses, however, are

- Inadequate conceptual integration of the household and community mobilization components, and
- Lack of customizing to suit variations in community practices, social constructs, and the availability of supportive health care.

Research has already proven the efficacy of the interventions. Programs in Bangladesh and in other developing countries would benefit greatly if a cost-effective, sustainable model can be demonstrated. Again, the current model needs continuous refining during the remainder of the project to transform it into a readily scalable model. Extensive documentation of processes is an

important project initiative; now, technology transfer to enable partner NGOs to do their own documentation is necessary.

There are several national opportunities for consideration of lessons from SMNC. The maternal, neonatal, and child health programs planned by the government, several UN agencies, and NGOs are targeting almost two-thirds of the districts in the country. Of these three new projects, at least one could directly benefit from a synergistic relationship with the SMNC program. The Joint UN Maternal and Newborn project is a $31.2 million five-year project (2007–12) funded by DFID and the European Commission. The project aims to reduce maternal and newborn mortality in 20 districts through four components: (1) district and subdistrict-level planning; (2) increased availability of MNH services; (3) increased demand for services; and (4) increased equity, participation, and accountability. The project will contract out community support activities to NGOs, for which the SMNC model for improving home-based practices and increasing service utilization would be relevant.

Within the USAID Portfolio

There are promising opportunities for other USAID activities to link with the SMNC project and even scale up some elements of it.

Social Marketing Company (SMC)

SMC has implemented a pilot project, Shukh Pakhi, to introduce healthy timing and spacing of pregnancy in Maulvibajar. It plans to expand the program into Chittagong and Sylhet in April 2008. This program will include promotion of birth spacing messages and social marketing of contraceptives. Since messages about birth spacing and postpartum family planning are clearly needed in the SMNC program area, the Shukh Pakhi would be a good link for SMNC.

SMC is about to launch a one-year pilot project in Barisal district that will train village doctors to promote maternal and newborn messages and to identify and refer complicated cases to health facilities, public or private. It will work with Integrated Rural Activation and Promotion Ltd., which will conduct two or three meetings in each village targeted primarily to adolescents, newlyweds, and pregnant women and secondarily to influencers like in-laws. The intent is to increase awareness and generate demand for both Blue Star and public providers. The project has three components: orientation of TBAs about clean delivery and referral; orientation of drug sellers about over-the-counter messages on MNH; and building the capacity of Blue Star member village doctors.

The last component is the strongest: village doctors will be given basic ANC equipment (weighing scale, urine test supplies) and training on antenatal and postnatal care and identification and referral of sick newborns. The potential is huge: the Blue Star network has 3,600 village doctors. SMC's baseline survey of village doctors in 2006 found that 94 percent provide ANC services, 46 percent provide postnatal services; and 30 percent deliver babies.

Smiling Sun Franchise Program (SSFP)

As noted earlier, the SSFP/Shimantik clinics demonstrated increased clientele and cost recovery (from 16 percent to 23 percent in less than a year) due to increased care seeking and demand generated by the SMNC program. Since a major objective of SSFP is to increase cost recovery, the SMNC model of demand generation should be reviewed, adapted, and replicated using the SSFP community structure (service promoter, depot holder, community resource persons).

Since SMNC plans to orient village doctors, the two programs should share the curriculum and other materials, tools, and lessons. UNICEF's curriculum for the government village doctor program can also be used.

Recommendations

- SMNC should advocate for replication of its model and share its experience with the NGOs that will implement community support systems in the UN program. SMNC's three partner NGOs should be members of the MNH Forum that the Joint UN program will set up. They should also be included in existing working groups dealing with maternal and newborn health issues.

- A senior management forum to discuss sustainability needs to be organized and meet regularly. NGOs should be encouraged to work with other partners and provide technical and financial support for developing and implementing sustainability plans and strategies. An institution-building management expert would be a helpful addition to the forum.

- Whatever sustainability model is finally developed, partner NGOs must begin to frame and act on those ideas starting immediately. Partner NGOs have very rich experiences in areas that can help integrate the program for greater sustainability. FIVDB's integrated financial service program (female credit groups with 98 percent repayment rates) and livelihood enhancement program (technical marketing support for small-scale income-generating initiatives) and Shimantik's clinics and maternities run through SSFP and the ADB-funded Urban Primary Health Care Program (cost recovery through revenue generation to keep a safety net for the poor) are examples of programs where synergy with ACCESS components might lead to sustainable models. The ACCESS capacity-building plan for partner NGOs should consider strategic and social business planning as priority areas.

- Investment in CRPs must be carefully planned. The communities should be encouraged to select CRPs from a variety of backgrounds: natural leaders, TBAs, and formal or informal service providers, for instance. If possible, their capacity can be built while they are running the CACs—let them take the lead in planning and conducting activities. Encourage ideas and let the more mature groups evolve in their own way.

VII. LESSONS LEARNED

The following summarizes lessons learned that were mentioned by project staff and observations from assessment team members:

- *Effectiveness and acceptability of young single women in newborn care*: Many have been surprised at how easily the ACs, who are young and usually single, have been accepted as credible in such a conservative rural society. Often they are advising women who have had five or six children, or are trying to change the behavior of TBAs who are much older and highly experienced. Project staff attribute their acceptance to careful community preparation; the tool kit of teaching materials, which gives them an aura of professionalism; and their supportive counseling style. Furthermore, ACs do not compete with the TBAs because they do not perform deliveries.

- *Rapid change is possible even in conservative, remote regions*: Many project planners and managers assumed that change would come very slowly and with great difficulty in areas of Sylhet that are more remote and socially conservative. This has not proven to be the case. The project MIS show that the uptake of some behavior changes has been rapid (e.g., delaying bathing of the newborn, not applying anything to the umbilical stump, wrapping, and immediate breastfeeding). Often women also ask for birth spacing messages and supplies, reinforcing the need to strengthen the family planning content of the program.

- *Community mobilization is easier in the poorest areas:* Interestingly, project staff report that the poorer the community, the easier it is to engage its members in the community action cycle process. This may be a result of a shared recognition of the need to address poor health conditions in their communities. Maternal and infant deaths are highly visible and affect the entire community, not just the family. Surprisingly, in some cases the enthusiasm for collective action has expressed itself in initiatives on their own to collect money for emergencies and other activities.

- *Male community action groups are very involved:* SMNC staff reported, and the team observed, a surprising amount of enthusiasm and involvement by male community action groups. Because the issues dealt with in this project are traditionally "women's problems," this too was unexpected. The male groups identify solutions to problems and monitor progress of the community plans, activities that seem to suit them well.

- *Local government entities have been highly interested:* The SMNC project rarely deals directly with government entities, although they were consulted and involved in preparation and advocacy when the project was being launched. Yet staff report that government health staff, members of Union Councils, and others show considerable interest and willingness to support project efforts. Health officials seem to recognize the value of the demand SMNC is generating for government services.

- *Cultural taboos are still operative:* One of the cultural practices the project has not changed is the reluctance of mothers to leave home with the newborn to seek postnatal care and immunizations. Part of this reluctance is undoubtedly related to the fact that services are often not readily accessible in the areas where SNMC works because of staff vacancies and other problems that plague the government health system. Part, however, is the traditional prohibition against taking a newborn out of the house within 40 days of birth. Postnatal visits by the ACs, however, have been widely accepted. The lesson for

the project is that services must be brought to the household if there is to be an uptake of those interventions. This is an area where SMNC needs the help of local government officials in finding solutions.

- *Partner NGOs need to be more assertive and proactive in program formulation:* There are a number of reasons why partner NGO ownership of the SMNC program is not optimal. The fact that most of the staff working on this activity were hired only when the project began contributes to difficulties in exploiting the institutional expertise of the NGO itself. All parties need to find a way of increasing partner NGO ownership; the NGOs themselves must be proactive. Clearly, while the team is not advocating major deviation from the basic strategic approach of the project, processes for mobilizing communities and assuring the sustainability of program interventions are areas where the NGOs should have much to offer. Senior NGO leaders need to become more engaged and more proactive in the process of thinking through their long-term strategic plans in maternal and newborn health and the role their organizations can ultimately play.

- *The balance of technical and managerial support needs constant monitoring:* SC, as the principal partner of the ACCESS program in Bangladesh, is responsible to USAID for implementation of SMNC. Its staff provide technical expertise and support to the NGOs that are the front-line implementers of the project. At the same time, to meet project timetables and ensure that work proceeds as planned, it has set up managerial procedures to help ensure that the work gets done. The NGO supervisors must then ensure that they manage their employees to meet those expectations. There were some complaints that SC staff go beyond their technical and programmatic support role and get more involved in administrative and personnel details than they should. SC staff, on the other hand, feel that if NGO managerial weaknesses are not addressed, they will interfere with project implementation. These challenges are typical of projects that require a partnership of several institutions. While the issues are unlikely to disappear, it is to be hoped that over time the capacity of NGO managers will grow and SC staff will be more willing to give them space to manage without interference.

VIII. SUMMARY OF KEY RECOMMENDATIONS

Each section of this report gives detailed recommendations. This section summarizes the most important to facilitate discussion and action.

PROGRAMMATIC/STRATEGIC/MANAGEMENT

- **Extend the project to September 2011** to provide enough time and field experience for SMNC to make a significant contribution to learning about the best approach to scaling up maternal and newborn health programs in Bangladesh.
- **Refine the maternal and newborn health model** the project is using to (1) better integrate the community mobilization and household behavior change components; (2) allow flexibility for modification to suit local conditions; and (3) streamline it to improve replicability. The most important SMNC contribution to Bangladesh at the end of five years would be a cost-effective and manageable MNH model.
- **Expand and improve the services provided by SMNC:** (1) Include more on family planning. (2) Enhance field workers' counseling skills and further train them in how to assess, identify, and refer newborns for infections and enhance their counseling skills. (3) Expand to new areas, such as use of misoprostol to prevent postpartum hemorrhage as that program is expanded nationally.
- **Adapt the Community Action Cycle** process to allow for accelerated expansion with less intensive staff inputs and to, the extent feasible, implement plans for using community leaders to take over.
- **Modify the monitoring and evaluation system** to simplify it, reduce duplication, and improve use of the information it generates; use the baseline information to help refine and tailor the MNH model to local conditions; cancel the mid-term mini-survey; and commission an external review of the neonatal mortality data generated by the baseline survey.

INSTITUTIONAL SUSTAINABILITY

- **Work with partner NGOs to formulate capacity development and sustainability plans** that will ensure that the project can contribute in practical and measurable ways to strengthen their technical and managerial capacity. Over the long term this will help assure that the kind of activities they are conducting in this project will not disappear when USAID funding ends.
- **Reinforce NGO ownership and strategic involvement** in the project by holding regular senior leadership consultative meetings and working together to solve problems.
- **Develop an explicit advocacy strategy** that identifies realistic objectives that the project wants to achieve through community, district, and national advocacy. That means working at the district level with members of local government, health officials, and other stakeholders to form coordinating committees or draft health plans that engage all of them in helping to solve problems related to maternal and newborn health services.

SCALING UP

- **Work actively with government and development partners** to disseminate lessons from SMNC that benefit all those engaged in maternal and newborn health work; continue engagement through the National Newborn Strategy Development Committee and other structures that can affect policy to ensure that the SMNC experience contributes to learning about the best MNH model for the country.
- **Proactively link SMNC with the new UN Joint MNH programs** to foster sharing of experience and lessons learned.
- **Seek opportunities to expand MNH activities within the USAID health portfolio** through projects like the SSFP and the SCM to explore scaling up MNH work through nongovernmental mechanisms.

ANNEXES

ANNEX 1: SCOPE OF WORK

ANNEX 2: LIST OF DOCUMENTS

ANNEX 3: LIST OF SITES VISITED AND PEOPLE INTERVIEWED

ANNEX 4: SUMMARY DESCRIPTION OF THE PROJAHNMO PROJECT

ANNEX 1: SCOPE OF WORK

Bangladesh: Safe Motherhood and Newborn Care (SMNC) Project Assessment
Global Health Technical Assistance Project
GH Tech
Contract No. GHS-I-00-05-00005-00
(GH Tech Comments/Suggestions)
(01-25-08)

PROJECT TO BE ASSESSED

Safe Motherhood and Newborn Care (SMNC) Project is a field support project funded through the global Access to Clinical and Community Maternal, Neonatal, and Women's Health Services (ACCESS) Leader with Associate (LWA) Cooperative Agreement No GHS-A-00-04-00002-00. The ACCESS cooperative agreement was signed in July 2004 and the current project end-date is July 30, 2009. JHPIEGO is the prime recipient. Save the Children USA implements the project in Bangladesh in partnership with two local nongovernmental organizations (NGOs), Shimantik and Friends in Village Development (FIVDB). The project covers seven Upazillas (sub-districts) in the Sylhet district with a total population of approximately 1.5 million.

The local Mission approved the SMNC project for three years starting February 1, 2006, and ending January 30, 2009. USAID/Bangladesh Population, Health and Nutrition Team (PHN) intends to support a follow-on activity to continue the project interventions for approximately another three years up to September 30, 2011.

The Mission expects to have this assessment completed as soon as possible, preferably by March 31, 2008.

SMNC PROJECT BACKGROUND

The overall objective of this program is to promote healthy maternal and newborn care practices in a sustainable and potentially scalable manner and generate utilization of relevant services from the existing health facilities. The primary focus of the project is to build awareness about healthy maternal and newborn care practices leading to increased number of women who will have:

- Made four antenatal visits during pregnancy
- Received two doses of tetanus toxoid
- Recognized and sought care for maternal and newborn complications
- Received adequate nutrition during pregnancy, including iron and folate supplements
- Used clean delivery practices
- Practiced prompt wrapping and drying of the newborn
- Initiated immediate and exclusive breastfeeding
- Delayed bathing of the newborn
- Practiced clean cord care

- Practiced immediate and exclusive breastfeeding and giving colostrum and no other foods

Modeled on Projahnmo I, a community-based neonatal health program funded by USAID and Save the Children's Saving Newborn Lives Initiative, the strategic focus of ACCESS Bangladesh project is on behavior change and community mobilization. For every 5,000 population, the project has one trained counselor who visits each pregnant woman four times: twice during pregnancy; once within the first 3 days, preferably 24 hours after childbirth; and once from five to seven days post delivery. During the first two visits the ACCESS Counselor (AC) provides the mother-to-be and family members, or other support persons, critical information about safe delivery and healthy outcome for mother and baby. The last two visits provide information and support to ensure that both mother and baby get the necessary preventive and, when needed, appropriate curative care for them to survive.

The Community Mobilization (CM) component works with both male and female groups to build their capacity and encourage their participation in supporting, facilitating, and eventually sustaining the project initiatives. These community groups are expected to support and facilitate the work of the counselors, identify community needs for maternal and newborn health care, and plan and implement actions to improve project coverage, availability, and utilization of services.

Recently, USAID Bangladesh improved some complementary activities to enhance the effectiveness of the intervention. The activities have been included in the current year's work plan and implementation is expected to be completed by end of September 2008. The activities are:

1. Community-base Kangaroo Mother Care (CKMC): This will be a part of the counseling package for home-based preventive care to improve health outcomes of low birth weight babies.

2. Training of TBAs and Orientation of Village Doctors: A selected number of TBAs from the project areas will be trained with focus on to reduce harmful practices, ensure clean delivery, increase timely and appropriate referral, and increase knowledge and practice of basic obstetric and newborn care.

3. Technical and clinical skills training on essential obstetric and newborn care: This training will be organized for the Sub-Assistant Community Medical Officers (SACMOs) and Family Welfare Visitors (FWVs) who provide maternal and newborn care services from the Family Welfare Centers (FWCs), the first referral point for the ACCESS project.

4. Technical updates of service providers at Upazilla (Sub-district) Health Complex: This will focus on knowledge update for medical doctors, nurses, and FWVs.

PURPOSE OF THE ASSESSMENT AND KEY ASSESSMENT QUESTIONS

The purpose of the proposed assessment is to assess progress made by the SMNC project toward achieving results and accomplishments to date and provide lessons learnt and recommend changes necessary to improve the intervention. The project is at the early stage of its implementation. However, the PHN Team considers that an independent external assessment of the project will be expedient to guide management decisions for designing a follow-on project that would better serve the Mission's purpose to achieve project objectives in future.

The assessment team will address the following objectives for the purpose of this assessment:

1. Assess overall progress and achievements in relation to the expected results of the project to date.
    a. What project interventions have accomplished the expected results? Which interventions are on the pathway to accomplish intended results? Which have failed to meet expected targets?
        i. Has the counseling approach used by the project to make desired behavior changes and achieve optimum coverage of pregnant women been effective? If not, why not?
        ii. Has the community mobilization approach been effective and adequate to achieve the intended results? If not, why not?
        iii. Has the project's monitoring and supervision system been effective in improving project performance in a timely manner? If not, why not?
        iv. What have been the major constraints to accomplishing the expected project results?
        v. What have been the project's major accomplishments?
    b. Have there been unexpected accomplishments as a result of the project's interventions?
    c. What have been the lessons learned from implementation of the project?
    d. What best practices have evolved from the project's intervention?
2. Recommend changes, if any, in the project approach or interventions for improving and strengthening the project.
    a. What project interventions should be continued or scaled-up in a follow-on project? Why? Which interventions should not be continued? Why?

STATEMENT OF WORK AND ASSESSMENT METHOD

The following steps for the assessment are proposed:

- Review program documents, including the program proposals, annual work plans and annual reports, technical and training materials, and the baseline survey (list and documents to be provided by the Mission).
- Engage in a one-day Team Planning Meeting (TPM) to discuss the assessment scope of work; agree on team member roles and responsibilities; clarify the assessment expectations of USAID; draft an assessment work plan; decide on methodology; develop tools/interview guides that will be used by the team for key informant interviews and focus group discussions (FGDs); and draft a report outline.
- Meet with USAID/B, ACCESS HQ, and ACCESS Bangladesh teams prior to visiting Sylhet.
- Conduct field visit in Sylhet and meet with SC, FIVDB, Shimantek, and ICDDRB staff.

- Conduct interviews with key informants from implementing partners, USAID, the Bangladesh Government, and selected community representatives.
- Conduct FGDs with pregnant women and male and female community members involved in community mobilization.
- Prepare a presentation and debrief USAID/Bangladesh, ACCESS Bangladesh, and ACCESS HQ and partners with main findings and recommendations.
- Prepare a draft report for the Mission before departure from the country.
- Prepare a final report with an executive summary that includes main findings, conclusions, and recommendations for program improvements.

DELIVERABLES

1. An assessment work plan and timeline
2. A detailed report outline
3. Questionnaire/guideline for conducting key informant interview and FGD
4. A PowerPoint presentation for debriefing, summarizing findings, conclusions and recommendations, and debriefing(s) to USAID, ACCESS Bangladesh, and ACCESS HQ and partners to share main findings and recommendations.

   A draft report of the findings and recommendations shall be submitted to USAID prior to departure from Bangladesh.
5. Based on preliminary feedback on the draft report from USAID, the final unedited content will be prepared and submitted within two weeks of receiving USAID feedback. GH Tech will provide the edited and formatted final document approximately 30 days after USAID provides final approval of the content. The report will not be longer than 30 pages total, excluding Annexes. GH Tech will provide five printed and an electronic file. GH Tech will make the results of its evaluations public on the Development Experience Clearinghouse and on its project Web site.

TEAM COMPOSITION

The assessment team should be comprised of five team members:

1. An expatriate who will act as the Team Leader/Maternal-Neonatal Health Expert;
2. A Local Technical Consultant (e.g., BCC/community participation expertise, if possible);
3. An Administrative/Logistics Assistant;
4. A Newborn Technical Advisor from USAID/Global Health Bureau; and
5. The Activity Manager of the ACCESS Bangladesh project (as determined by the USAID/Bangladesh Mission).

The independent consultants should have the following mixture of expertise and experiences:

1. Advanced degree in public health or related discipline;
2. Previous experience assessing/evaluating USAID-funded programs;

3. Minimum of 10 years experience in public health, with significant concentration in maternal and child health;
4. Program planning, assessment/evaluation, and design experience;
5. Experience managing and/or working with USAID-funded projects;
6. Experience in behavior communication change (BCC) and community mobilization; and
7. Excellent writing skills.

The Team Leader will be responsible for overall management of the assessment, including coordinating and packaging the deliverables in consultation with the other team members. In addition to the technical responsibilities outlined in the scope of work for the assignment, team leader responsibilities include:

Preparations

1. Finalize and negotiate with client for the team work plan for the assignment.
2. Establish assignment roles, responsibilities, and tasks for each team member.
3. Ensure that the logistics arrangements in the field are complete.

Management

1. Facilitate the Team Planning Meeting or work with a facilitator to set the agenda and other elements of the TPM.
2. Take the lead on preparing, coordinating team member input, submitting, revising, and finalizing the assignment report.
3. Manage the process of report writing.
4. Manage team coordination meetings in the field.
5. Coordinate the workflow and tasks and ensure that team members are working to schedule.
6. Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

Communications

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

Direction

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

The Local Technical Consultant, the Administrative/Logistics Assistant, the USAID Newborn Health Expert, and the ACCESS Activity Manager will serve under the Team Leader. Duties will be determined in consultation with the Team Leader, but are likely to include: conducting and documenting interviews with potential and current permanent and long-term methods (PLTM) clients, PLTM service providers, and other key informants; providing translation services as necessary for Team Leader; and assisting Team Leader as directed in all aspects of completing assessment deliverables.

TIMELINE

The expected timeframe for this task is March/April 2008. Specific start and end dates, travel dates, and due dates for deliverables will be determined in collaboration with USAID and based on the availability of the consultants, and a detailed timeline will be produced during the team planning meeting.

ESTIMATED LEVEL OF EFFORT

Activity	Total Person-Days (per person)
Make preparations and review documents (to be provided by USAID), to occur out of country and prior to beginning the assessment.	Team Leader: 3 Local Consultant: 2 Administrative Assistant: 0
Plan and conduct a team planning meeting; develop an assessment work plan and timeline; develop interview/ FGD questions including list of people to be interviewed, develop report outline.	TL: 3 LC: 3 AA: 3
Conduct key informant interviews and meetings.	TL: 3 LC: 3 AA: 3
Field visit for interviews/FGDs in Sylhet (project site) and Dhaka; translate and summarize interviews/FGDs.	TL: 4 LE: 4 AA: 4
Finalize outline for the report, team analysis of findings/ consensus on conclusions and recommendations, prepare draft report and presentation.	TL: 4 LE: 4 AA: 4
Conduct USAID and/or ACCESS debriefings	TL: 1 LE: 1 AA: 1
Report finalization (based on Mission's comments) - to take place out of country.	TL: 2 LE: 2 AA: 0

Activity	Total Person-Days (per person)
Travel (to and from Bangladesh)	TL: 4 LE: 0 AA: 0
Total	**TL: 24 days** **LE: 19 days** **AA: 15 days**

Total LOE: 58 Days

FUNDING AND LOGISTICAL SUPPORT

The proposed assessment will be funded through GH Tech using Mission field support funds. GH Tech will provide technical and administrative support, including identification and fielding appropriate consultants.

A six-day work week is authorized for the assessment team while in Bangladesh. GH Tech will be responsible for all off-shore and in-country logistical support. This includes arranging and scheduling meetings, international and local travel, hotel bookings, working/office spaces, computers, printing, and photocopying. The Administrative/Logistics Assistant will arrange field visits, local travel, hotel, and appointments with stakeholders.

AUDIENCE

The audience for this assessment includes local Mission, staff involved in the management of the ACCESS program in Global Health Bureau in USAID/Washington, and the implementing partners.

POINT OF CONTACT

Krishnapada Chakraborty (Kishan), Activity Manager, ACCESS Bangladesh Safe Motherhood and Newborn Care Project, USAID Bangladesh Office of Population, Health and Nutrition.

Tel: 880-2-885 5500 x 2515
Cell: 01713-009879
Email: kchakraborty@usaid.gov

ANNEX A. LIST OF PERTINENT DOCUMENTS

1. Approved proposal submitted by JHPIEGO for the Safe Motherhood and Newborn Care Project
2. Approved proposal for the additional complementary activities
3. Annual work plans
4. Annual reports
5. Monitoring and evaluation plan
6. Training curriculum for counseling training
7. Training curriculum for Community Mobilization training

ANNEX 2: LIST OF DOCUMENTS

Safe Motherhood and Neonatal Care (SMNC) Project, *First Annual Report,* JHPIEGO/ACCESS, October 2006.

Safe Motherhood and Neonatal Care (SMNC) Project, *Year Two Annual Report,* JHPIEGO/ACCESS, October 2007.

ACCESS Bangladesh – Year Two Work Plan (October 06–September 07).

ACCESS Bangladesh – Year Three Work Plan (September 07–October 08).

ACCESS, "Improving Safe Motherhood and Newborn Care in Bangladesh: Enhancing Program Effectiveness, 2007–2009" (proposal for additional activities), September 2007.

ACCESS – Bangladesh, *Facilitators Guides,* April 2007.

ACCESS, "Project Proposal for Improving Safe Motherhood and Neonatal Health in Bangladesh, 2006–2008, January 2006.

ACCESS Bangladesh, Updated Monitoring and Evaluation Plan, October 2007.

ACCESS Bangladesh, *Reference Manual for ACCESS Counselors*, April 2007.

Mercer, Khan, Daulatuzzaman, and Ried, "Effectiveness of an NGO Primary Health Care Programme in Rural Bangladesh: Evidence from the Management Information System," Health Policy and Planning, Oxford University Press, 2004, pp. 187–98.

Rasmussan, Carrie, "The Role of Village Doctors in the Provision of Maternal and Neonatal Health in Sylhet, Bangladesh," London School of Hygiene and Tropical Medicine, supported by USAID-Bangladesh (undated).

USAID, Safe Motherhood and Newborn Care Activity, USAID Draft Description of Program.

ANNEX 3: INDIVIDUALS AND ORGANIZATIONS INTERVIEWED

Name	Title	Organization
Dr. Lubana Ahmed	Program Manager	SMNC Project, SAVE
Dr. Mohibbul Abrar	Deputy PM, M&E	SMNC Project, SAVE
Ms. Sheri-Nouane Johnson	Chief, OPHN	USAID-Bangladesh
Dr. Ahmed Al-Kabir	Chief Executive	RTM International
Ms. Farhtheeba Rahat	Business Development	RTM International
Ms. Parveen Rashid	Managing Director	Social Marketing Company
Ms. Hasina Begum	Head, Social Franchising and Quality Assurance	Social Marketing Company
Prof. Kishwar Azad	Project Director, Perinatal Care Project	Diabetic Association of Bangladesh
Professor Shahidullah	Chairperson	Newborn Sepsis Subcommittee
Dr. Asiruddin	Program Manager	Saving Newborn Lives, SAVE
Dr. Uzma Syed	Regional Director	Saving Newborn Lives, SAVE
Mr. Zahin Ahmed	Executive Director	Friends in Village Development
Bazle Mustafa Razee	Associate Director	(FIVDB)
Dr. Kaosar Afsana	Program Coordinator	BRAC
Dr.Mizanur Rahman	Program Manager – IMCI	Ministry of Health/Family Welfare
Dr. Altaf Hossain	DPM, – IMCI	
Dr. A J Faisel	Country Representative	Engender Health
Mr. Muslehuddin	Program Manager	Engender Health
Mr. Juan Carlos Negrette	Chief of Party	Smiling Sun Franchise Program
Dr. Umme Salma Meena	Health Officer	(SSFP)

Dr. Iyorlumun Uhaa	Chief, Health/Nutrition	UNICEF
Dr. Ziaul Matin	Health Officer	
Dr. Ataur Rahman	Project Officer	
Dr. A.T.M. Mostafa Kamal	Director, Family Planning	Ministry of Health/Family Welfare
Pornchai Suchitta	Deputy Representative	UNFPA, Bangladesh
Mr. Shakil Ahmed	Technical Officer – M & E	
Mr. Aftab Ali	Chairman	Telikhal Union
Mr. Shomik Shahid Jahan	Vice President	FIVDB
Mr. Zahid Hossain		FIVDB
Mr. Asaduzzaman	Technical Focal Person	ACCESS/FIVDB
Mr. Wahid		FIVDB
Mr. Jahangir Hossain	Deputy Director, FP Sylhet Division	Directorate of FP
Mr. Humayun	Technical Focal Person	ACCESS/Shimantik
Mr. Shamim Ahmed	President (?)	Shimantik
Mr. Parvez		Shimantik
Dr. A.Z. Mahbub Ahmed	Civil Surgeon, Sylhet	Fenchuganj Upazila Health Complex

ANNEX 4: SUMMARY DESCRIPTION OF PROJAHNMO PROJECT

COMMUNITY-BASED EFFECTIVENESS TRIAL OF NEWBORN INTERVENTIONS: SYLHET, BANGLADESH

Summary write-up prepared from presented, unpublished and in-press data.

The Context

Over 10 million children die every year in the world. Four million of them die before they are 1 month old (Black, Morris, Bryce, Lancet 2003). Trends in under-5 child mortality in Bangladesh show that almost half of under-5 deaths in Bangladesh are neonatal. Most neonatal deaths can be attributed to infections, asphyxia, and low birth weight/prematurity.

The Projahnmo Partnership

Projahnmo is a broad-based partnership involving the following governmental and non-governmental organizations:

- Government of Bangladesh
- International Centre for Diarrhoeal Disease, Research, Bangladesh (ICDDR,B)
- Shimantik
- BRAC
- Institute of Child and Mother Health
- Dhaka Shishu Hospital
- Save the Children Federation
- Johns Hopkins University

Support from:

The following funding agencies provided support for the study:

- Saving Newborn Lives Initiative/SCF, USA
- USAID/Washington and Bangladesh
- Others

Projahnmo, Sylhet: Phase-1

It is a community-based cluster randomized trial to evaluate the impact of a package of obstetric and neonatal care interventions provided by two different health service delivery approaches at the rural level.

Description

Projahnmo intervention package has been designed to improve newborn health in 3 Beanibazar, Zakigonj and Kanaighat sub-districts (*upazilla*s) of Sylhet District. The *upazillas* have been divided into 24 clusters each having about 20,000 people; randomly allocated to Home Care (HC) arm, Community Care (CC) arm, and Comparison arm. The study outcomes were knowledge and

practices, cost and cost-effectiveness, equity, and neonatal mortality. The study was hypothesized to reduce neonatal mortality by 40%.

In the Home Care arm of the study the following services and activities were carried out:

1. CHWs: Surveillance to identify pregnant women
2. CHWs: 2 antenatal home visits (BNCP)
3. CHWs: 3 postpartum home visits (days 1, 3, 7)
4. CHWs: Home screening/management of sick child
5. Community mobilizers: Meetings for men/women
6. Orientation for TBAs on newborn care
7. Strengthened health facilities for routine maternal/ neonatal care and management of maternal/newborn complications
8. Usual care through government health facilities and outreach services and private providers

In the Community Care arm of the study, there were no community health worker activities—meaning activities 1-4 as stated above were absent. In the comparison arm, no interventions were carried out.

Projahnmo, Sylhet: Phase-1 Evaluation

In order to evaluate the activities of the project, the following surveys were carried out.

- Baseline and end-of-project surveys in 2002 and 2006
- Interventions introduced in July 2003
- MIS data, process evaluation, and periodic sample household surveys

Results

Below, some of the selected results are presented.

Coverage with Birth and Newborn Care Preparedness Visits During Pregnancy:
High coverage was achieved of birth and newborn care preparedness (BNCP) home visits during pregnancy by CHWs. For the first home visit, the coverage remained about 90% throughout the life of the project, while for the second visit it remained around 80%.

Neonatal Care Visit Coverage: Achieving coverage of newborn care home visits proved to be more difficult and required more time for CHWs to gain acceptance in the community. Initially it was only 42% and during the end-of-project survey it was 81%.

Increased Use of Antenatal Care Services: ANC use increased by 30% in Home Care, 17% in Community Care, and 20% in Comparison areas.

Increased Consumption of Iron Folic Acid During Pregnancy: IFA consumption increased by 40% in Home Care with no change observed in Community Care and Comparison areas.

Increased Use of Clean Cord Cutting Instruments: Compared to baseline rates, the use of clean cord cutting instruments increased by 51% in Home Care, 28% in Community Care, and 20% in Comparison areas.

More Families Applying Nothing to the Umbilical Stump: Practice of applying nothing to the umbilical stump increased by 62% in Home Care, 29% in Community Care, and 17% in Comparison areas.

Increased Adoption of Delayed Bathing After Birth (> 3 days): There was a substantial and sustained increase in families in Home Care area who were delaying the first bath of the baby by >3 days. There was a smaller increase in the Community Care area, with some increase also in the Comparison area.

Neonatal Mortality Rates by Study Arms, <u>All Live Births:</u> We were able to demonstrate a 33% reduction in last 6 months of the project in the HC area, with no such reduction in the CC area.

Neonatal Mortality Rates by Study Arms, <u>Singletons:</u> When only the singletons were considered in the analysis, we were able to demonstrate a 43% reduction in the last 6 months in the HC area, while we observed a 9% reduction in the CC area.

Conclusions

We demonstrated that:

- A cadre of community-based health workers can gain high acceptance in the community with the information and services they provide.
- A package of maternal and newborn interventions, when delivered through community-based workers and existing health facilities, is
  - effective in improving pregnancy, delivery, and newborn-care practices; and
  - significantly reduces neonatal mortality.

Significant mortality reduction in the Home Care arm was achieved within a year of implementation.

Lack of impact in the clinic-care arm may be due to the fact that a longer period of implementation was required or the inputs were inadequate for an under-served population to achieve a mortality impact.

For more information, please visit
http://www.ghtechproject.com/resources/

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