The Final Evaluation Report

Bangladesh Child Survival Project

Christian Reformed World Relief Committee

Cooperative Agreement No. **GHS-A-00-04-00010-00**
Netrokona, Dhaka and Panchagor Districts, Bangladesh

October 1, 2004 - March 31, 2010

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Executive Summary

A. Introduction

The Final Evaluation took place June 6-17, 2009. The 15-person evaluation team included an external consultant team leader, staff of CRWRC/Bangladesh and CRWRC/US, the head of training from LAMB hospital, and representatives from the three implementing partners (PARI, SATHI and SUPOTH). The evaluation process answered six questions (AMPLOS):

A: What were the project **Achievements**?
M: Were the implementation **Models** and approaches effective?
P: What are some **Promising Practices** initiated by this project?
L: What are the **Lessons Learned** from this project?
O: What **Opportunities** exist for scaling up or replication?
S: How can the project achievements be **Sustained**?

The evaluation team divided into two teams for field visits to project areas (see map). The teams conducted almost 40 group interviews with Super CHVs, Trained TBAs, Village Docs, Peoples' Institutions (PI), PI Health Sub-teams, health facility staff, MOH authorities, local government leaders, training institutions, NGO partner staff, CRWRC staff, and USAID. Findings were compiled and discussed to answer the six key evaluation questions. The evaluation results were presented to a meeting of stakeholders on June 17.

B. Project description and objectives

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

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

These objectives were implemented within the framework of the national strategy for Community-based Integrated Management of Childhood Illness (C-IMCI) to 1) improve links to health facilities, especially for referral; 2) increase community-based care by TTBAs; and 3) CHV Promotion of key family practices through Primary Groups.

C. Main accomplishments

The CSP achieved 93% or more of targets for 15 of the 16 project objectives. For most objectives the project surpassed the targets by a margin of more than 110%. The project also made very good progress in reducing the number of underweight children by 37%, although they did not achieve the 50% reduction target (which, in retrospect was overly ambitiously).

The CSP has effectively and efficiently used proven approaches, e.g., Dialogue Education, BEHAVE framework, and Doer/Non-doer Analysis to train and monitor the development of community groups and volunteers for technical interventions. They have also successfully used the CRWRC Peoples' Institutions model to create an impressive and sustainable network of community groups.

Many people interviewed felt that the CSP has significantly reduced child and maternal deaths. Using the *Lives Saved Calculator* it is estimated that there has been a 34% reduction of under-five mortality in the project area.

The project has also successfully created an "outreach" link from community-based to facility-based care. The CSP has created a support network for community-volunteers that seems very sustainable. CHVs and TTBAs are very complementary to government health services.

The following are selected highlights of Promising Practices, Lessons Learned, Opportunities for Scaling Up and Potential for Sustainability.

Selected Promising Practices include:

1) Peoples' Institutions are now well established, respected and very independent.
2) Formal MOUs help to create and sustain working relationships between PIs and health facilities.
3) The Emergency Health Fund has evolved into a widely recognized and respected tool.
4) Super CHVs have proven to be dynamic and effective leaders who are capable of replacing project-paid animators.
5) Trained TBAs ensure that pregnant women receive antenatal checkups, that deliveries are clean, and that complicated deliveries are properly referred.

Important Key Lessons Learned include:

1) Volunteerism in the community (without money) works with a diversified support system involving community, health facilities and local government.
2) A network of support resources enhances sustainability.
3) The CSSA Framework can be adapted into a community-managed capacity monitoring tool.
4) Community members from different religious and cultural backgrounds can work effectively and harmoniously together.
5) Local Government and health workers welcome the work of PIs as they are helping them achieve their programmatic targets and goals.
6) The number of contact "points" created between community volunteers and health workers is proportional to their working relationship.
7) All family members need to be involved in health education, not only mothers.

Opportunities for Scaling Up include:

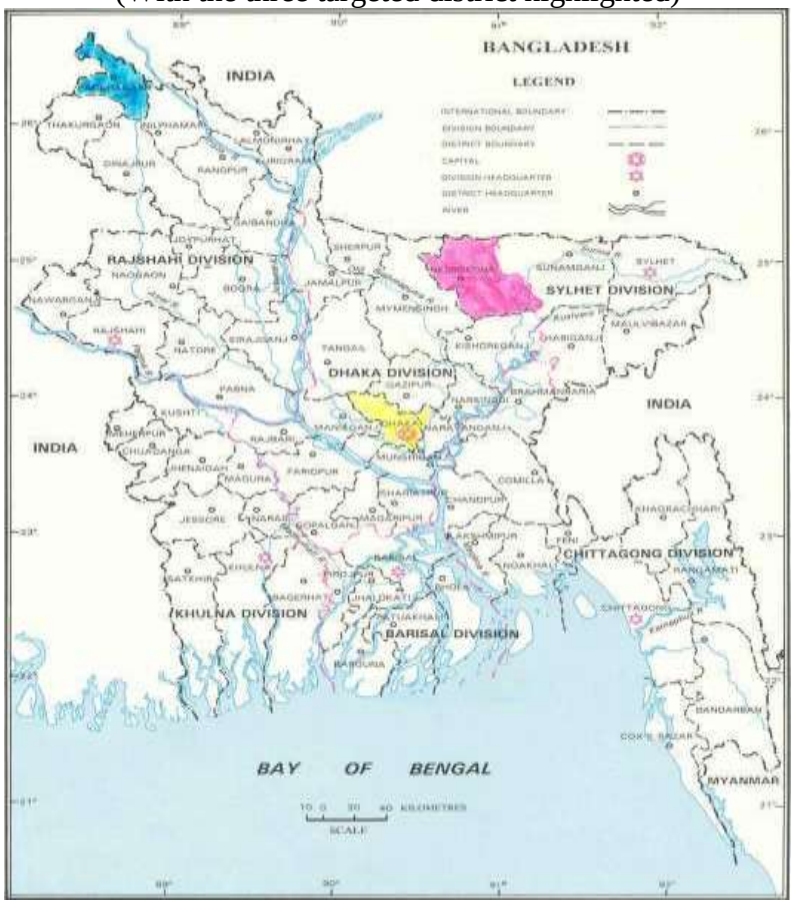
1) Replication of the PIs and community volunteers to other districts. Peoples' Institutions provide an opportunity to expand into new geographic areas.
2) There is a potential partnership for PIs with Community Clinics. The reopening of community clinics is an opportunity to explore how PIs might be involved.
3) Opportunities exist to replicate and expand the CCM approach, and, in the process, to influence government policy.

The Potential for Sustainability appear to be good because:

1) The PI is the key to sustainability. PIs, CHVs, and the TTBAs all feel a high level of ownership and independence for their work and are confident that they have the knowledge to continue. They also have strong relationships with health facilities.
2) Monthly/Quarterly meetings for reporting and planning are important for sustainability. The meeting "habit" is firmly established and appreciated by all stakeholders.
3) Super CHVs can train new CHVs to replace the occasional drop out.
4) The NGO Partners (PARI, SATHI, and SUPOTH) are not leaving. This project has "certified" their ability to manage health programs. The end of the CSP will not be the end of their commitment to CHVs and TTBAs, but rather a strong continuation.

Project Map

(With the three targeted district highlighted)



List of Acronyms

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

I. INTRODUCTION

A. Project Background

The Christian Reformed World Relief Committee (CRWRC) was established in 1962 by the Christian Reformed Church in North America. CRWRC partners with over 100 faith-based and non-governmental organizations in 29 countries throughout Africa, Asia, and the Americas. CRWRC began working in Bangladesh to provide relief and agricultural assistance in the early 1970's after the Liberation War. Today, CRWRC collaborates with five Bangladesh development agencies serving over 40,000 families. CRWRC focuses on strengthening national development organizations so that they are equipped for capacity building of their communities.

The CSP works with three local non-governmental development organizations (PARI, SATHI and SUPOTH) in selected unions and wards in the districts of Netrokona, Dhaka and Panchagor, respectively (see map). The total beneficiary population is around 170,000 with over 20,000 children less than five years of age and nearly 45,000 women of reproductive age (see table).

The CSP Beneficiary Population

Partner NGO	Locations	Popula-tion	Beneficiaries	
			Children < 5	Women of Reprod. Age
PARI	**Netrokona:** Durgapur, Kullagora & Lengura Unions	**89,068**	**10,599**	**23,603**
SATHI	**Dhaka:** Wards/Slums of Lalbagh, Sutrapur, Maniknagar and Mirpur	**45,445**	**5,408**	**12,043**
SUPOTH	**Panchagor:** Chaklahat and Kamatkazaldighi Union	**35,290**	**4,200**	**9,352**
	Totals	**169,803**	**20,207**	**44,998**

The objectives of the CRWRC Child Survival Project are to:

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

The project implemented these objectives as part of the national Community-based Integrated Management of Childhood Illness (C-IMCI) program and based on three strategic approaches:

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

B. Final Evaluation Methodology

The final evaluation provides an opportunity for all project stakeholders to take stock of accomplishments to date and to listen to the beneficiaries at all levels: including mothers and caregivers, other community members and opinion leaders, health workers, health system administrators, local partners, other organizations and donors. The final evaluation includes:

1) The comparison of baseline and final data;
2) The description and assessment of the project's achievement of planned results and its overall impact;
3) The analysis of the model or implementation approach; and
4) The identification and/or elaboration of the lessons learned from innovative activities and new approaches, promising practices and opportunities for scaling up and/or replication.

The Final Evaluation of the CRWRC Child Survival Project took place June 6-17, 2009. The 15-person evaluation team included an external consultant team leader, staff of CRWRC/Bangladesh and CRWRC/US, the head of training from LAMB hospital, and representatives from the three implementing partners (PARI, SATHI and SUPOTH). The evaluation process answered six questions (AMPLOS):

A: What were the project's **Achievements**?
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S: How can the project achievements be **Sustained**?

The evaluation team formed two teams for field visits, and conducted 40 group interviews with:

- Super CHVs
- Trained TBAs
- Village Doctors
- Peoples' Institutions
- PI Health Sub-committees
- Health Center staff
- Local Government (Union)
- Local Government (District)
- Training Institutions
- Partner Staff
- CRWRC Staff
- USAID Mission staff


Interview of Muktah Society Peoples' Institution in Netrakona

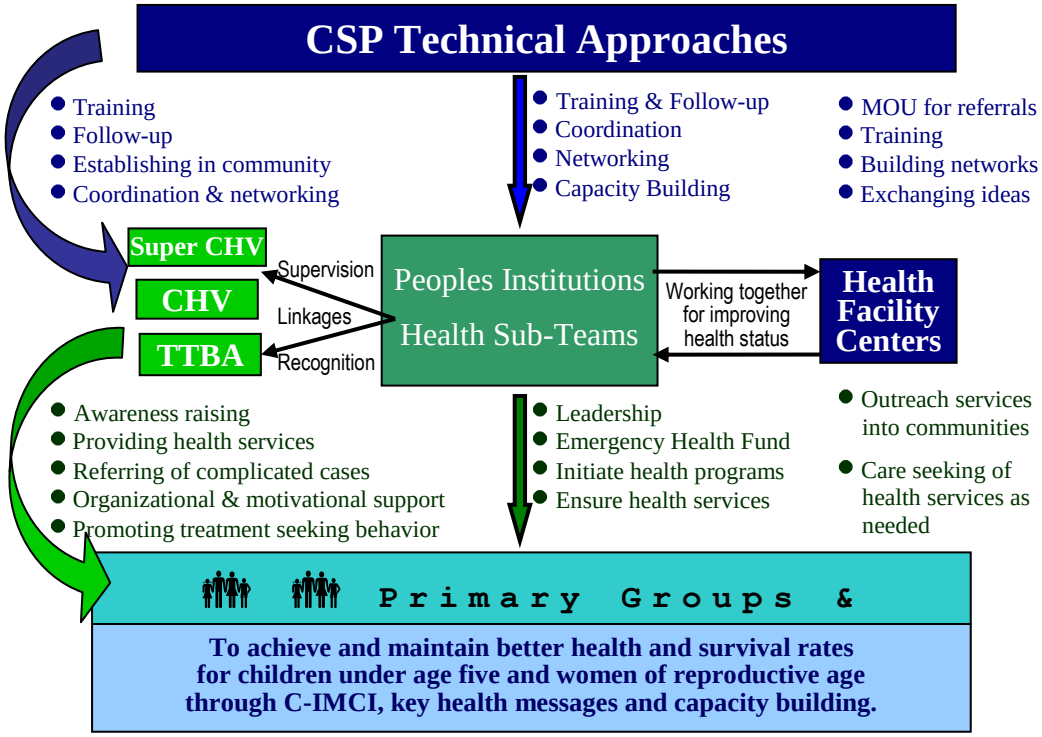
The findings from field visits were compiled and discussed to answer the six key evaluation questions. A consensus was established on project achievements, promising practices, lessons learned, opportunities, and potential for sustainability. The evaluation results were presented and discussed with stakeholders during a meeting on June 17. Additional details about the Evaluation Methodology, including the interview questionnaires, can be found in Annex 9.

II. RESULTS AND IMPACT OF THE PROJECT

A. Technical Interventions, Models and Approaches

1. Overview of Models and Approaches

The overall approach of the CSP centers on the capacity building of community-based health volunteers and local institutions to support the network of volunteers and link them to the health system. These relationships are shown in the following chart:



The key approaches include

a) Training of community-based volunteers, including

- TBAs to ensure safe home delivery and prompt referral of complications;
- Community Health Volunteers for behavior change communication;
- Village Docs for treatment of common ailments and referral of complications; and
- Super CHVs to supervise CHVs and TTBAs

b) Creation and capacity building of Community-Based Organizations (CBOs) to support the community-based volunteers and to manage many community-wide resources, e.g., Health Emergency Fund. The CBOs include:

- Primary Groups at the village level;
- Community Central Committees at the union level; and
- Peoples' Institutions at the *upazila* or sub-district level.

c) Training the above CBOs to link and leverage their volunteers to health facilities and local authorities for referral of complicated cases and support for supervision and continued training.

The CSP used proven approaches to train and monitor the development of community groups and volunteers for technical interventions. These have included Dialogue Education; BEHAVE framework; Doer/Non-doer Analysis; Supportive Skilled Supervision, and Positive Deviance (PD)/Hearth.

<u>Models</u>: The CRWRC-developed model of the *Learning Circle* is the vehicle to disseminate learning from the CSP to 15 NGO partners.

2. Achievement of Technical Objectives

The CSP reached the end of project targets for number of primary and adolescent groups formed, number of beneficiaries served, and number of TBAs and CHVs trained (see table). CSP is reaching more children under five than expected. This is mainly due to the interest of mothers who are not in Primary Groups to have their children participate in growth monitoring and other CSP initiatives.

Beneficiaries, Group Formation, People Trained by CSP through June 2009

Particulars		Dhaka		Netrokona		Panchagor		TOTAL	
		Actual	EOP Target	Actual	EOP Target	Actual	EOP Target	Actual	EOP Target
Primary Groups		165	227	203	203	226	225	594	655
Primary Group Members		3645	3750	3267	3248	4493	4470	11405	11468
Adolescent Group	Girls	50	40	7	6	12	12	69	58
	Boys	21	20	4	4	12	10	37	34
Adolescent Group Member	Girls	525	400	143	115	325	325	993	840
	Boys	208	240	80	82	270	270	558	592
Peoples' Institutions		15	15	3	1	1	1	19	17
Children under 5		1861	1810	2243	1662	1680	1600	5784	5072
CHVs Trained		187	166	203	203	120	120	510	489
TBAs Trained		85	88	74	75	79	75	238	238

Final Data is in Annex 13 on page 102

The CSP surpassed or nearly achieved almost all of its technical objectives.

- The project surpassed its targets for 11 of the 16 objectives -- in most cases by a very large margin ranging up to 161%;
- The CSP achieved very good progress for 4 additional objectives, i.e., achieving 93% or more of the target objective; and
- Very good progress was also made in reducing the number of underweight children by 37%. However, the project did not achieve the very (perhaps overly) ambitious target of a 50% reduction.

These achievements are clearly shown in the table on the following page. The percentage of target achievement has been calculated by implementing partner for each objective and indicator, i.e., final KPC result compared to the baseline KPC. In addition, the percentage in the far right column is based on a population-weighted average of all three implementing partners. These findings were color-coded for easy visibility according to percentage as follows:

Scoring the Achievement of CSP Objectives	130% + of target	100-129% of target	90-99% of target	80-89% of target	< 80% of target

CRWRC CSP Achievement of Project Objectives

Intervention	Indicator **BOLD** = KPC Rapid CATCH Indicators	Part-ner*	Base-line	MTE KPC	Final KPC	EOP Target	% of Target Reached	Over All %
Strategic Objective I. Improve Maternal and Neonatal Care		* P=Panchagor, N=Netrokona, D=Dhaka						
Delivery by Skilled Health Personnel (including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel	P	18	61	95	60	158%	159%
		N	21	31	94.7	50	189%	
		D	34	76	96.3	71	136%	
Antenatal Care Rate	Percentage of mothers who had at least 4 prenatal visit prior to the birth of her youngest child less than 24 months of age	P	31	76	87	79	110%	141%
		N	6	9	86.3	30	288%	
		D	34	58	76	85	89%	
Tetanus Toxoid (TT)	Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age	**P**	**80**	**49**	**96**	**98**	**98%**	105%
		N	**62**	**61**	**98.3**	**85**	**116%**	
		D	**59**	**65**	**93.7**	**85**	**110%**	
Knowledge on Maternal Danger Signs/Symptoms	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/ symptoms during the prenatal, natal and postnatal period	P	35	66	100	58	172%	161%
		N	31	62	100	55	182%	
		D	37	71	99	80	124%	
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease								
ORT Use During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	P	64	46	77.4	84	92%	93%
		N	56	54	68.4	75	91%	
		D	55	67	75.9	80	95%	
Increased Fluid and Continued Feeding During an illness	Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food	**P**	**94**	**95**	**100**	**70**	143%	131%
		N	**64**	**75**	**97.3**	**72**	135%	
		D	**57**	**56**	**100**	**95**	105%	
Zinc Supplementation During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness	P	14	43	83.9	78	108%	95%
		N	11	48	86.8	90	96%	
		D	9	39	62.1	90	69%	
Availability of Soap for Hand Washing	**Percentage of mothers of children age 0-23 months that have soap readily available for hand washing**	**P**	**53**	**98**	**95.7**	**73**	**131%**	136%
		N	**15**	**90**	**93**	**55**	**169%**	
		D	**37**	**98**	**99.7**	**82**	**122%**	
Strategic Objective III. Detect ARI and Make Appropriate Referrals								
Care Seeking for ARI	Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility	P	29	14	92.9	59	157%	144%
		N	8	19	60.9	33	185%	
		D	63	61	75	88	85%	

Intervention	Indicator **BOLD** = KPC Rapid CATCH Indicators	Part-ner*	Base-line	MTE KPC	Final KPC	EOP Target	% of Target Reached	Over All %
Maternal Knowledge of Child Danger Signs/Symptoms	Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms	**P**	**70**	**82**	**99**	**86**	**115%**	112%
		N	**73**	**80**	**99**	**90**	**110%**	
		D	**62**	**91**	**97.3**	**92**	**106%**	
Strategic Objective IV. Improve Child Nutrition								
Underweight	Percentage of children aged 0-23 mother who are more than 2 SD below the median weight-for-age (WA) of WHO/NCHS reference population	**P**	**38**	**26**	**26.8**	**20**	**62%**	71%
		N	**41**	**37**	**26.1**	**20**	**71%**	
		D	**39**	**27**	**22.5**	**20**	**87%**	
Exclusive Breastfeeding	Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours	**P**	**88**	**74**	**89.6**	**97**	**92%**	98%
		N	**74**	**63**	**89.9**	**85**	**106%**	
		D	**64**	**67**	**90.9**	**89**	**102%**	
Appropriate Complementary Feeding Practice	Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours	**P**	**27**	**47**	**81.1**	**57**	**142%**	122%
		N	**14**	**75**	**79.6**	**80**	**100%**	
		D	**55**	**79**	**76.1**	**75**	**101%**	
Vitamin A Coverage	Percentage children aged 6-23 months who received a Vitamin A dose in the past six months	P	62	76	81.1	91	89%	96%
		N	61	84	76.1	75	101%	
		D	53	77	85.4	80	107%	
Strategic Objective V. Reduce Morbidity and Mortality from Vaccine Preventable Diseases								
Complete Immunization Coverage	Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio	**P**	**57**	**92**	**94.2**	**87**	**108%**	110%
		N	**32**	**74**	**96**	**85**	**113%**	
		D	**28**	**82**	**90.1**	**80**	**113%**	
Strategic Objective VI. Increase Awareness of HIV/AIDS								
Maternal Knowledge of HIV Risk Reduction	Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV	**P**	**12**	**58**	**99.3**	**64**	**155%**	142%
		N	**13**	**59**	**99**	**70**	**141%**	
		D	**51**	**84**	**100**	**85**	**118%**	

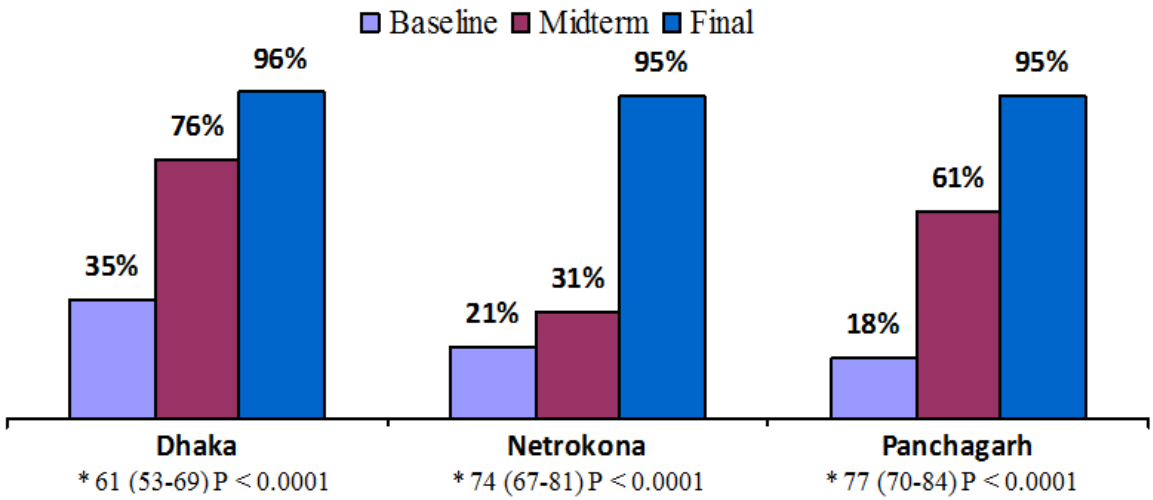
a) Improve Maternal and Neonatal Care

<u>Delivery by skilled health personnel (including TTBAs):</u>

All three areas showed remarkable increases from baseline. During the MTE it was observed that Dhaka and Panchagor achieved higher progress than Netrokona. But Netrokona overcame the shortcomings at midterm and achieved results similar to the other two areas. Compared with baseline, the final results for all three areas are statistically significant. Because of the availability of trained TBAs (TTBAs) in the community, mothers prefer using TTBAs to attend their delivery. According to the Bangladesh Demographic and Health Survey (BDHS) 2007, "18% of births in Bangladesh are attended by a medically trained provider, that is, a qualified doctor, nurse, midwife, paramedic, family welfare visitor (FWV), or community skilled birth

attendant (CSBA). Additionally, trained traditional birth attendants (TBAs) assist in 11% of deliveries." [1] The CSP far exceeded the national average (29%) with 95% of all deliveries being conducted by skilled health personnel, including TTBAs.

Chart 1: Delivery by Skilled Health Personnel (including TTBAs)
Percentage of children aged 0-23 months whose births were attended by skilled health personnel.

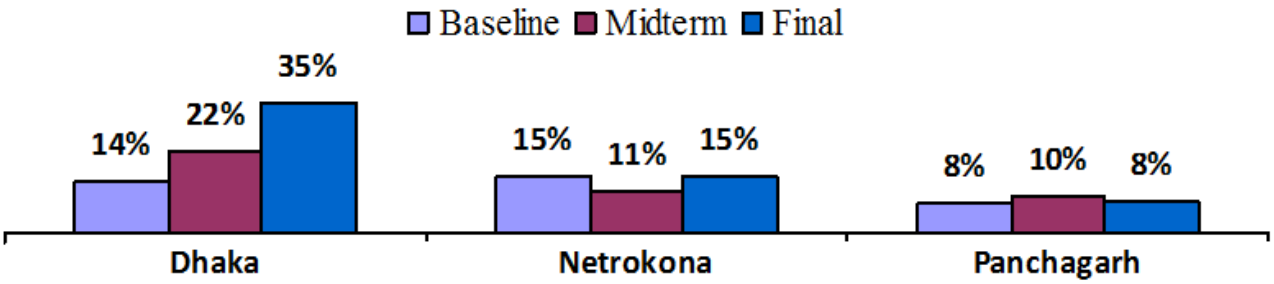


Delivery by skilled health personnel (excluding TTBAs):

The Dhaka domain showed commendable results compared to baseline. The Netrokona and Panchagar domains showed no change compared to baseline. These results are comparable to the national statistics in urban (36.5%) and rural (13.1%) areas.[2] In addition, qualitative research showed that because of the availability of trained TBAs (TTBAs) in the community, mothers prefer using TTBAs to attend their delivery. In Dhaka, where there are Skilled Birth Attendants (SBAs) and other skilled personnel, there was an increase in the use of skilled personnel. The qualitative findings also showed that if skilled personnel were more available in the rural areas, they would be used. Currently, beneficiaries in all domains seek help from a doctor or nurse only when they have complications at the time of birth; therefore, delivery by skilled health personnel, not including TTBAs, remains relatively low for all three working areas, especially the rural domains

[1] National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and Macro International.
[2] Ibid.

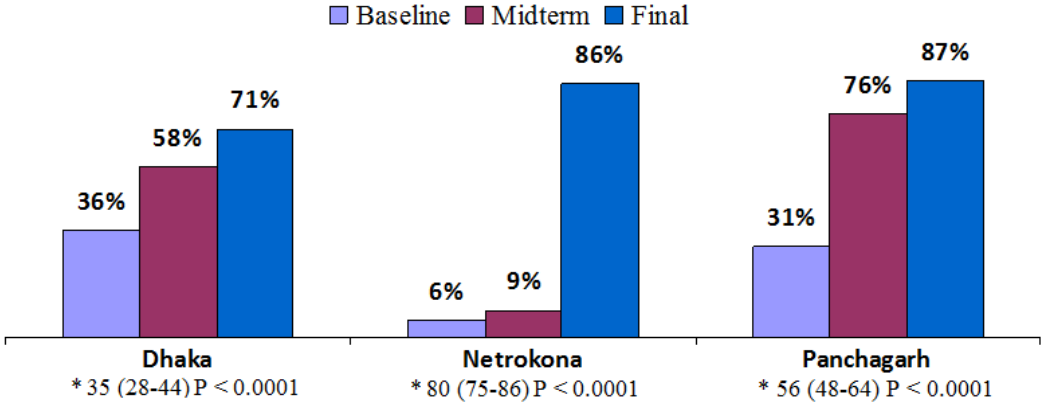
Chart 2: Delivery by Skilled Health Personnel (not including TTBAs)
Percentage of children aged 0-23 months whose births were attended by skilled health personnel.



Antenatal Care Rate:

The percentage of mothers receiving all four prenatal visits is a good indicator of general health system performance. All three areas performed equally well during final KPC survey and the differences were statistically significant compared to baseline for all three areas. Nationally, only 20.6% of women age 15-49 made four or more antenatal visits during their last pregnancy.[3] The Netrokona domain showed little progress during the midterm survey, so the achievement at the final survey was surprising. CHVs and TTBAs gave emphasis on antenatal care after midterm. PARI carried out a Behavior Change Framework and Doer/Non-Doer Analysis, which was followed by specific steps to improve this area.

Chart 3: Antenatal Care Rate
Percentage of mothers who had at least four prenatal visits
prior to the birth of her youngest child less than 24 months of age.



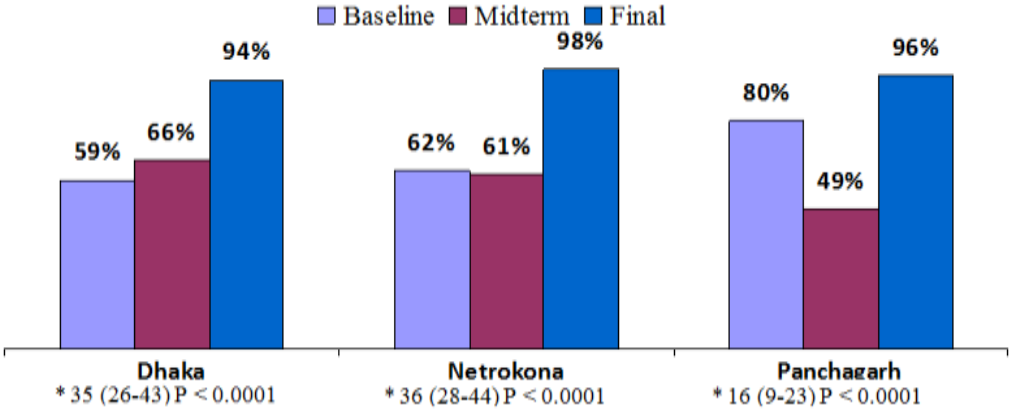
Tetanus Toxoid (TT):

The percentage of mothers who received two doses of TT before the birth of their youngest child was high for all three areas at baseline, but lower than the national average (63.6%). According to the final survey, the interventions were able to achieve almost 100% coverage in all the three areas, which is now above the national average (90.2%).[4]

[3] Ibid.
[4] Ibid.

Chart 4: Tetanus Toxoid during Pregnancy

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

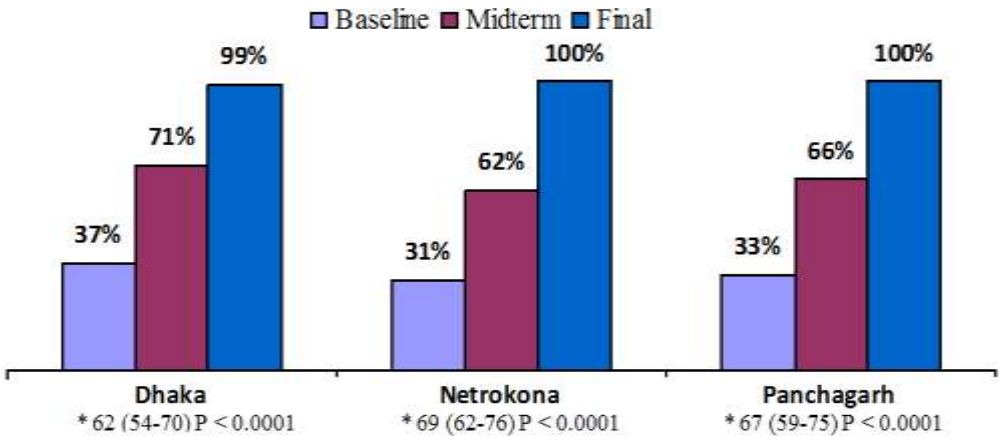


Knowledge on maternal danger sings/symptoms:

Mothers' knowledge of at least two danger signs/symptoms during the prenatal, natal and postnatal period has improved in all three areas over the intervention period. At baseline the proportion of mothers with knowledge of at least two maternal danger signs/symptoms was around 30% in all three areas. The proportion almost doubled during the midterm evaluation. At the end of the project, almost all of the mothers of children aged 0-23 months were able to report at least two danger signs for all three areas. It should also be noted that the increase in knowledge about danger signs was associated with an increase in care seeking behavior during the prenatal, natal and postnatal period.

Chart 5: Knowledge of Maternal Danger Signs/Symptoms

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



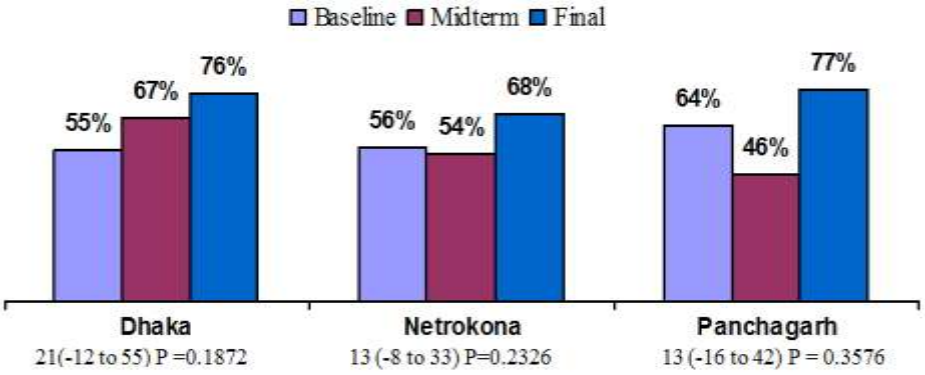
b) Prevent and Properly Treat Diarrheal Disease:

ORT use during diarrheal episode:

Use of Oral Rehydration Solution (ORS) and/or recommended home fluids for children with diarrhea was high, more than 50% in all three areas at baseline. While only the Dhaka domain improved at midterm, all three areas improved from baseline. However, differences were not statistically significant, and were below the national average (81.2%).[5]

Chart 6: ORT Use During Diarrheal Episode

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

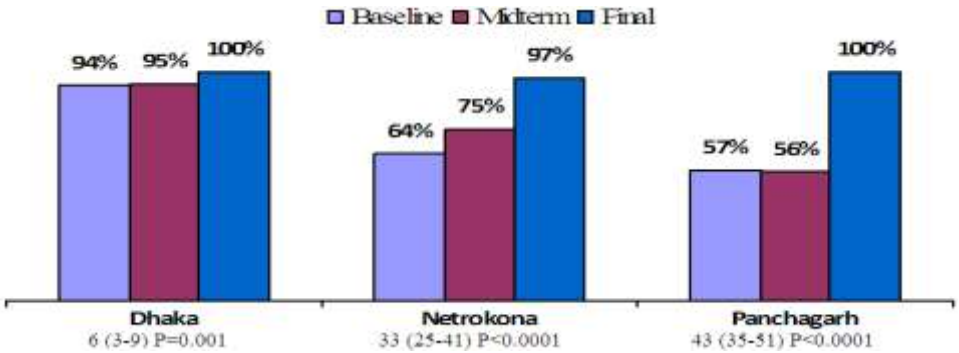


Increased fluid and continued feeding during an illness:

The proportion of children receiving increased fluid and continued feeding at baseline was very high in Dhaka and the trend sustained throughout the study period. The difference was not statistically significant for Dhaka because it was already high during baseline. In Netrokona and Panchagor the proportion increased at midterm and at final survey. The difference from baseline to final was statistically significant. Additionally, all three areas were above the national average of 37.9%.[6]

Chart 7: Increased Fluid and Continued Feeding During an Illness

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



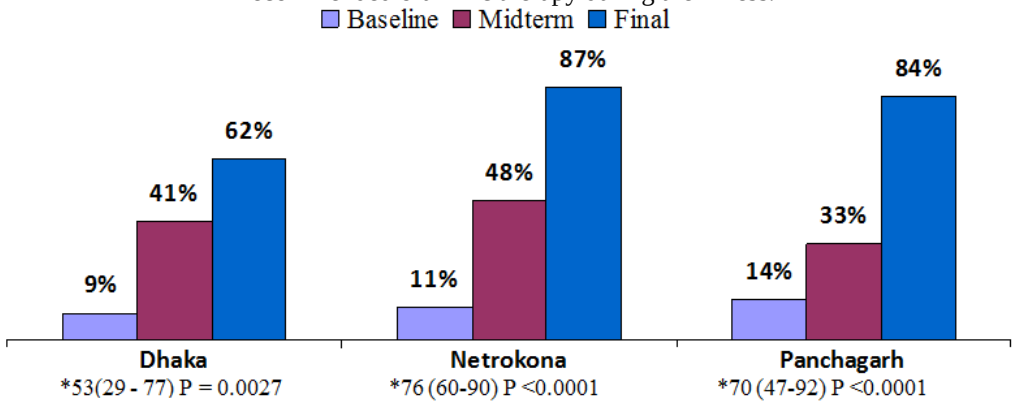
Zinc supplementation during diarrheal episode:

[5] Ibid.
[6] Ibid.

All three working areas showed significant improvement from baseline for this indicator. The Netrokona and Panchagor regions achieved 87% and 84%, respectively, coverage while the Dhaka region lagged behind at 62%. This is remarkable considering the national average for oral zinc therapy during diarrheal disease was 23%.[7]

Chart 8: Zinc Supplementation during Diarrheal Episode

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

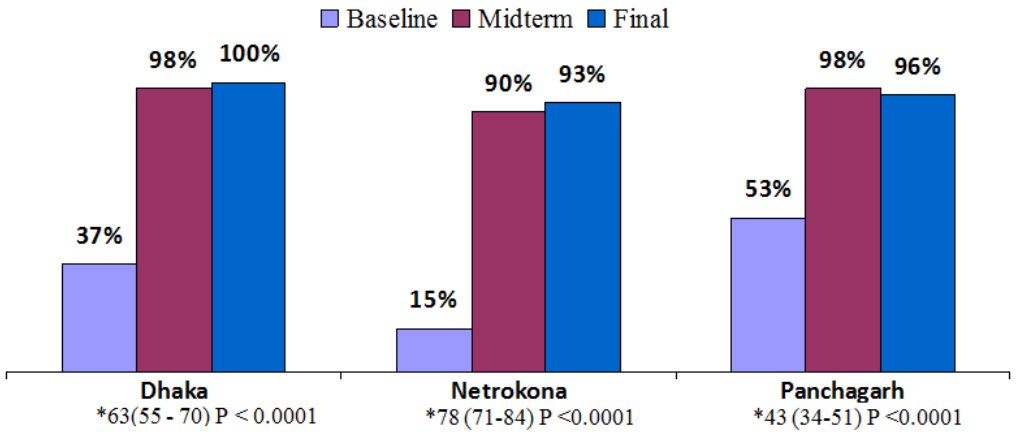


Availability of soap for hand washing:

The CSP used the availability of soap for hand washing as the indicator for hand washing behavior during all three surveys. Using this indicator, all three working areas reached almost 100% coverage at midterm survey, and the achievement was sustained at final survey. Dhaka increased from 37% to 100%, Netrokona increased from 15% to 93%, and Panchagor increased from 53% to 96%. All three changes were statistically significant.

Chart 9: Availability of Soap for Hand Washing

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



[7] Ibid.

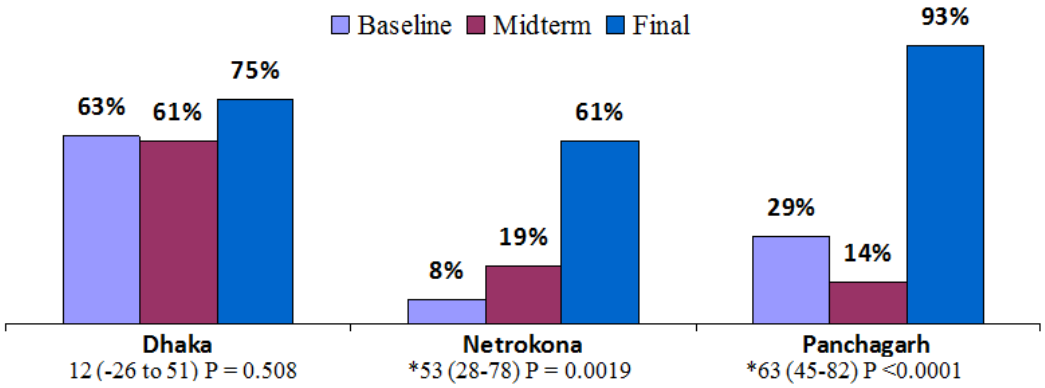
c) Detect ARI and Make Appropriate Referrals

ARI care seeking:

The percentage of mothers reporting taking their child to an appropriate health provider when the child had fast or difficult breathing increased in all three areas. Differences were statistically significant except Dhaka, where the baseline proportion was much higher (63%). All three areas were higher than the national average for care seeking during ARI (37.1%).[8] Care seeking for ARI was highest at Panchagor (93%), which was probably due to the Community Case Management (CCM) operations research.

Chart 10: ARI Care Seeking

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

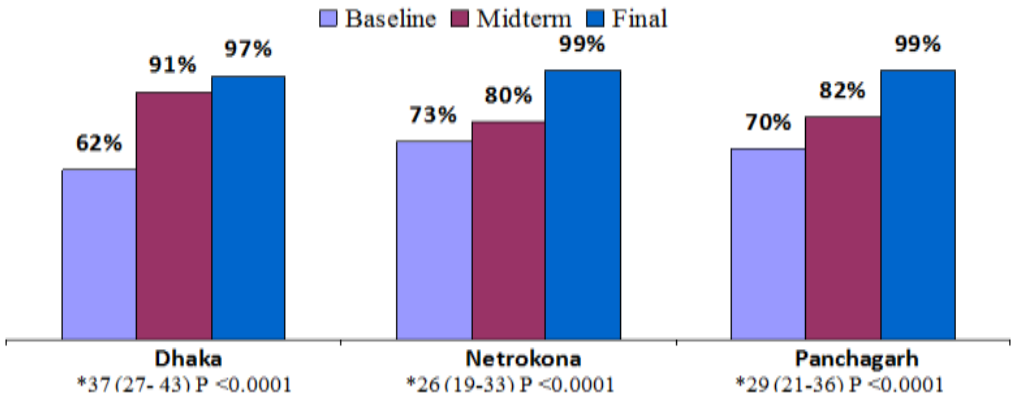


Maternal knowledge of child danger sings/symptoms:

The proportion of mothers with knowledge of danger signs/symptoms for childhood illnesses was found to be high during baseline (62% to 70%) which increased further at midterm and achieved almost 100% coverage at final survey. Knowledge results tend to be highest because the CSP was working with a relatively small population base. CHVs and TTBAs were able to provide good house-to-house coverage and follow-up was done in Primary Group and PI meetings.

Chart 11: Maternal Knowledge of Child Danger Signs/Symptoms

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



[8] Ibid.

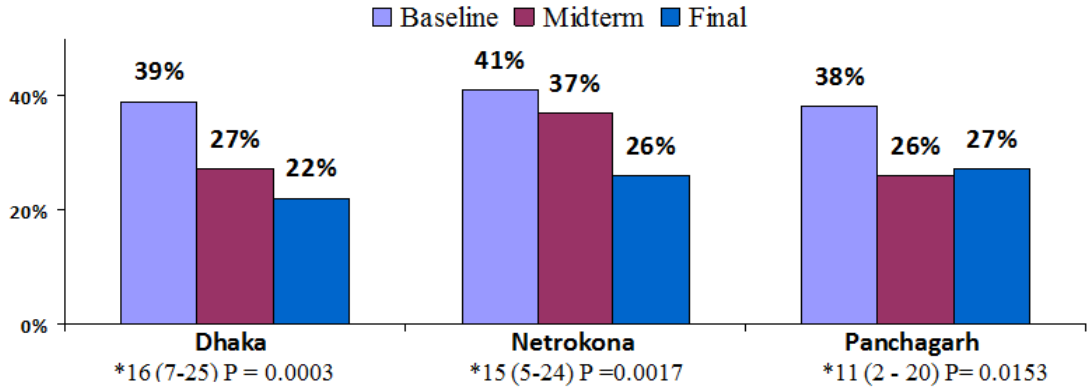
d) Nutrition & Micronutrients

Underweight (<-2 z-score):

The prevalence of underweight was around 40% at baseline in all three areas. The proportion of underweight children declined significantly in all areas after five years of project implementation. Although the CSP did not achieve the target of a 50% reduction in underweight, the project made very good progress in reducing the number of underweight children by 37%. The national average of children more than two standard deviations below the median weight-for-age is 41%.[9]

Chart 12: Underweight Children

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



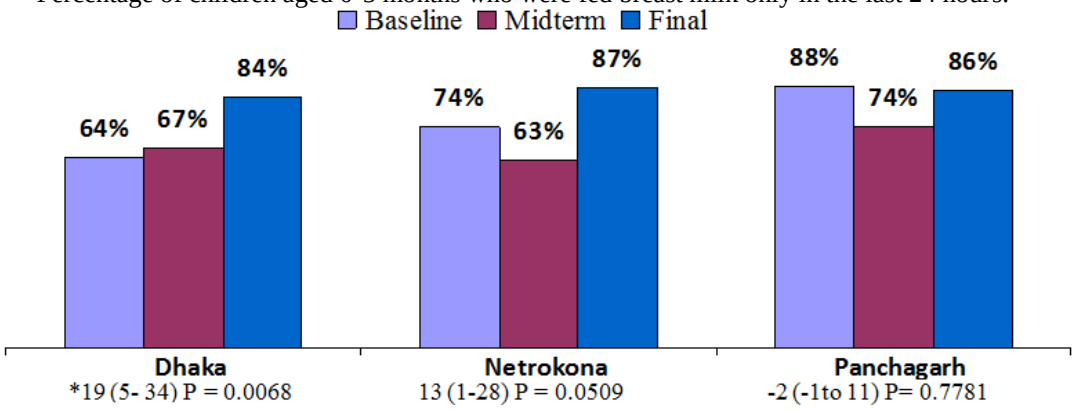
Exclusive breastfeeding:

Exclusive breastfeeding rates increased significantly from baseline in Dhaka (64% to 84%) even though there was little improvement during midterm. Both Netrokona and Panchagor achieved around 86% exclusive breastfeeding coverage, but the rate went down a bit during midterm in both of the areas. At baseline the exclusive breastfeeding rate was high at Netrokona (74%) and higher at Panchagor (88%) which was the main reason the differences were not statistically significant. Nationally, only 43% of children less than six months were exclusively breastfed.[10]

[9] Ibid.
[10] Ibid.

Chart 12: Exclusive Breastfeeding

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

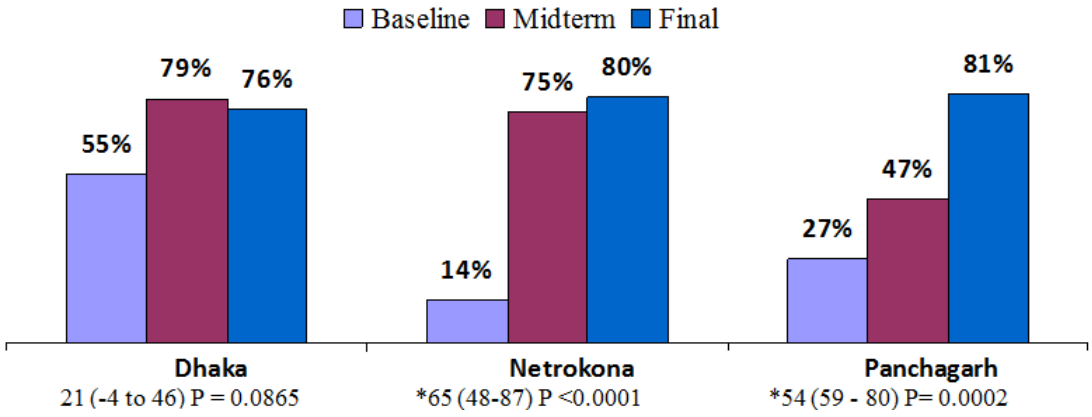


Appropriate complementary feeding practices:

All three intervention areas reached commendable success in ensuring complementary food for children aged between six to nine months, especially Netrokona and Panchagor. Panchagor achieved good progress at midterm and the success continued at final survey. All three domains were near the national average for appropriate complementary feeding practices (81%).[11] Feeding demonstrations and nutrition lessons were provided during the weighing sessions. Complementary feeding practices were given emphasis in the time since the midterm.

Chart 14: Appropriate Complementary Feeding Practice

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



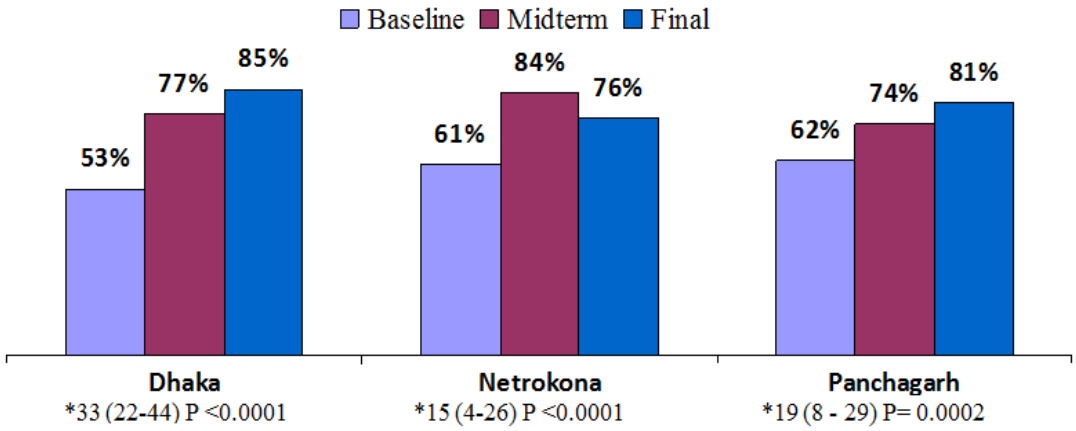
Vitamin A coverage:

All three working areas exceeded their midterm target and reached far above the baseline. All three domains remained below the national average for Vitamin A coverage (88.3%).[12] However, the national statistics are based on children between the age of nine to 59 months and the KPC statistics are based on children age six to 23 months. Therefore, it is difficult to compare.

[11] Ibid.
[12] Ibid.

Chart 15: Vitamin A Coverage

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

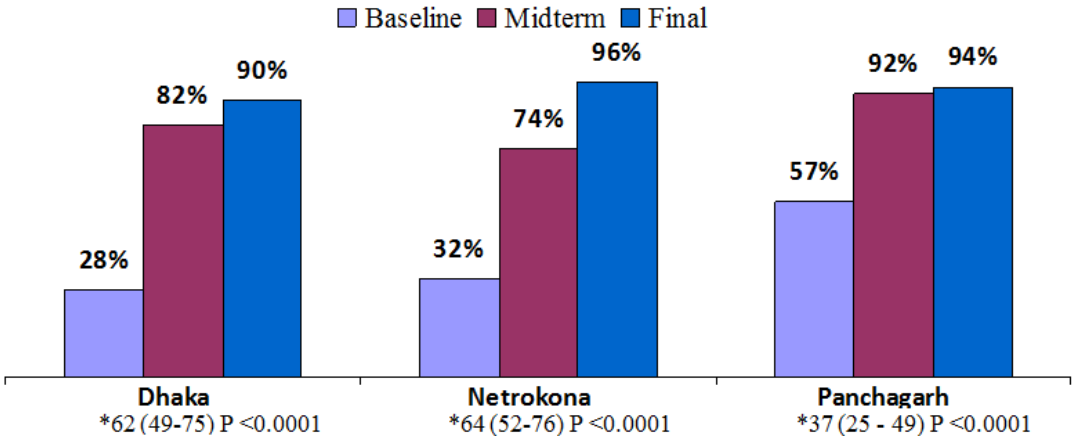


e) Reduce Morbidity and Mortality from Vaccine Preventable Diseases

Complete immunization coverage: All three areas achieved much higher complete immunization rates compared to midterm and final targets. In addition, all three areas out-performed the national average for complete immunization (82%).[13]

Chart 16: Complete Immunization Coverage

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



f) Increase Awareness of HIV/AIDS

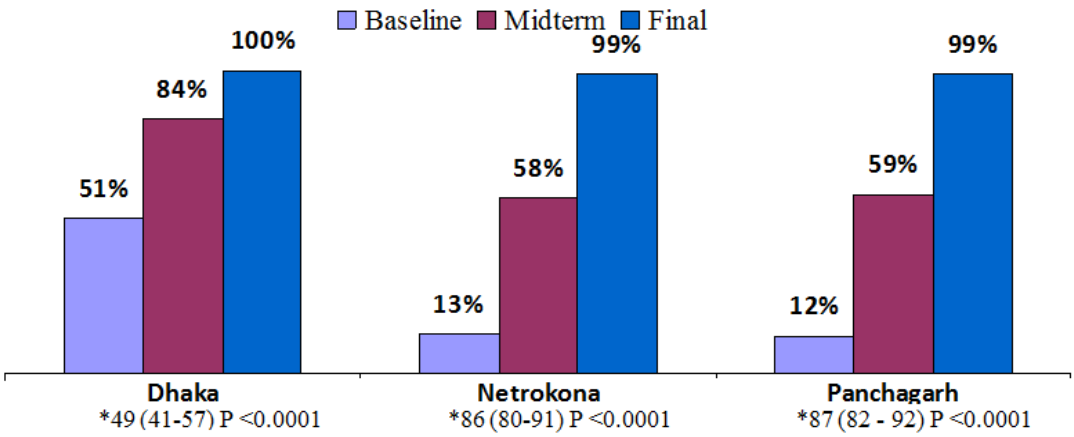
Maternal knowledge on HIV risk reduction:

All three working areas have demonstrated an increase of maternal knowledge related to HIV prevention from baseline. Again, this was an area where CHVs and TTBAs gave emphasis on increasing knowledge through health education.

[13] Ibid.

Chart 17: Maternal Knowledge of HIV Risk Reduction

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



3. Lives Saved

Many health workers interviewed, including SBAs, felt that the CSP had contributed to a reduction of child and maternal deaths. To quantify this observation, the final evaluation team performed a *Lives Saved Analysis* using the Bellagio Group Methodology.[14] This methodology estimates the proportion of deaths attributable to the six most common causes of child mortality. It is based on the estimated effectiveness of interventions against these causes of mortality for which there was strongest evidence. The model shows the potential impact on child mortality (*Lives Saved*) when these interventions are scaled up.

- The model accounts for effect of malnutrition;
- The model accounts for effect of interventions on multiple conditions, e.g. vitamin A reduces measles, diarrhea and malaria deaths; and
- The model avoids double counts.

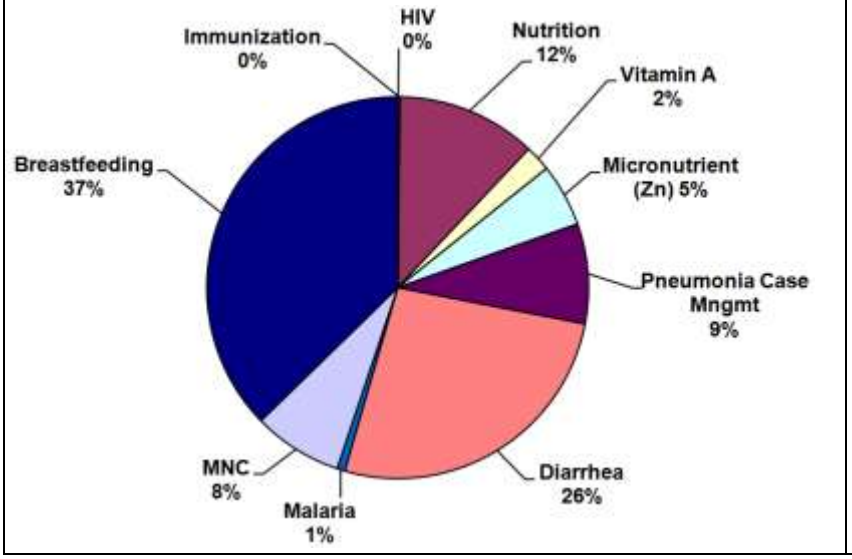
Lives saved for each intervention = (Baseline number of deaths for that cause) x (intervention effectiveness) x (change in coverage)

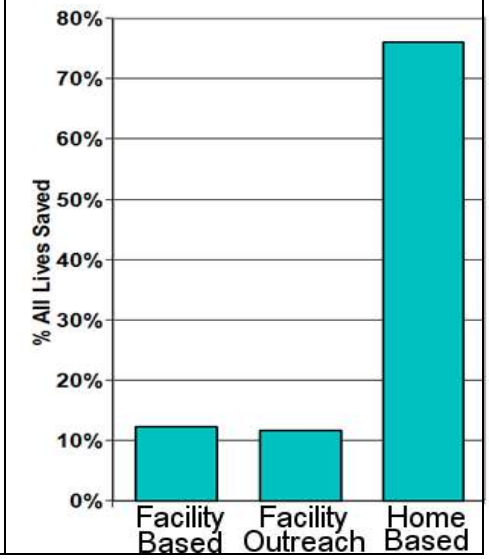
The results of the "Lives Saved" calculation (see charts below) were that:

1) an estimated **399** children's lives were saved over the five year project period;
2) There was an estimated **36%** overall reduction in under-five child mortality; and
3) U5MR was estimated to be 56.6 (per 1,000 live births) in the project working areas (compared to 65 nationally).
4) Over 60% of the lives saved were due to breastfeeding and diarrheal disease interventions
5) Over 70% of the lives saved were due to home care interventions.

[14] Based on the calculations used for the series in the Lancet in 2003 on Child Survival and in 2005 on Neonatal Health.

Distribution of Lives Saved by CSHGP Intervention and by Intervention Location

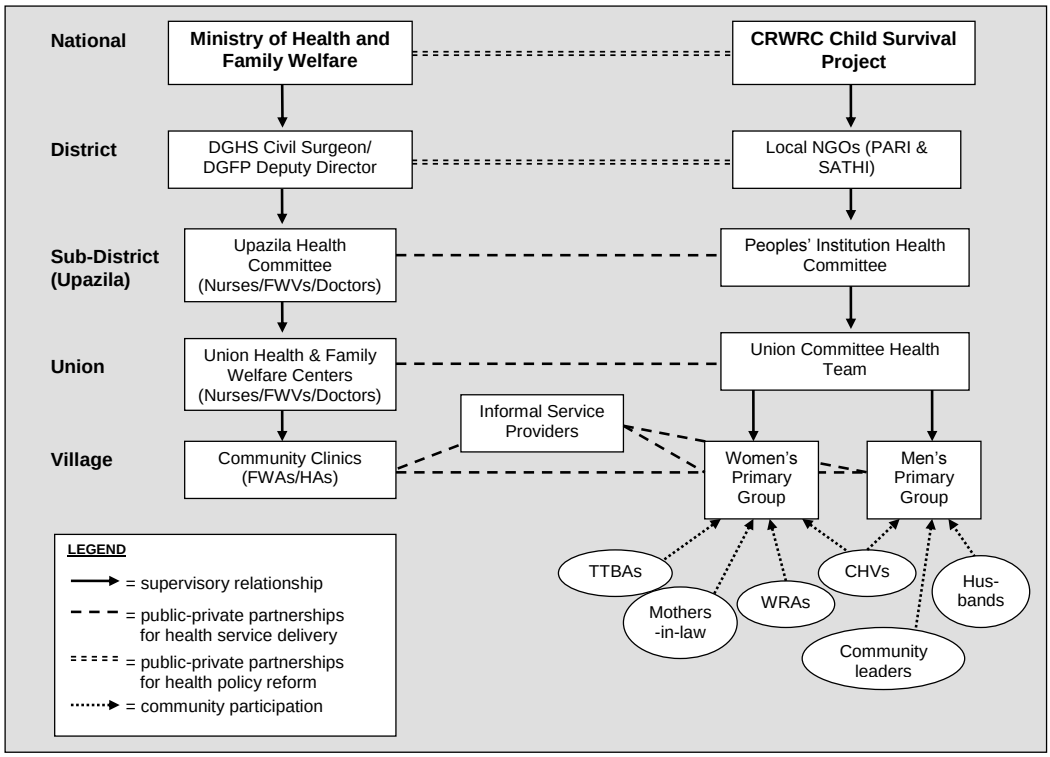




B. Cross-cutting approaches

1. Community Mobilization

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



This development model has created an institution that holds much promise for supporting the work of community volunteers and serving as the institutional links to health facilities and local authorities. PIs are looking to recruit and train more CHVs in the community; they feel ownership of this and won't stop doing it. They are supporting CHVs and TTBAs with encouragement, gifts and supplies.

<u>Models</u>: CRWRC's Peoples' Institutions model for developing Primary Groups and Peoples' Institutions to manage health programs is an effective and sustainable approach for community development. PIs are now well recognized and respected by health workers and local authorities.

<u>Promising Practices</u>: Peoples' Institutions are well established, respected and very independent.

<u>Opportunities</u>: In cases where the PI is focused exclusively on health, expand PI activities to include other community development programs, e.g., savings, IGA, literacy, leadership, and business development. At the same time, some other groups are doing general community development without community health volunteers. These groups should be introduced to the approach of training CHVs, TTBAs and Village Docs.

<u>Promising Practices</u>: Other community funds, e.g., the Seed Fund (the PI capital fund) and micro-enterprise activities managed by the PI are providing additional sources of support for PI operations, including the funding of training activities for CHVs and TTBAs.

<u>Opportunities</u>: People (outside of Primary Groups) contributing to community funds. There are many people already contributing to these funds, including the EHF and Seed Fund, and more in the community that could. The profit from the use of the seed fund will be used for honorarium and support for CHVs and TTBAs. May also add refresher training and training of replacement CHVs. PIs are also making plans to use their regular group savings for purchasing rickshaw vans for emergency transport to health facilities.

2. C-IMCI

CRWRC wisely established the implementation of the project within the framework of the national IMCI and C-IMCI strategies. This provided CRWRC the opportunity to be part of the IMCI National Working Team. The Ministry of Health recognizes that it needs the help of NGO partners because they do not have the human resources to reach everyone on their own. The CSP has been an effective demonstration of that collaboration by increasing access to and demand for priority health interventions.

The MOH IMCI approach includes three components of 1) technical training, 2) systems strengthening, and 3) Community-based IMCI. C-IMCI, in turn, also includes three elements:

- links to health facilities;
- community-based service delivery; and
- behavior change communication (BCC).

To this end the CSP embraced three strategic approaches:

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

The success of the CSP now provides an opportunity to build on the C-IMCI cross-cutting platform of interventions and to expand the project to new geographic areas. Health and local authorities would like to see an expansion of activities and groups to other unions within their district. CRWRC has pursued several possible sources of funding to support this kind of expansion at the upazila and district level, e.g., via follow-on awards from the Child Survival and Health Grants Program (CSHGP) of USAID and the Maternal, Newborn, and Child Survival (MNCS) Program managed by UNICEF. As this report was being finalized, the new CS award was announced. Meanwhile some partners have begun a limited expansion at the union level.

Union Chairmen have volunteered to allow the PIs to use the Union Council meeting room for their meetings and training activities. There are now opportunities to:

- **Replicate the PIs and community volunteers to other districts.**
- **Seek additional support and resources from local government.**

a) Community Based Health Workers

The emphasis on BCC by CHVs and TTBAs created a demand for services that was well noted and appreciated during interviews with health facility personnel and local authorities. The final evaluation team was repeatedly told that CHVs and TTBAs had increased demand for services at health facilities and that the CSP fills gaps in the government health system. The project has brought about changes in health practices, created demand for services (e.g. antenatal and postnatal care), and has linked community-based care with government health facility care. These links have been forged in such a way to optimize the change of sustaining this work. Some of the evidence of these sustainable links includes the following:

1) Health Facilities workers are very quick to note the contributions that CHVs and TTBAs have made in referring clients to health facilities;
2) An established and functional systems of signed referral slips provides concrete evidence of referrals that are being made;
3) The number of contact "points" and events between health facility personnel and community volunteers has increased both formally and informally;
4) Health facility personnel and local authorities noted (without prompting) that they have made personal contributions of funds to PI Emergency Health Funds;

CHVs and TTBAs are seen as being very complementary to the government health system. The community volunteers round up business for the government workers. Community volunteers, in effect, provide an "outreach" link from community-based to facility-based care (rather than waiting for the facility to provide outreach into the community). In addition to CHVs and TTBAs, there are other members of the PI Health Sub-Committee that play an active role in the health of their community.

> **<u>Promising Practices</u>: One Health Sub-Committee appointed a Logistics Manager (or dispatcher) to manage health-related emergencies in the community. This is a key person that could be linked to other persons in the community who own cell phones, e.g., Village Docs, for rapid communications.**

<u>Community Health Volunteers and Trained TBAs</u>

The CSP demonstrated that CHVs can be motivated primarily through respect acquired through training and the performance of their activities. TTBAs and CHVs gained a lot of respect in the community because of the training they received and the valuable service they provide to the whole community. Some respect-building activities include signing referral slips, meeting with health officials, filling leadership positions in the Primary Groups, having the ability to recommend use of the EHF, and being respected by religious leaders. In addition, each year

volunteers are recognized during a community gathering where they receive small gifts, e.g., a lantern, umbrella or *saree*. One PI in Panchagor is offering a reduced rate at the PI's semi-English medium school for children of the volunteers.

> **Lesson Learned: Volunteerism in the community (without giving money) works with a diversified support system involving community, health facilities and local government.**

The project has also demonstrated that good working relationships with health facilities can be created through working together on a variety of collaborative activities, including non-health activities. For example, TTBAs bringing people for immunizations helped to establish multiple points of contact with the government health system and improve their working relationship. These multiple contacts provide a strong foundation of collaboration for a sustainable collaboration.

> **Lesson Learned: The number of contacts "points" created between community volunteers and health workers is proportional to their working relationship.**

> **Promising Practice: Referral Slips signed by TTBAs and CHVs are effective in getting high-risk cases to health facilities. The actual signing of the slips by volunteers is reportedly a motivation. It confirms that they have the authority to refer and that their advice is being respected**

Trained TBAs know key messages really well and will continue doing what they learned. TTBAs shouldn't be ignored, and cannot be replaced by SBAs (at least not anytime soon). In the past USAID had opted not to work with TBAs and thought they had no significant role, but this program has demonstrated TBAs can make sure that deliveries are clean, and that complicated deliveries are properly referred.

> **Promising Practice: TTBAs are also effectively bringing more women into the government health system for checkups and immunizations.**

Super CHVS

Following the Mid-Term Evaluation, CRWRC followed the recommendation to *Explore and test approaches to reinforce supervision and support linkages between community-based workers and PI health sub-teams.* The result was the creation of Super CHVs as the connecting link.

This one change in the program transformed everything in a very positive way. The concept of a Super CHV serving as a liaison between the PI and the health system was an immediate success. Super CHVs serve as communication links with various government officials and health facilities and also serve as supervisors for the CHVs and TTBAs. Super CHVs are even able to train new CHVs to replace those that dropout. Super CHVs have received special training to facilitate and sustain these kinds of groups. There may also be opportunities to introduce the concept of CHVs and TTBAs into programs implemented by other organizations.

<u>Promising Practice</u>: Super CHVs were created following the MTE, and have proven to be dynamic and effective leaders that are capable of replacing project-paid animators.

<u>Opportunities</u>: Super CHVs are creating social networks of CHVs. Super CHV supervision of a cluster of 5-6 CHVs is creating small group cohesiveness, sort of like a Care Group.

<u>Opportunities</u>: There may be an opportunity for CHVs to selectively become government-paid staff. One trained CHV moved to another geographic area where she was hired as a Family Welfare Assistant. This is indicates the level of respect that is accorded these volunteers and could be a promising practice for occasional CHV integration into the health system.

<u>Village Doctors</u>

Village Docs are an intriguing type of "community volunteer." They have limited medical training that varies from one week to several months. Yet, they are very appreciative of training in modern methods such as IMCI for treatment of fevers, ARI and diarrhea. They do not consider themselves to be "traditional healers." They function more as community pharmacists than as "doctors." They are very practical businessmen, equipped with cell phones, who could provide a complementary role to that of CHVs and TTBAs. TTBAs and Village Docs now consult with each other to deal with complicated cases.

<u>Lesson Learned</u>: Village Docs can be an effective partner to complement the work of CHVs and TTBAs.

3. Communication for Behavior Change

The CSP has continued to provide targeted BCC messages to the community through CHVs and TTBAs. During the past two years the reach of that work has broadened and deepened into the communities, to include some promising practices (community theatre) and new opportunities for using local resources to enhance BCC.

<u>Promising Practice</u>: Community Theatre teams organized by PIs are reinforcing messages taught by CHVs, Super CHVs and TTBAs. They also provide a good way to involve adolescents in community actions.

<u>Lesson Learned</u>: All family members need to be involved in health education, not only mothers. It is important to involve husbands, fathers-in-law and mothers-in-law because their support is needed for adopting new care seeking practices. Involve adolescents so that knowledge and practices are transferred to next generation.

<u>Opportunities</u>: Explore local resources to expand good health promotion and communication. For example, use the microphone/loud speaker from a mosque to announce health-related events, like an immunization campaign, to gather children and mothers.

Significant behavior changes were consistently noted in all communities, especially for behaviors related to the "four times check up", child weighing, and referrals of high-risk pregnancies. Key messages are well known throughout the community including mothers of children, CHVs, PI members, health workers, and even the Union Chairman.

4. Capacity Building

a) Local partners

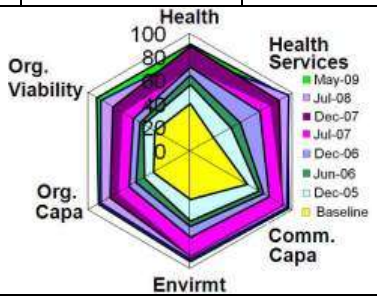
CRWRC and its partners believe that all organizations need to monitor their growth in capacity in order to understand where they are and where they hope to be in the future. With this in mind CRWRC establishes two-year renewable partnership agreements with local partners to identify and prioritize the areas in which each partner needs capacity building assistance.

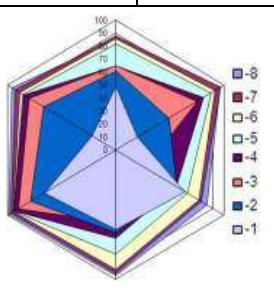
Capacity building activities by CRWRC include field visits and feedback, establishing connections with donors to diversify their partner's funding, assisting in the establishment of a board of directors for each partner and developing each partner's capacity measurement system.

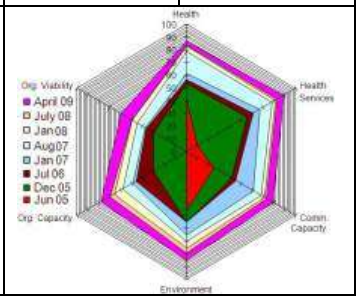
As part of the current project CRWRC and its three local partners have developed monitoring tools using the Child Survival Sustainability Assessment (CSSA) framework to measure and visualize organizational development components such as Health, Health Services, Community Capacity, Environment, Organizational Capacity, and Organizational Viability. A tabular summary of the CSSA dashboards for the three partners is shown in the table and graphs below.

CSSA Progress in Panchagor, Netrokona and Dhaka
(Composite Percentage for all Indicators in Each Component)

	SATHI		SUPOTH		PARI	
	Baseline	Final	Baseline	Final	Baseline	Final
Health	41	92	49	96	42	87
Health	23	95	20	97	10	89
Comm.	56	96	64	84	25	79
Environment	41	94	61	96	46	85
Org. Capacity	36	90	66	99	0	78
Org. Viability	35	92	22	98	0	60







The local partners (PARI, SATHI, SUPOTH) have noted that the organizational development approach of CSP have been a "certificate" confirming their ability to run Child Survival projects.

> **<u>Sustainability</u>: The NGO Partners (PARI, SATHI, SUPOTH) are not leaving. This project as "certified" their ability and confidence in implementing, managing community-sustaining health development as part of their PI networks. The end of CSP will not be the end of their commitment to CHVs and TTBAs, but rather a strong continuation.**

b) Peoples' Institutions

The CSSA Framework was also adapted into a community-managed capacity monitoring tool. Peoples' Institutions (PIs) and Primary Groups (PGs) completed self-assessment every 6 months using an organizational development monitoring tool that is appropriate to the culture and context of the organization. Peoples' Institution Capacity Indicators (PICI) were used as a tool for monitoring the capacity building.

CSP helped organizations develop its own tool for talking about and monitoring its development. The process was similar as that for the local partners, but with slightly different indicators chosen by PIs and PGs to measure capacity and sustainability. For PIs these areas included human resource development; leadership and management; legal identity; finance; gender; and networking. For PGs, the areas included management, finance, technical, community governance, and networking. When the organizations or groups reached a predetermined level of capacity in each area they could graduate and operate more independently from the NGO partner or the PI.

> **<u>Lesson Learned</u>: The CSSA Framework can be adapted into a community-managed capacity monitoring tool. CSP is using components of the CSSA framework to enhance the pre-existing Peoples' Institution Capacity Indicators (PICI) system.**

c) Training Institutions

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

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

An important unplanned achievement of the CSP was that CRWRC sub-contracted the training of CHVs and TTBAs to indigenous training institutions. This provided an opportunity to provide training of trainers in Adult Dialogue Education and in using similar curricula. The TTBA curriculum was revised to make it more participatory and to provide a better overall learning experience. By working through existing training facilities rather than developing its own training system, CRWRC has achieved an impressively low cost per TTBA and CHV (see table on right) and contributed to capacity building of local institutions.

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

using a quality improvement checklist. This provides a good balance of group meeting for cross-learning as well as one-on-one supervision.

Opportunities: Follow-up support visits by Training institutions. Training institutions, like Joyramkura, could provide more TTBA follow-up visits, as well as new training. Perhaps PIs could contract them for less money than they received under the CSP grant. Or, TTBAs could use mobile phones to call the trainers when they have questions about cases.

Opportunities: Ask Upazila and Union health personnel trained in IMCI to provide additional training for community volunteers. These health workers have already used their IMCI training to train Village Docs. They could also provide training to TTBAs and CHVs after CSP ends.

Sustainability: Super CHVs can train new CHVs to replace the occasional drop out. Super CHVs have been trained and equipped in using nine designs/lessons for training new CHVs selected by the PIs. In this way, it does not depend on outside trainers to continue recruiting and training new/replacement CHVs. This should include the training of Teen CHVs as the future generation of volunteers.

5. Health Systems Strengthening

One of the main areas of improvement since the MTE has been the efforts to establish more direct links to and working relationships with health facilities. Those linkages have grown stronger and will provide an element for the sustainability of the CSP. They have also helped to strengthen the health system by increasing the demand for services.

Lesson Learned: Local Government and health workers welcome the work of PIs as they are helping them achieve their programmatic targets and goals. Too often government health systems and community-based systems compete with each other. But the CSP has formed a collaboration and demonstrated the benefits of the two systems working together.

Promising Practice: Formal MOUs are helping to institutionalize and sustain working relationships between PIs and health facilities and establish a system for regular meetings.

Sustainability: PIs, CHVs, and TTBAs have strong and sustainable relationships with government health facilities. They work together as a complementary and supportive network. Government health facilities now count on TTBAs to enlist pregnant mothers and bring them to the SBA.

Sustainability: Monthly/Quarterly meetings for reporting and planning are important for sustainability. The meeting "habit" is firmly established and appreciated by all stakeholders. Such meetings will continue between the PI, CHVs, TTBAs, and health facilities. A good relationship with health workers means that people in the community can continue to access services without involvement of NGO staff.

<u>Opportunities</u>: There is a potential partnership for PIs with Community Clinics.

The reopening of community clinics by the MOH, the current under-utilization of those clinics, and the excellent relationship with Union authorities has created a further opportunity to strengthen the health system. A community network of more than 13,000 community clinics was built in the 1990s, but never activated due to change of government. The government that has recently "returned" to power has pledged to make these community clinics functional in order to increase access to health services. Each two-room clinic was designed to serve a population of 6,000 and to be staffed by a Health Assistant (HA) and Family Welfare Assistant (FWA). According to the MOH, 4,500 community clinics were "reopened" in May 2009. However, in practice most of them (see picture) are only open a couple of hours a week.

One intriguing opportunity for the CSP will be to explore ways that PIs might become involved with the operations of community clinics. One option might be for local government to establish a MOU with the PI to partner with, or even manage, a community clinic or a cluster of clinics. This would include using the building for PI-hosted meetings, discussion groups and trainings, and hosting MOH activities for NID, EPI, and antenatal checkups. This arrangement could further reinforce links between PIs/CHVs/TTBAs with health workers and government authorities to ensure increased access to health services. The follow-on Child Survival project and a proposal for MNCS with UNICEF could be opportunities to experiment with these enhanced approaches of collaboration.

6. Policy and Advocacy

The Government of Bangladesh has been implementing a policy on IMCI. As noted previously, CRWRC specifically adapted the CSP to serve as a testing ground for implementation of that IMCI and C-IMCI policy. CRWRC serves on the National Working Team for IMCI, along with eleven other government agencies and NGOs. In this capacity, CRWRC has been contributing to the formation of national strategy on community-based IMCI, including key aspects related to caring and care-seeking for the sick child, feeding and nutrition, essential newborn care, referrals, and promotion of safe deliveries.

CRWRC has practical experience to contribute after implementing C-IMCI in its current Child Survival Project for the past four years. CRWRC has also been carrying out operational research on community case management of pneumonia and diarrhea which is being viewed favorably for adoption into the C-IMCI policy. See Annex 11 for a Special Report on the Community Case Management research conducted by CSP.

In addition, CRWRC has been an active member of the Neonatal Technical Group. This is a sub-group of the National Working Team for IMCI, which developed the draft National Neonatal Health Strategy. The Government has shown a strong commitment to working with NGOs in the areas of IMCI and neonatal health and is currently ensuring that one NGO is the lead in each upazila. CRWRC has had extensive contact with the Deputy Program Manager on IMCI and neonatal health, and he has given assurances that CRWRC will be recognized as the designated organization working on IMCI and neonatal health in Kendua and Durgapur.

CRWRC has also been an executive member of the White Ribbon Alliance since 2005. Through this collaboration CRWRC helps to inform stakeholders of key findings from CRWRC's innovation model at the upazila, district and national level.

In collaboration with ICDDR,B, CRWRC has attended national scientific meetings, e.g., the Annual Scientific Conference at ICDDR,B and the *International Conference on Scaling Up* organized by BRAC to present findings from their operations research.
The advocacy and policy work of CRWRC and its partners is not, however, limited to the national level. Through the current Child Survival Project and earlier community-based programming, PARI and SATHI have gained experience in advocacy and networking with local government within the People's Institution model. This approach ensures that the community's collective voice will be heard at these meetings at every level to express their concerns.

> **<u>Opportunities</u>: Documenting the TTBA experience for advocacy work. The CSP should write up a case study of how TTBAs were trained in this project, because there is potential for scaling up that approach and influencing policy.**

> **<u>Opportunities</u>: Scaling up CCM and Emergency Health Fund. Opportunities exist to replicate and expand these approaches and, in the process, to influence government policy. CSP can promote this via the IMCI working group and maybe through incorporating it into a future program. CRWRC should continue to put in effort at the national level to influence policy.**

7. Contribution to Scale/Scaling Up

As noted above in the "Health Systems Strengthening" section, the current Government of Bangladesh is reopening (scaling up) a community network of more than 13,000 community clinics According to the MOH, 4,500 community clinics began a limited reopening of services in May 2009. The CSP with its strong network of CHVs, TTBAs, Primary Groups, and People's Institutions is providing a number of approaches to reinforce and scale-up that process.

CRWRC's operational research on community case management of pneumonia and diarrhea which is being viewed favorably for adoption into the C-IMCI policy, and for scaling up those interventions in additional geographic areas.

One of the most frequent requests addressed to the CSP implementing partners by local authorities is the request to replicate the training of CHVS and the organization of community groups into neighboring geographic areas. The three local partners have already taken some initiatives along those lines with the mobilization of non-CSP funding. In addition, the new CSP project will provide funding for geographic scaling up in the Netrokona area.

> **Models: The Community Case Management (CCM) best practice has been implemented by the CSP through a network of Community Health Volunteers (CHVs). This innovative use of volunteers has created a new opportunity for CCM in Bangladesh.**
>
> **Promising Practices: The EHF has evolved into a widely recognized and respected tool that is attracting contributions from all levels, including local elites, health workers and government officials.**

8. Equity

A key innovation of the CSP project with respect to equity has been addressed in the management of an Emergency Health Fund (EHF). Details of this fund are noted in several sections of this report, including in the Results Highlights section of Chapter VII. The EHF helps to ensure that all community members have access to emergency assistance, usually emergency transportation services, regardless of whether they have materially contributed to the EHF. This is, in fact, a form of community-based equity-care insurance.

The referral by CHVs and TTBAs to have community members seek services at health facilities is also a factor in increasing the equity of health care, i.e., to ensure that care is being made accessible to those who are most in need.

Women's leadership has also been emphasized by CSP. The role of women has grown significantly in the community to become somewhat more equitable. Women became engaged and empowered as leaders in the community with support from their family.

It was also encouraging to find that PI members come more or less equitably from multiple religions and tribes, at least with respect to population. It's important to first to talk to religious leaders and involve them in the program.

> **Lesson Learned: Community members from different religious and cultural backgrounds can work effectively and harmoniously together without conflict for health.**

9. Sustainability

The PIs are the key to sustainability. The systems that have been successfully transferred to volunteers (CHVs and TTBAs) and the community can be sustained. PIs, CHVs, and TTBAs all feel a high level of ownership and independence for their work and are confident that they have the knowledge to continue. The PIs expect not just to sustain the current CSP work, but also to

expand it in a sustainable way. A portion of the profits from the PI's profit-making activities will be used to support these activities and expansion.

Most PIs already have sustainable assets, e.g., their own meeting house. This establishes a long-term investment for meetings, trainings and continued developmental support to their communities. The healthy bank balances maintained by PIs is a good indication of their sustainability. Many PIs already have capital and resources and that can be used this to sustain their programs. These funds are being used for training activities and support to CHVs, e.g., for supplies like lanterns, umbrellas, and *sarees.*

> **Sustainability: The PI is the key to sustainability. Most PIs already have sustainable assets, e.g., their own meeting house.**

Through efficient capacity building, from Primary Groups to Peoples' Institutions, the CSP has created a strong and sustainable network of community-based groups to support community-based volunteers and promotion of health messages. An expansion of this approach has created links to health facilities and local authorities and opened up additional resources to support community volunteers. CHVs and TTBAs are providing services where there is a gap in the government health system. The project has also created supportive links from community groups to local government and health facilities, including signed MOUs of collaboration. This multi-directional system of support bodes well for the sustainability of this program.

> **Lesson Learned: A network of support resources enhances sustainability. The CSP project was designed to create community-based groups to support the work of CHVs and TTBAs.**

10. Project Management

The CSP management teams sometimes think that evaluations, such as the MTE, are simply administrative hurdles to overcome. In this case, however, the MTE provided several key

changes in direction, e.g., Super CHVs and reinforcing links to health facilities and government. Those changes have improved the potential for sustaining the work of CHVs and PIs.

> **Lesson Learned: Midterm Evaluations can be extremely helpful.**

The project management team has also learned that:

> **Lesson Learned: Dissemination meetings can be a good way to leverage government support.** A variety of meetings hosted by CSP, NGO partners, or PIs can be opportunities to increase awareness of the program, to develop relationships and to leverage additional support.

> **Lesson Learned: The best project staff came from an integrated community development experience.** Those with experience in community development are able to apply concepts of program sustainability more quickly than those coming from a single sector background.

Lesson Learned: Using the PI approach, a few project-paid staff can "cover" a whole community. It's like small tree bearing a big fruit. Supporting volunteers through community group members is a better and more sustainable approach then using many project paid staff.

III. CHANGES IN GRANTEE ORGANIZATION CAPACITY

CRWRC has been working to strengthen its organizational capacity in the areas of financial management (especially of grants), human resource management, and technical interventions for health. The four organizational capacity objectives that CRWRC has been tracking as part of the CSP are shown in the table below.

CRWRC Capacity Building Objectives and Status	
1) CRWRC maintains a positive financial position.	CRWRC net assets increased from $14.3 million in FY07 to $16 million in FY08. The CSP in Bangladesh was CRWRC's first CSHGP award (entry category). Since that time, CRWRC won a second CSHGP award in 2007 and also received awards under the New Partners Initiative and the Malaria Communities Program. Recently, CRWRC was recommended for another CSHGP award which is set to begin in October 2009. During FY08, CRWRC received $2,562,221 in revenue from the US Government, which accounted for about 6.7% of the organization's total annual revenues. In July 2007, CRWRC created a new position for a Chief Financial Officer. The CFO has strengthened many of CRWRC's financial management and internal control systems and has set in place policies to ensure compliance with USG regulations for grants.
2) CRWRC increases clarity about lines of accountability and performances expectations for all its personnel.	In 2004 when CRWRC began implementing the CSP, lines of accountability were not clear, and the team leader position was not invested with much authority. A new position of the Regional Team leader has been clarified and strengthened lines of authorities and responsibilities. CRWRC uses the Main Team Self-Assessment Survey (MTSAS) on an annual basis to evaluate team performance and inter-team collaboration. All CRWRC personnel have position descriptions and receive an annual performance evaluation. In 2007, the US and Canadian Executive Directors revised CRWRC's "Boundaries Document" to provide greater clarification on decision making authority and lines of accountability in CRWRC. As a result of these changes, there is greater alignment of programs with CRWRC's mission and vision, and staff are being held more accountable for achieving measurable results.
3) CRWRC knows the specific results that its programs are achieving and can identify programs that need to be strengthened.	In 2004, CRWRC initiated a contract with Newdea – a company that was developing an online system for results-based project management. This system went online in 2006, with all teams and field offices now entering annual plans and quarterly financial and progress reports into this online system. All teams and local partners were trained in Results-Based Management (RBM). Teams are now reporting on outcome-level changes that make it clearer whether program activities are achieving the medium- and long-term results. Customized Newdea reporting tools help to identify programs that need to be strengthened.

CRWRC Capacity Building Objectives and Status	
4) CRWRC increases its capacity to provide high quality consultation to its local partners on sustainable health programming.	CRWRC Bangladesh has hosted four Learning Exchanges with other CRWRC staff and partner organizations in Ecuador, Uganda, Laos, Cambodia, Tanzania, Zambia, Senegal, Nigeria and Niger. Will Story and Nancy TenBroek have provided technical assistance to several countries to provide training and follow-up for learning exchanges. As a result, Laos is beginning to adapt the Peoples' Institution model for village development committees, the Regional Health Advisor for Asia is providing consultancy to Laotian and Cambodian health programs, and a five-day Designing for Behavior Change workshop was conducted for the Latin America Ministry Team. The Learning Exchanges have been an extremely effective means of disseminating learning and promising practices from the CSP into CRWRC and its partner network around the world.

In February 2006, CRWRC became a member of the Child Survival Collaborations and Resources (CORE) Group. The Child Survival and Health Technical Advisor, Will Story, has served on the Board of Directors and as co-chair of the Social and Behavioral Change Working Group for the CORE Group. He has also worked through the CRWRC Regional Health Advisors (one in each regional team) to disseminate the best practices and innovative ideas gleaned from the CORE Group. Some of the tools that have entered CRWRC this way include the BEHAVE Framework (a.k.a. Designing for Behavior Change), Positive Deviance/Hearth, Partnership Defined Quality, and the Child Survival Sustainability Assessment.

The most unexpected area of capacity growth was in networking and policy advocacy. Prior to this grant, CRWRC had little knowledge of the government health system and was not known by organizations engaged in health programming. CRWRC is now well known by the USAID Mission in-country, participates actively in important national-level working groups that are developing health strategies for Bangladesh, and has connections with high ranking national-level health officials in the Bangladesh government. These connections have proven extremely useful in influencing policy and creating a better enabling environment for community-based health strategies in Bangladesh. There are lessons in this experience for the other countries were CRWRC works, and a new mentality of engaging with local government is beginning to emerge, especially for staff and partners that participated in CSP learning exchanges.

IV. MISSION COLLABORATION

CRWRC Bangladesh has maintained regular contact with the local mission via Mr. Kishnapada Chakraborty in the Health and Population Division. Mr. Chakraborty participated in the midterm evaluation and meets regularly with CRWRC staff. USAID was also instrumental in CRWRC's membership on the newly formed Maternal Health Committee led by Engender Health, Bangladesh.

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

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

V. CONTEXTUAL FACTORS THAT INFLUENCED RESULTS

There were no additional contextual factors identified by the evaluation team that influenced the results of the CSP.

VI. CONCLUSIONS

The final evaluation process answered the six "AMPLOS" questions:

- **A**: What were the project's **Achievements**?
- **M**: Were the implementation **Models** and approaches effective?
- **P**: What are some **Promising Practices** initiated by this project?
- **L**: What are the **Lessons Learned** from this project?
- **O**: What **Opportunities** exist for scaling up or replication?
- **S**: How can the project achievements be **Sustained**?

The conclusions section summarizes the responses to those questions:

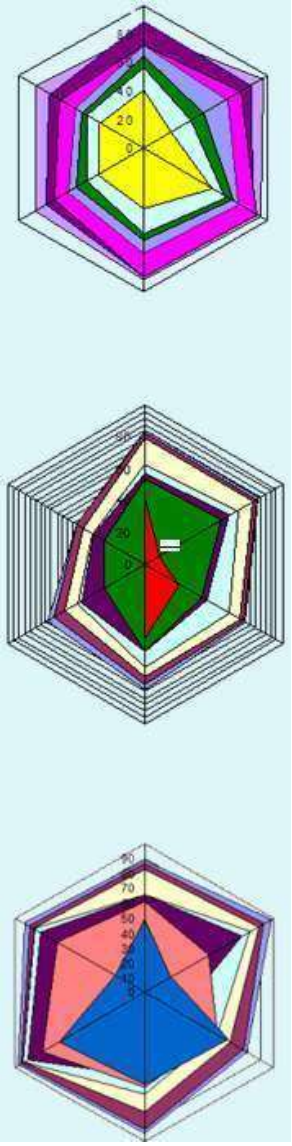
A. Achievements

Did the project achieve its objectives? What were project achievements?

The answer to the first question is a resounding "YES." The CSP achieved 93% or more of targets for 15 of the 16 project objectives. For most objectives the project surpassed the targets by a margin of more than 110%.

With regard to achievements by the project, the following are notable:

- Many health workers interviewed, including SBAs, felt that the project had contributed to a reduction of child and maternal deaths. An estimated number of 399 children's lives were saved based on calculations using the *Lives Saved Calculator*. There was also an estimated 36% overall reduction in under-five child mortality.
- The CSP fills gaps in the government health system. The project has brought about changes in health practices, created demand for services (e.g. antenatal and postnatal care), and has linked community-based care with government health facility care.
- CHVs and TTBAs are very complementary to the government health system. The community volunteers round up business for the government workers.



- Community volunteers provide an "outreach" link from community-based to facility-based care (rather than waiting for the facility to provide outreach into the community).
- Significant behavior changes were consistently noted in all communities, especially for behaviors related to the "four times check up", child weighing, and referrals of high-risk pregnancies. Key messages are well known throughout the community including mothers of children, CHVs, PI members, health workers, and even the Union Chairman.
- Through efficient capacity building, from Primary Groups to Peoples' Institutions, the CSP has created a strong and sustainable network of community-based groups to support community-based volunteers and the promotion of health messages.
- The project has also created supportive links from community groups to local government and health facilities, including signed MOUs of collaboration. This multi-directional system of support bodes well for the sustainability of this program.
- Women's leadership was emphasized and grew in the community. Women became engaged and empowered as leaders in the community with support from their family.
- The CSP project has become a "certificate" for the NGO partners (PARI, SATHI, SUPOTH) that confirms their ability to run Child Survival projects.

B. Models and Approaches

Were the implementation Models and approaches effective?

CRWRC and its implementing partners were very effective and efficient in using and combining synergistically proven approaches as part of this project. This included approaches such as Dialogue Education, the BEHAVE framework, Doer/Non-doer Analysis, Supportive Skilled Supervision, PD/Hearth, and Kangaroo Care to train and monitor the development of community groups and volunteers for technical interventions.

Models and approaches that are particularly noteworthy include:

1) **CRWRC's Peoples' Institution** model for developing Primary Groups and Peoples' Institutions to manage health programs is an effective and sustainable approach for community development. PIs are now well recognized and respected by health workers and local authorities.
2) **Peoples' Institution Capacity Indicators (PICI)** were used as a tool for monitoring the capacity building of PIs. See also Lesson Learned #8.

3) **The Community Case Management (CCM)** best practice has been implemented by the CSP through a network of Community Health Volunteers. This innovative use of volunteers has created a new opportunity for CCM in Bangladesh.

4) The CRWRC-developed model of the ***Learning Circle*** is the vehicle to disseminate learning from the CSP to 15 NGO partners.

C. Promising Practices

What are some Promising Practices initiated by this project?

The CSP initiated a number of interventions which may be considered Promising Practices for sustaining and expanding the work. These include the following:

1) **Peoples' Institutions** are well established, respected and very independent. This development model has created an institution that holds much promise for supporting the work of community volunteers and serving as the institutional link to health facilities and local authorities. PIs are looking to recruit and train more CHVs in the community; they feel ownership of this and won't stop doing it. They are supporting CHVs and TTBAs with encouragement, gifts and supplies.

2) **Formal MOUs** are helping to institutionalize and sustain working relationships between PIs and health facilities and establish a system for regular meetings. Getting the support of local leaders like the Union Chairman is also very encouraging. PIs now have a better relationship with the Civil Surgeon and Deputy Director of Family Planning.

3) **A Community-based financing approach, called the Emergency Health Fund (EHF)**, has been created and managed by PIs though a monthly contribution of a few pennies (2 taka) by its members. A small amount is kept on hand as cash, and the rest is banked. This solidarity approach provides a way to quickly provide emergency care, especially transportation to health facilities and emergency treatment. The EHF has evolved into a widely recognized and respected tool that is attracting contributions from all levels, including local elites, health workers and government officials. One Member of Parliament donated 3 metric tons of rice for a PI to sell and use the money for the EHF.

4) **Other Community Funds**, e.g., the Seed Fund (the PI capital fund) and micro-enterprise activities managed by the PI are providing additional sources of support for PI operations, including the funding of training activities for CHVs and TTBAs.

5) **Super CHVs** were created following the MTE, and have proven to be dynamic and effective leaders that are capable of replacing project-paid animators. This one addition to the program has transformed everything in a very positive way. Super CHVs liaise with PIs, various government officials and health facilities, and even train new CHVs to replace those that dropout.

6) **Trained TBAs** know key messages really well and will continue doing what they learned. TTBAs shouldn't be ignored, and cannot be replaced by SBAs (at least not anytime soon). In the past USAID had opted not to work with TBAs and thought they had no significant role, but this project has demonstrated that you can use TBAs to make sure that deliveries are clean, and that complicated deliveries are properly referred. TTBAs are also effectively bringing more women into the government health system for checkups and immunizations.

7) **Referral Slips** signed by TTBAs and CHVs are effective in getting high-risk cases to health facilities. The actual signing of the slips by volunteers is reportedly a motivation. It confirms that they have the authority to refer and that their advice is being respected.

8) **A Logistics Manager (or dispatcher)** has been appointed by the Health Sub-Committee to manage health-related emergencies in the community. This is a key person that could be linked to other persons in the community who own cell phones, e.g., Village Docs, for rapid communications.

9) **Community Theatre teams** organized by PIs are reinforcing messages taught by CHVs, Super CHVs and TTBAs. They also provide a good way to involve adolescents in community actions.

D. Lessons Learned

What are the Lessons Learned from this project?

1) **Volunteerism in the community (without giving money) works with a diversified support system involving community, health facilities and local government.** CHVs are motivated primarily through respect acquired through training and the performance of their activities. TTBAs and CHVs gained a lot of respect in the community because of the training they received and the valuable service they provide to the whole community. Some respect-building activities include signing referral slips, meeting with health officials, filling leadership positions in the Primary Groups, having the ability to recommend use of the EHF, and being respected by religious leaders. In addition, each year volunteers are recognized during a community gathering where they receive small gifts, e.g., a lantern, umbrella or saree. One PI in Panchagor is offering a reduced rate at the PI's semi-English medium school for children of the volunteers.

2) **A network of support resources enhances sustainability.** The CSP was designed to create community-based groups to support the work of CHVs and TTBAs. An expansion of this approach has created links to health facilities and local authorities and opened up additional resources to support community volunteers. CHVs and TTBAs are providing services where there is a gap in the government health system.

3) **Community members from different religious and cultural backgrounds can work effectively and harmoniously together without conflict for health.** It is encouraging to find PI members coming from multiple religions and tribes. It's important to first talk to religious leaders and involve them in the project.

4) **Local Government and health workers welcome the work of PIs as they are helping them achieve their programmatic targets and goals.** Too often government health systems and community-based systems compete with each other. But the CSP has formed a collaboration and demonstrated the benefits of the two systems working together

5) **The number of contacts "points" created between community volunteers and health workers is proportional to their working relationship.** Good working relationships with health facilities can be created through working together on a variety of collaborative activities, including non-health activities. For example, TTBAs bringing people for immunizations helped to establish multiple points of contact with the government health system and improve their working relationship.

6) **All family members need to be involved in health education, not only mothers.** It is important to involve husbands, fathers-in-law and mothers-in-law because their support is needed for adopting new care seeking practices. It is also important to involve adolescents so that knowledge and practices are transferred to next generation.

7) **Village Docs can be an effective partner to complement the work of CHVs and TTBAs.** Village Docs have limited medical training (one week to several months). They are very appreciative of training in modern methods such as IMCI for treatment of fevers, ARI and diarrhea. TTBAs and Village Docs now consult with each other to deal with complicated cases.

8) **The CSSA Framework can be adapted into a community-managed capacity monitoring tool.** The CSP is using components of the CSSA framework to enhance the pre-existing Peoples' Institution Capacity Indicators (PICI) system.

9) **Midterm Evaluations can be extremely helpful.** Projects sometimes think that evaluations such as the MTE are simply administrative hurdles to overcome. In this case, however, the MTE provided several key changes in direction, e.g., Super CHVs and reinforcing links to health facilities and government. Those changes have improved the potential for sustaining the work of CHVs and PIs.

10) **Dissemination meetings can be a good way to leverage government support.** A variety of meetings hosted by the CSP, NGO partners, or PIs can be opportunities to increase awareness about the program, to develop relationships and to leverage additional support.

11) **The best project staff came from an integrated community development experience.** Those with experience in community development are able to apply concepts of program sustainability more quickly than those coming from a single sector background.

12) **Using the PI approach, a few project-paid staff can "cover" a whole community.** It's like small tree bearing a big fruit. Supporting volunteers through community group members is a better and more sustainable approach then using many project paid staff.

E. Opportunities

What Opportunities exist for scaling up or replication?

1) **Replication of the PIs and community volunteers to other districts.** Peoples' Institutions provide an opportunity to continue the work and also expand to new geographic areas. Health and local authorities would like to see an expansion of activities and groups to other unions within their district. CRWRC is pursuing several possible sources of funding to support this kind of expansion at the *upazila* and district level, e.g., via a follow-on award from the CSHGP of USAID and funding from MNCS Program managed by UNICEF. Meanwhile some partners have begun a limited expansion at the union level.

2) **There is a potential partnership for PIs with community clinics.** The reopening of community clinics by the MOH, the current under-utilization of those clinics, and the excellent relationship with Union authorities has created an opportunity to explore a variety of ways that PIs can be involved with the operations of community clinics. One option might be for local government to establish a MOU with the PI to partner with, or even manage, a community clinic or a cluster of clinics. This would include using the building for PI-hosted meetings, discussion groups and trainings, and hosting MOH activities for NID, EPI, and antenatal checkups. This arrangement could further reinforce links between PIs/CHVs/TTBAs with health workers and government authorities to ensure increased access to health services. The follow-on Child Survival project and a proposal for MNCS with UNICEF could be opportunities to experiment with these enhanced approaches of collaboration.

3) **There may be an opportunity for CHVs to selectively become FWAs.** One trained CHV moved to another geographic area where she was hired as a FWA. This indicates the level of respect that is accorded these volunteers and could be a promising practice for occasional CHV integration into the health system.

4) **People (outside of Primary Groups) contributing to community funds.** There are many people interested in contributing to these funds, including the EHF and Seed Fund. The profit from the use of the seed fund will be used for honorarium and support for CHVs and TTBAs. May also add refresher training and training of replacement CHVs. PIs are also making plans to use their regular group savings for purchasing rickshaw vans for emergency transport to health facilities.

5) **Super CHVs are creating social networks of CHVs.** Super CHV supervision of a cluster of 5-6 CHVs is creating small group cohesiveness, sort of like a Care Group. Super CHVs have received special training to facilitate and sustain these kinds of groups. There may also be

opportunities to introduce the concept of CHVs and TTBAs into programs implemented by other organizations.

6) **Documenting the TTBA experience for advocacy work.** The CSP should write up a case study of how TTBAs were trained in this project, because there is potential for scaling up of that approach and influencing policy.

7) **Expand PI activities to include other community development programs**, e.g., savings, IGA, literacy, leadership, and business development. At the same time, some other groups are doing general community development without community health volunteers. These groups should be introduced to the approach of training CHVs, TTBAs and Village Docs.

8) **Seek additional support and resources from local government.** Union Chairmen have volunteered to allow the PIs to use the Union Council meeting room for their meetings and training activities.

9) **Explore local resources to expand good health promotion and communication.** For example, use microphone/loud speaker from mosque to announce health-related events, like the immunization program, to gather mothers and their children.

10) **Ask Upazila and Union health personnel trained in IMCI to provide additional training for community volunteers.** These health workers have already used their IMCI training to train Village Docs. They could also provide training to TTBAs and CHVs after the CSP ends.

11) **Follow-up support visits by Training institutions.** Training institutions, like Joyramkura, could provide more TTBA follow-up visits, as well as new training. Perhaps PIs could contract them for less money than they received under the CSP grant. Or, TTBAs could use mobile phones to call the trainers when they have questions about cases.

12) **Scaling up CCM and Emergency Health Fund.** Opportunities exist to replicate and expand these approaches and, in the process, to influence government policy. The CSP can promote this via the national IMCI working group and maybe through incorporating it into a future program. CRWRC should continue to make an effort at the national level to influence policy.

F. Sustainability

How can the project achievements be sustained?

1) **The PI is the key to sustainability.** The systems that have been successfully transferred to volunteers (CHVs and TTBAs) and the community can be sustained. PIs, CHVs, and the TTBAs all feel a high level of ownership and independence for their work and are confident that they have the knowledge to continue. The PIs expect not just to sustain the current CSP work, but also to expand it in a sustainable way. A portion of the profits from the PI's profit-making activities will be used to support these activities and expansion.

2) **Most PIs already have sustainable assets, e.g., their own meeting house.** This establishes a long-term investment for meetings, trainings and continued developmental support to their communities. The healthy bank balances maintained by PIs is a good indication of their sustainability. Many PIs already have capital and resources and that can be used to sustain their programs. These funds are being used for training activities and support to CHVs, e.g., for supplies like lanterns, umbrellas, and *sarees.*

3) **Monthly/Quarterly meetings for reporting and planning are important for sustainability.** The meeting "habit" is firmly established and appreciated by all stakeholders. Such meetings will continue between the PI, CHVs, TTBAs, and health facilities. A good relationship with health workers means that people in the community can continue to access services without involvement of NGO staff.

4) **PIs, CHVs, and TTBAs have strong and sustainable relationships with government health facilities.** They work together as a complementary and supportive network. Government health facilities now count on TTBAs to enlist pregnant mothers and bring them to the SBA.

5) **Super CHVs can train new CHVs to replace the occasional drop out**. Super CHVs have been trained and equipped in using nine designs/lessons for training new CHVs selected by the PIs. In this way, it does not depend on outside trainers to continue recruiting and training new/replacement CHVs. This should include the training of Teen CHVs as the future generation of volunteers.

6) **The NGO Partners (PARI, SATHI, SUPOTH) are not leaving**. This project as "certified" their ability and confidence in implementing, managing community-sustaining health development as part of their PI networks. The end of the CSP will not be the end of their commitment to CHVs and TTBAs, but rather a strong continuation.

VII. ANNEXES

Annex 1: Results Highlights

A. Innovative Idea: Super CHVs

A Super Community Health Worker

Following the Mid-Term Evaluation, CRWRC followed the recommendation to *Explore and test approaches to reinforce supervision and support linkages between community-based workers and PI health sub-teams.* The result was the creation of Super CHVs as the connecting link.

Milon Tara is a mother, wife, and a Super CHV (Community Health Volunteer). In a society with numerous limitations for women, she, and several dozen other CHVs, have received additional training and responsibility to further promote good health in their communities.

With her willingness to work for others and good acceptance in the community, Milon was chosen to be trained as a CHV in her area of Mirpur. She received a 5-day training on primary health care followed by a 3-day refresher training from SATHI. Once she completed the training, she began teaching nutrition and health lessons to pregnant mothers and adolescent girls, and visited 15 to 20 households a week in order to make sure that mothers and children were well. Milon especially enjoyed monitoring children's growth through child-weighing sessions and participating in national health observances such as the National Immunization Day (NID) and HIV/AIDS Day.

"When I first began working as a CHV, people were not interested in health lessons, but now they understand the importance of health and voluntarily come to the meetings to learn more. Mothers are extremely happy when they see their children growing, but tell me that they need to feed them more when their weight remains the same," Milon told us with a smile of satisfaction on her face. "And pregnant mothers now ask for TTBAs (trained traditional birth attendant) instead of TBAs (traditional birth attendant) when they are expecting."

In 2007 Milon was selected by her Peoples' Institution to become a Super CHV, and went through leadership and networking training to supervise CHVs. The role of Super CHV was created by CRWRC in order to ensure the sustainability of their Child Survival Program. Super CHVs work closely with the government and the Peoples' Institutions so that their health program can carry on for years to come, even without the NGO in the picture. The already existing, unique governance structure of Peoples' Institutions, Primary Groups, and health sub-committees is a strong foundation on which this health initiative can sustain and grow stronger.

Some may think of her as a "Super"-woman with all the work that she does inside and outside of her home. As Milon shared with us, "I used to think of myself as an ordinary woman, but through many trainings and experience in working with others, I have come to see myself

differently. I know that I can do many things for my community and my community respects me for the work that I do. I am very happy and satisfied with my work as a Super CHV, and I want to continue to learn more." As a Super CHV, Milon has witnessed positive changes both within her community and her life.

The problem being addressed: During the life of a child survival project, supervision and training for the unpaid community workers, such as community health volunteers (CHVs) and trained traditional birth attendants (TTBAs), is provided by paid project staff. At the end of the project it is difficult to find ways to continue to pay these staff to continue providing support. Therefore, one of the primary threats to the sustainability of a child survival project is providing continued supervision and training to this cadre of unpaid community workers.

The project's input to address it: CRWRC developed the position of "Super CHV" during the Midterm Evaluation as an alternative way to provide supervision and training when the financial support is reduced. During the past year, Super CHVs were selected based on literacy skills (minimum class five in rural areas and eight in urban area), willingness to serve, recommendation of the Peoples' Institution (PI), good results on post-test trainings in basic courses, and good communication skills.

The magnitude of the intervention: During the past year, Super CHVs were trained to oversee the work of all of the other CHVs. In Dhaka, SATHI selected and trained 52 Super CHVs. This is a large number because SATHI works in four distinct areas and the PIs felt this many were needed to cover the areas. In Panchagor, SUPOTH selected and trained 18 Super CHVs, and 23 Super CHVs were selected and trained in Netrokona by PARI.

Specific results: The Super CHV training was designed by CRWRC in collaboration with Global Learning Partners (GLP) and included a training of trainers on the nine lessons designed by CRWRC and GLP in 2006. These lessons included report writing, module writing, record keeping, communication skills with government, supervision skills and leadership skills. The initial workshop was five days, with a two day refresher workshop. Community Health Animators (paid CSP staff) met monthly with the Super CHVs. The Super CHVs are also the primary link between the PI health sub-committees and the local government and non-governmental health facilities. The health sub-committees organized and led quarterly networking and coordination meetings with the local government health facilities with support from partner organization staff as needed.

B. Promising Practice: Peoples' Institutions - The Muhkta Society

The problem being addressed: In Bangladesh, most NGOs working in integrated community development follow a community mobilization model which consists of villagers or slum dwellers forming small groups of 15-20 people. The small groups participate in literacy, health, income generation, and agriculture programs developed by the NGO. Often, when the NGO leaves, the small groups tend to dissolve due to dependence on the NGO. CRWRC's mission is to help communities develop their own sustainable community-based organizations (CBOs) that will continue to function after the local NGO moves to other areas.

The project's input to address it: In the early 1990's, CRWRC developed a three-tier system of group formation beginning with the primary groups which are formed at the village level. This was supplemented by Central Committees, which helped to oversee the daily activities of the primary groups in the small geographic unit called a union. As these groups developed and flourished, the communities and CRWRC's partner organizations realized that a CBO would help primary groups with advocacy, ensuring the continuation of activities at the local level, networking with Government and other NGOs, procuring resources, and assisting the broader communities in which they lived. The CBO, also know as a Peoples' Institution (PI), represents a larger geographic area and is registered with the Government. At the beginning of the CSP in 2004, CRWRC and its partner organizations worked with the PIs to develop a stronger health support system in the community that would ensure sustainability of the CSP interventions. The PIs ensure that the CSP activities are reaching all members as well as the broader community. Each PI has a health sub-committee that is responsible for selecting TBAs and CHVs for training, as well as establishing linkages with local clinics and Government health services. This system is designed to be embedded in the community and not dependent on the external NGO.

The magnitude of the intervention: The PI model includes all 593 primary groups and almost 20,000 individuals in the CSP (over 12,000 adult and adolescent group members and almost 6,000 children under five), as well as an additional 900 primary groups and 20,000 individuals in the non-CSP activities of the three projects.

Specific results: The CSP achieved 93% or more of targets for 15 of the 16 project objectives. For most objectives the project surpassed the targets by a margin of more than 110%. In addition, the project reduced the number of underweight children by 37% (from 40% to 25.3%). Peoples' Institution Capacity Indicators reveal a five-year growth from 36 to 90 in Dhaka, 0 to 78 in Netrokona, and 66 to 99 in Panchagor. Each of the 19 PIs under the CSP program is now functioning with a leadership executive body and a health sub-committee made up of at least six members. The PIs meet formally on a monthly basis to review reports of activities by the various technical teams. The health sub-committees directly oversee the work of the CSP in their localities. They have selected the 510 CHVs and 238 TBAs for training and continue to work with the local Government to procure resources and provide necessary health services. The health sub-committee is also working to involve the broader community in the programs and arranges semi-annual dissemination meetings, monthly drama events, fathers meetings, and other gatherings for the entire community. They are working to involve the whole community in improving and sustaining health care for all community members. PIs have also started overseeing the Super CHVs (a cadre of CHVs that provide supervision for other CHVs in their working area) and the trained TBAs. The PIs are holding quarterly meetings with the local Government health facilities and attending District meetings with the Government as requested. The PIs are committed to sustaining the CSP activities as well as replicating the activities in other villages.

C. Promising Practice: Emergency Health Fund of the Muktha Society

The Emergency Health Fund managed by Peoples' Institutions was highlighted in the Mid-Term Evaluation report, but merits mentioning again. During the past two years it has evolved into a widely recognized and well respected tool that receives contributions from all levels, including local elites, health workers and government officials. In fact, almost every health worker and local authority interviewed during the final evaluation made a point of letting the evaluation team know that they personally contribute to their local Emergency Health Fund. One Member of Parliament even donated three metric tons of rice for a PI to sell and use the money for the EHF.

The CSP developed the Emergency Health Funds to assist medical treatment and transportation costs. EHF bi-laws encourage community primary group members to contribute a small amount (2 taka = 3 cents) each month. Primary Group members, TTBAs and CHVs can apply for emergency health funds on a 24/7 basis for group and non-group members in the form of loans, especially for emergency transportation. There are also provisions on a case-by-case basis for the extremely poor to receive assistance without a commitment to repay funds. The beneficiary population eligible for assistance includes, therefore, not only the 7,000 current Primary Group members but also the general population of more than 100,000.

A good example of a well-managed EHF is by the Mukta Society of Netrokona. Mukta means "pearl" in Bangla, and, according to its members, they want to be like a pearl -- pure, clean and valuable. Mukta Society members include an intriguing and inspiring cross-section of society, with Muslim, Hindu, and Christian members working harmonious and in unity for a good cause. They currently have about several thousand taka in their EHF bank account. They also keep two or three thousand taka in cash in order to be able to respond rapidly to emergencies. They have used the fund 17 times during the past two years.

The EHF has also "spun off" to create other community funds, for example a PI capital fund (a.k.a. "Seed Fund") and micro-enterprise activities to generate revenue to support for PI operations, and on-going training activities for CHVs and TTBAs. The Mukta Society also has plans to purchase a fleet of 5 or 6 van rickshaws to strategically place in communities for emergency transportation.

The work of the Emergency Health Fund and the Peoples' Institutions was aptly summarized by the Kullagora Union Chairman when he said:

> *We really appreciate the Mukta Society. No other group works like they do on health matters and in talking with people about health. We want them to do more. Mukta's work is our work!*

The problem being addressed: Lack of transportation and cost of health services are major barriers to care-seeking, especially in rural areas of Bangladesh. The distance to health facilities, the lack of

available vehicles, the high cost of transportation and the lack of funds during an emergency contribute to low utilization of health services. Community-based health financing is a critical component to increasing access to health care in poor countries.

The project's input to address it: A community-based health financing scheme, called the emergency health fund (EHF), was developed by three community-based organizations (CBOs) in three unions of the Netrokona district of Bangladesh covering a population of 89,000. CBO members voluntarily contributed 2 taka (~0.03 USD) each month to a community-managed bank account. CBO members, trained traditional birth attendants, and community health volunteers were permitted to apply for interest-free loans on behalf of the general population. The existing funds and the number of emergency referrals made were monitored on a monthly basis. A population-based maternal and child health survey was conducted at baseline (January 2005) and at midterm (January 2007) to assess care-seeking behavior using 30-cluster random sampling.

The magnitude of the intervention: Women and children from all three unions had access to the emergency health funds in Netrokona district. Approximately 11.9% of the population are children under the age of five and 27.0% are women aged 15 to 49[15]. Therefore, the beneficiary population was estimated to be 33,400. The EHF was also implemented in two unions in Panchagor district as well as in four slums in Dhaka; however, those data are not presented here.

Specific results: Two years after the creation of the EHF, the percentage of children aged 0-23 months whose mother sought advice/treatment increased from 78% to 94% for diarrhea and from 8% to 19% for pneumonia. During this two year period the total amount of money collected was 30,862 taka (~455 USD) and the total amount distributed for emergency purposes was 20,266 taka (~298 USD) with each loan ranging from 300 to 4,000 taka (~4 to 58 USD). Twenty-nine people received loans from the EHF including 18 women aged 15 – 49 years and 11 children under the age of 5 years. The types of services received included severe pneumonia, burn, post-natal complications, delivery complications, cancer, asthma and malaria. Of the 29 loans distributed, 100% have started and 48% have completed repayment. The community-led initiative to create the emergency health fund was associated with an increase in care-seeking for children with diarrhea or pneumonia.

D. Best Practice: Community Case Management

The problem being addressed: Pneumonia and diarrhea are the leading causes of death in under-five children in Bangladesh accounting for 28%of all deaths. The current Community Integrated Management of Childhood Illnesses (C-IMCI) strategy in Bangladesh emphasizes the need for strengthening existing facility-based health services. However, in areas where health facilities are inaccessible, care seeking remains low. Community case management (CCM) is a strategy to deliver curative interventions for serious childhood illnesses at the household level using trained, supervised community members.

The project's input to address it: In 2005, 90 CHVs were selected by the community and trained in counseling and referral as part of the national C-IMCI strategy. In 2007, 39 of the CHVs received seven days of additional training from C-IMCI Certified Trainers in pneumonia and diarrhea case management using clinical criteria and algorithms derived from UNICEF/WHO (2006) guidelines. The quality of CHV-delivered services was assessed for each case using a C-IMCI checklist that was developed in collaboration with the Ministry of Health and the International Center for Diarrheal Disease, Bangladesh.

[15] National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training, Mitra and Associates, and Macro International.

The magnitude of the intervention: The CHVs visited 357 children under two in two unions of the Panchagor District of Bangladesh from August 2007 to March 2008.

Specific results: Among the 255 cases of childhood illness managed by the CHVs, 25% presented with pneumonia, 72% with diarrhea, and 3% with both. CHVs correctly diagnosed and treated diarrhea and/or pneumonia in 85% of the cases. Forty percent were properly referred to a local heath facility; however only 23% were actually taken to a health facility. While 11% of mothers were satisfied with care received from health facilities, 91% of mothers were satisfied with the CCM services provided by the CHVs. Levels of satisfaction were higher when CHVs provided direct care to sick children compared to counseling alone. In conclusion, the integration of CCM by trained CHVs into the national C-IMCI strategy is feasible and shows promise for improved care delivery to children at risk for pneumonia and diarrhea in rural Bangladesh.

Annex 2: List of Publications and Presentations Related to the Project

Sarkar N, TenBroek N, Daring K, and Story W. Comparison of Health and Nutritional Status between Tribal and Bengali Children Aged 0-23 Months in Rural Bangladesh. 8th Commonwealth Congress on Diarrhea and Malnutrition. Dhaka, Bangladesh. February 2006.

Sarkar N, TenBroek N, Daring K, and Story W. Scaling-up zinc for young children with diarrhea through village health care providers and drug-sellers: findings of a pilot study from a child survival program in Bangladesh. Recent Advances in Scaling-Up Zinc – 2006 Conference. International Centre for Diarrheal Disease Research, Dhaka, Bangladesh. April 2006.

Sarkar N, TenBroek N, Daring K, and Story W. Promotion of infant and young child feeding practices through community health volunteers: experience from a child survival program in Bangladesh. 2nd National Conference on Breastfeeding and Complementary Feeding. Dhaka, Bangladesh. August 2006.

Story, W. Assessing Equity Among Different Ethnic Groups in Bangladesh. Collaborations and Resources (CORE) Group Spring Membership Meeting, Atlanta, GA. April 2008.

TenBroek N, Daring K, Story W, and Hajong P. Improving Access to Maternal and Child Health Services through Community-Based Health Financing. 12th Annual Scientific Conference (ASCON). International Centre for Diarrheal Disease Research, Dhaka, Bangladesh. February 2009.

TenBroek N, Story W, Parveen S, Biswas P, and Kreulen G. Managing Childhood Illnesses Using Community Health Volunteers in Rural Bangladesh. 12th Annual Scientific Conference (ASCON). International Centre for Diarrheal Disease Research, Dhaka, Bangladesh. February 2009.

Annex 3: Project Management Evaluation

A. Planning

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

The Project Directors and Health Coordinators in each of the organizations work with CRWRC in all the planning activities. Each of the three partners are responsible for working with their own organization's staff in beginning "bottom up" planning for the interventions. The MTE team felt that the planning and management of these partnerships merits documentation as a case study, and included this as one of the recommendation for CRWRC headquarters, i.e., that *CRWRC headquarters should document and share the CSP experience in Bangladesh as a case study in developing and managing local partnerships.* That recommendation was fulfilled.

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

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

B. Staff Training

CRWRC CSP staff attended workshops when they were available. All CSP staff received an initial two-week orientation to the specific project in which they were working. They also received a one-week orientation on the Child Survival Project and extensive training in specific health-related topics, e.g., baseline survey implementation, nutrition surveillance, values and health, dialogue education (basic, advanced, curriculum design and facilitation), BEHAVE framework, PD Hearth, CSSA, and supportive supervision of CHVs and TTBAs. Additional training was added for Kangaroo Care. Mini-workshops on health-related topics have been held during the monthly staff meetings at each project. KPC or nutrition surveillance refresher training was also held for all staff prior to each survey/surveillance. CSP staff and Learning Circle representatives also received training in August 2007 on growth monitoring from the National Nutrition Council of Bangladesh. Special training on community case management was also held for the Health Coordinator and Community Animators in Panchagor.

C. Supervision of Project Staff

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

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

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

D. Human Resources and Staff Management

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

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

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

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

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

E. Financial Management

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

In each year of the CSP, the Finance Officer conducts quarterly visits to each of the three partner organizations to do an internal audit of the financial activities. Written reports of these audits are then shared with each organization and necessary strengthening of the financial systems, if needed, are made. The CSP Program Manager is responsible for the overall financial system and reviews and approves all financial reports. As part of the end of the first fiscal year, an external financial audit and financial management review took place yearly and most recently in October, 2008 by a GOB approved firm, Azad Zamir and Company. This audit included a total review of CSP expenditures at the CRWRC Bangladesh and partner level. This company will also conduct the final audit in October, 2009.

F. Logistics

There have been no major equipment needs for the CSP. All supplies such as flip charts, growth monitoring charts, CHV and TTBA record books, mother cards and growth monitoring scales have been readily available. CRWRC is currently planning to use the new Government approved weight scales, and expect the supply of these to be available from August 2009.

G. Information Management

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

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

H. Technical and Administrative Support

CRWRC received USAID and GOB permission to conduct operations research in Community Case Management for diarrhea and pneumonia using community health volunteers in Panchagor. CRWRC contacted Dr. Shams El Arifeen and Dr. Dewan Emdadul Hoque at ICDDR, B and USAID Bangladesh for technical assistance support in this research.

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

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

Annex 4: Full M&E Table

Legend: Degree of progress in meeting EOP targets	130% + of target	100-129% of target	90-99% of target	80-89% of target	< 80% of target

Intervention	Indicator **BOLD** = KPC Rapid CATCH Indicators	Part-ner*	Base-line	MTE KPC	Final KPC	EOP Target	% of Target Reached
Strategic Objective I. Improve Maternal and Neonatal Care		* P=Panchagor, N=Netrokona, D=Dhaka					
Delivery by Skilled Health Personnel (including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel	P	18	61	95	60	158%
		N	21	31	94.7	50	189%
		D	34	76	96.3	71	136%
Antenatal Care Rate	Percentage of mothers who had at least 4 prenatal visit prior to the birth of her youngest child less than 24 months of age	P	31	76	87	79	110%
		N	6	9	86.3	30	288%
		D	34	58	76	85	89%
Tetanus Toxoid (TT)	**Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age**	P	80	49	96	98	**98%**
		N	62	61	98.3	85	**116%**
		D	59	65	93.7	85	**110%**
Knowledge on Maternal Danger Signs/Symptoms	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and postnatal period	P	35	66	100	58	172%
		N	31	62	100	55	182%
		D	37	71	99	80	124%
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease							
ORT Use During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	**P**	**64**	**46**	**77.4**	**84**	92%
		N	**56**	**54**	**68.4**	**75**	91%
		D	**55**	**67**	**75.9**	**80**	95%
Increased Fluid and Continued Feeding During an illness	**Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food**	**P**	**57**	**56**	**90.3**	**70**	**129%**
		N	**64**	**75**	**60.5**	**72**	**84%**
		D	**94**	**95**	**96.6**	**95**	**102%**
Zinc Supplementation During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness	**P**	**14**	**43**	**83.9**	**78**	108%
		N	**11**	**48**	**86.8**	**90**	96%
		D	**9**	**39**	**62.1**	**90**	69%
Availability of Soap for Hand Washing	**Percentage of mothers of children age 0-23 months that have soap readily available for hand washing**	**P**	**53**	**98**	**95.7**	**73**	**131%**
		N	**15**	**90**	**93**	**55**	**169%**
		D	**37**	**98**	**99.7**	**82**	**122%**
Strategic Objective III. Detect ARI and Make Appropriate Referrals							
Care Seeking for Illness	Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility	P	29	14	92.9	59	157%
		N	8	19	60.9	33	185%
		D	63	61	75	88	85%
Maternal Knowledge of Child Danger Signs/Symptoms	**Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms**	P	70	82	99	86	**115%**
		N	73	80	99	90	**110%**
		D	62	91	97.3	92	**106%**
Strategic Objective IV. Improve Child Nutrition							
Underweight	**Percentage of children aged 0-23 mother who are more than 2 standard deviations (SD) below the median weight-for-age (WA) of WHO/NCHS**	P	38	26	26.8	20	**62%**
		N	41	37	26.1	20	**71%**
		D	39	27	22.5	20	**87%**
Exclusive Breastfeeding	**Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours**	P	88	74	89.6	97	**92%**
		N	74	63	89.9	85	**106%**
		D	64	67	90.9	89	**102%**
Appropriate Complementary Feeding Practice	**Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours**	P	27	47	81.1	57	**142%**
		N	14	75	79.6	80	**100%**
		D	55	79	76.1	75	**101%**
Vitamin A Coverage	Percentage children aged 6-23 months who received a Vitamin A dose in the past six months	P	62	76	81.1	91	89%
		N	61	84	76.1	75	101%
		D	53	77	85.4	80	107%
Strategic Objective V. Reduce Morbidity and Mortality from Vaccine Preventable Diseases							
Complete Immunization Coverage	**Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio**	P	57	92	94.2	87	**108%**
		N	32	74	96	85	**113%**
		D	28	82	90.1	80	**113%**
Strategic Objective VI. Increase Awareness of HIV/AIDS							
Maternal Knowledge of HIV Risk Reduction	**Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV**	P	12	58	99.3	64	**155%**
		N	13	59	99	70	**141%**
		D	51	84	100	85	**118%**

Annex 5: Work plan Table

Objectives/Results/Activities	Objective Met			Comments
	SATHI	PARI	SUPOTH	
Strategic objective I. Improved Maternal/Neonatal Care.	✓	✓	✓	
Intermediate Result A. Increased community capacity to provide preventive and promotional health services to women of child bearing age and children under 5.	✓	✓	✓	
Activity I.A.1. Adequate number of CHVs will be trained to work in key areas related to maternal child health.	✓ 187	✓ 203	✓ 120	CHVs trained, replacement system in place.
Activity I.A.2. CHVs will be adequately supervised	✓	✓	✓	Super CHV system for supervision of 4-5 CHVs. Also, PI health team supervises, and close link with local Government facilities.
Activity I.A.3. Adequate number of TBA will be trained to work in key areas related to maternal child health.	✓ 85	✓ 79	✓ 74	
Activity I.A.4. TTBAs will be adequately supervised.	✓	✓	✓	Supervised by PI health team with close relationship/MOU with SBAs.
Activity I.A.5. Increase the percent of women of childbearing age who indicate their husbands support for prenatal care by 4% per year	data not avail.	data not avail.	data not avail.	
Activity.I.A.6. Training of community people to effectively present health messages (for behavior change) to the community through drama medium. 20 group members trained per year.	✓ 56	✓ 60	✓ 20	Drama teams in place in each union and each slum.
Activity.I.A.7: Trained up Thana federation/ Community Central Committee (CCC) /health sub-committee to effectively present health messages (for behavior change) to the community through active participation. 24 group members will be trained per year.	✓ 51	✓ 99	✓ 25	Members training new members.
Activity I A. 8: Increase the percent of deliveries conducted by TTBAs (or other skilled birth attendants) by 6% per year.	✓ 96%	✓ 95%	✓ 95%	Increased dramatically.
Activity I. A. 9: Increase the percent of pregnant women who received at least 4 prenatal visits by 5% per year.	✓ 76%	✓ 86%	✓ 87%	Increased as TTBAs bring the women to the SBAs for check ups.
Activity I A.10. Increase the percent of immunization (TT) of pregnant women against tetanus before delivery by >4% per year.	✓ 94%	✓ 98%	✘ 96%	TTBAs and CHVs bring women for the vaccinations.
Activity I A. 11.Increase the percent of women practicing increased dietary intake during pregnancy and lactating by >7% per year.	✓ 61%	✓ 59%	✓ 72%	Improved – emphasized at group meetings.
Activity I A. 12. Increase the percent of reproductive aged women with knowledge of two known risk factors of danger sign/symptoms during prenatal, natal and postnatal period by 5% per year.	✓ 99%	✓ 100%	✓ 100%	House to house messaging – reinforced at group meetings.
Activity I. A.13. Decrease the percent of severe undernourished women & mother by more than 2% per year.	✘ 28%	✘ 43%	✓ 38%	

Objectives/Results/Activities	Objective Met			Comments
	SATHI	PARI	SUPOTH	
Activity I.A.14. Increase the percent of dietary practice (offering more nutritious food by family) of adolescent by more than 8 % per year	✘ 37%	✓ 59%	✘ 8%	
Intermediate Result B: Increased utilization of available prenatal services.	✓	✓	✓	
Activity I. B. 1. Increase the percent of consumption of iron tablets during pregnancy, postpartum and lactating women by >3% per year.	✓ 92%	✓ 98%	✓ 98%	Yes, CHVs linked with Government
Activity I. B. 2. Increase the percent of Vitamin A capsule consumption within 6 weeks of delivery by>7% per year	✓ 96%	✓ 98%	✓ 97%	Yes, CHVs linked with Government
Activity I B. 3. Increase the percent of de-worming of women >5% per year.	✘ 9%	✓ 42%	✓ 59%	
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease.	✓	✓	✓	
Intermediate Result A. Promote the use of appropriate household behavior to prevent and manage childhood diarrhea.	✓	✓	✓	
Activity II. A. 1. Increase the percent of ORS packet users by >3% per year.	✓ 76%	✘ 68%	✘ 77%	
Activity II. A. 2. Sustain the percent of breast feeding continuing during diarrhea.	✓ 100%	✓ 100%	✓ 90%	
Activity II. A.3. Increase the percent of more food intake during a diarrheal episode more than 7% per year.	✓ 97%	✘ 61%	✓ 90%	Activity II. A.3 and A.4 were reported as one indicator.
Activity II. A. 4. Increase the percent of care providers who offer increased water/fluids during a diarrhea episode by 6% per year.	✓ 97%	✘ 61%	✓ 90%	Activity II. A.3 and A.4 were reported as one indicator.
Activity II. A. 5. Increase the percent of mothers of 0 - 23 month olds who know at least two danger signs and symptoms by > 2% per year.	✓ 97%	✓ 99%	✓ 99%	House to house messaging
Activity II. A. 6. Increase the percent of soap used by household by 8% per year.	✓ 100%	✓ 93%	✓ 96%	
Activity II. A.7. Increase the percent of household will have access to sanitary latrine by >5% per year.	✓ 99%	✓ 80%	✓ 96%	
Activity II. A. 8. Increases the percent of zinc use in diarrhea episode children age 0-23 month by more than 15% per year.	✘ 62%	✓ 87%	✘ 84%	Ambitious targets set.
Intermediate Result B. Improve treatment seeking behavior for children under age 5.	✓	✓	✓	
Activity II.B. 1. Increase the percent of care seeking at diarrhea by 1% per year	✓ 93%	✓ 97%	✓ 90%	
Activity II.B. 2. Increase the percent of women of childbearing age who indicate their husbands support for care seeking during illness of child 0-23 month by 3% per year.	Data not avail.	Data not avail.	Data not avail.	

Objectives/Results/Activities	Objective Met			Comments
	SATHI	PARI	SUPOTH	
Strategic Objective III. Detect ARI and Make Appropriate Referrals	✘	✓	✓	
Activity III. A. 1. Increase the percent of appropriate referrals for treatment of ARI by 5% per year.	✘ 75%	✓ 61%	✓ 93%	
Strategic Objective IV. Improve Child Nutrition.	✓	✓	✓	
Intermediate Result A. Reduce the prevalence and severity of malnutrition in children under 5 years of age.	✓	✓	✓	
Activity IV. A. 1. Decrease the overall percent of mal-nutrition (2 SD below median weight for age) among children under 5 by more than 4% per year.	✘ 23%	✘ 26%	✘ 27%	PD Hearth used in all three areas. Targets set too high.
Activity IV. A. 2. Decreases the percent of severe under nourished children (3 SD below median weight for age) of under 2 years by 2% per year.	Data not avail.	Data not avail.	Data not avail.	
Activity IV. A. 3. Increases the percent of appropriate complementary feeding for 6-9 months children by > 3% per year.	✓ 76%	✓ 80%	✓ 81%	
Activity IV. A. 4. Increases the percent of regular participation at Growth monitoring and promotion (GMP) session of under 5 years child by 10% per year.	✓ 95%	✓ 98%	✓ 82%	Growth monitoring conducted by Super CHVs
Activity IV. A. 5. Increases the rate of use antihelminthic 12-23 months old children every six month by >6% per year.	✘ 15%	✘ 25%	✘ 32%	
Activity IV. A. 6. Increases the percent of new born given breast milk within one hour of delivery by more than 1% per year.	✓ 73%	✓ 90%	✓ 91%	
Activity IV. A. 7. Increases the percent of exclusively breast feeding infants under six months by more than 2% per year.	✓ 91%	✓ 90%	✘ 90%	
Activity IV. A. 8. Continuing the percent of children who are given breast milk until two years of age.	✓ 98%	✓ 99%	✓ 99%	
Activity IV. A. 9. Increase the percent of homestead gardening by more than 12% per year.	Data not avail.	✓ 96%	✓ 90%	Target not appropriate.
Activity IV. A. 10. Increase the percent of poultry for nutrition by 3% per year,	Data not avail.	Data not avail.	Data not avail.	
ActivityIV.A.11. Increase the percent of women of childbearing age who indicate their husbands support for Growth monitoring of child 0-23 month by 3% per year.	Data not avail.	Data not avail.	Data not avail.	
Intermediate result B. Decrease micro-nutrient deficiencies among children under 5 years of age.	✓	✓	✓	
Activity IV. B. 1. Increases the percent of high dose vitamin A capsules for children 6-59 months every six month by 3% per year.	✓ 85%	✓ 76%	✓ 81%	

Objectives/Results/Activities	Objective Met			Comments
	SATHI	PARI	SUPOTH	
Activity IV. B. 2. Increases the percent of use Iodine (packet salt/ iodize oil) by 2% per year.	✓ 100%	✓ 100%	✓ 98%	
Strategic Objective V. Reduce mortality and morbidity from vaccine preventable diseases.	✓	✓	✓	
Activity V. 1. Increase the percent of completely immunized children under 1 year of age by >7% per year.	✓ 90%	✓ 96%	✓ 94%	
Strategic objective VI. Prevention of HIV/AIDS	✓	✓	✓	
Activity VI. 1. Increase the percent of knowledge level about HIV/ AIDS of community by more than 5% per year.	✓ 100%	✓ 99%	✓ 99%	
NUTRITION SURVEILLANCE	✓	✓	✓	
Activity: To see the changes of nutritional status among mothers and children age 0-23 months 6 monthly for 5 years	✓	✓	✓	This was conducted every six months except for midterm and final evaluations.
OPERATION RESEARCH	✘	✘	✘	
Activity. Zinc research on children age 24-35 months	✘	✘	✘	Zinc research not done due to difficulty with procurement and Government rules. Instead OR was on Community Case Management
DISSEMINATION WORKSHOP	✓	✓	✓	
Activity: Dissemination workshop held after base line survey, midterm evaluation and final evaluation.	✓	✓	✓	Yes, disseminations done at baseline, midterm, final and after LQAS (total 6 times in each of the 3 areas).

Annex 6: Rapid CATCH Table

P=Panchagor, N=Netrokona, D=Dhaka

Intervention	Rapid Catch Indicator	Part-ner*	Base-line	MTE KPC	Final KPC
Underweight	Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age according to the WHO/NCHS reference population)	P	38	26	27
		N	41	37	26
		D	39	27	23
Birth Spacing	Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	P	74	88	83
		N	80	78	85
		D	81	86	88
Delivery Assistance	Percentage of children 0-23 months whose births were attended by skilled health personnel.	P	8	10	8
		N	15	11	15
		D	14	22	35*
Maternal Tetanus Toxoid (TT)	Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	P	80	49	96
		N	62	61	98*
		D	59	66	94*
Exclusive Breastfeeding	Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	P	88	74	90
		N	74	63	90
		D	64	67	91
Complementary Feeding	Percentage of infants aged 6-9 months receiving breastmilk and complementary foods	P	27	47	81
		N	14	75	80*
		D	55	79	76
Full Vaccination	Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday	P	57	92	94
		N	32	74	96*
		D	28	82	90*
Measles	Percentage of children age 12-23 months who received a measles vaccine	P	n/a	95	94
		N	n/a	75	96
		D	n/a	87	92
Bednets	Percentage of children age 0-23 months who slept under a bednet the previous night (in malaria risk areas only)	P	91	71	98
		N	89	90	99
		D	93	98	96
Danger Signs	Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	P	70	82	99*
		N	73	80	99
		D	62	91	97*
Sick Child[16]	Percentage of sick children age 0-23 months who received increased fluids AND continued feeding during an illness in the past two weeks	P	57	56	100
		N	64	75	97.3
		D	94	95	100
HIV/AIDS	Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	P	12	59	99*
		N	13	58	99*
		D	51	84	100*
Hand washing	Percentage of mothers of children age 0-23 months that have soap readily available for hand washing.	P	53	98	96*
		N	15	90	93*
		D	37	98	100*

[16] Baseline data for this indicator was not collected. The baseline data presented in this table was collected during the September 2005 Nutritional Surveillance.

Annex 7: Final KPC Report

Final KPC Survey Report and Comparative Analysis:
A Quantitative Assessment of Progress towards the Targets of Key Health Objectives
(Excerpts from the full report)

Introduction

This report contains the findings and results of the three Knowledge, Practice and Coverage (KPC) surveys which were conducted in December 26, 2004 to January 7, 2005 (baseline); January 24, 2007 to January 31, 2007 (midterm); and March 7, 2009 to March 21, 2009 (final). The KPC survey was conducted in each of the three field sites of the Christian Reformed World Relief Committee (CRWRC) Child Survival Program (CSP) – Dhaka slums, Netrokona and Panchagar districts. The goal of the survey is to obtain information about the impact of the program on key health objectives set at the start of the program. The specific objectives of the KPC survey are:

- To find out the health and nutrition status in the respective working areas regarding maternal and child health;
- To identify whether the CSP program was able to address the health problems in the specific geographic areas included in the grant; and
- To be able to assess the major accomplishments of the project after five years of implementation.

The Child Survival Program of CRWRC

CRWRC received funding from the USAID Child Survival and Health Grants Program in the Entry category for a five-year program in Bangladesh that seeks to achieve and sustain improved health and rates of survival for children under age five and women of reproductive age.

The program targets two rural districts (Panchagar and Netrokona) and one urban district (Dhaka) in Bangladesh where rates of under- five child mortality and maternal mortality are very high. The six strategic objectives for CRWRC's CSP are: 1) Improve maternal and neonatal care; 2) prevent and properly treat diarrheal disease; 3) detect ARI and make appropriate referrals; 4) improve child nutrition; 5) reduce mortality and morbidity from vaccine preventable diseases; 6) increase awareness about HIV/AIDS.

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

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

In order to achieve these objectives, CRWRC works with three partner organizations; PARI (Netrokona), SATHI (Dhaka) and SUPOTH (Panchagar). The project focuses on Sadar Thana in Panchagar; Kolmakanda and Durgapur Thanas in Netrokona; and four Dhaka slum areas; Lalbag,

Sutrapur, Maniknogar and Mirpur. Working with local non-governmental development organizations based in these areas, the project includes participants and beneficiaries from a total of nine Thanas, 22 unions (or wards), and 126 villages (or slums) and serves a total of 20,207 children under five and 44,998 women of reproductive age.

CRWRC's CSP in Bangladesh seeks to build community capacity to carry out technical interventions that foster better health for infants, children, and mothers. Each partner organization implements an integrated program of child and maternal health involving neonatal and maternal care, community-based integrated management of childhood illness (IMCI), nutrition, immunization, family planning and disease prevention.

The Final KPC Survey

The final KPC surveys were done using the USAID recommended 30-cluster random sampling methodology having 300 interviews from each of the program locations (Figure 1).

In order to compare the data with the baseline, all indicators used in the baseline KPC survey have been analyzed and presented in this report. In addition to those indicators, some new and revised Rapid CATCH 2006 indicators were also included in the questionnaire. The indicators were revised in order to make sure that they reflect state-of-the-art for the main intervention areas of the CSP and the broad array of interventions included in the program. Questions from the semi-annual nutritional surveillance survey were also incorporated and analyzed in the KPC survey.

For the survey, data collectors and supervisors were selected from the three implementing partner organizations. This was done in order to bring a higher degree of ownership within the projects and to build capacity of the staff of those organizations on survey design and data collection. Although these three projects work in different parts of the country and with different beneficiaries, boards, and project structures; the training for the survey work was done together in Dhaka. Surveyors did not survey in their own projects – as noted in the surveyor list, all went to other organizations to conduct the survey.

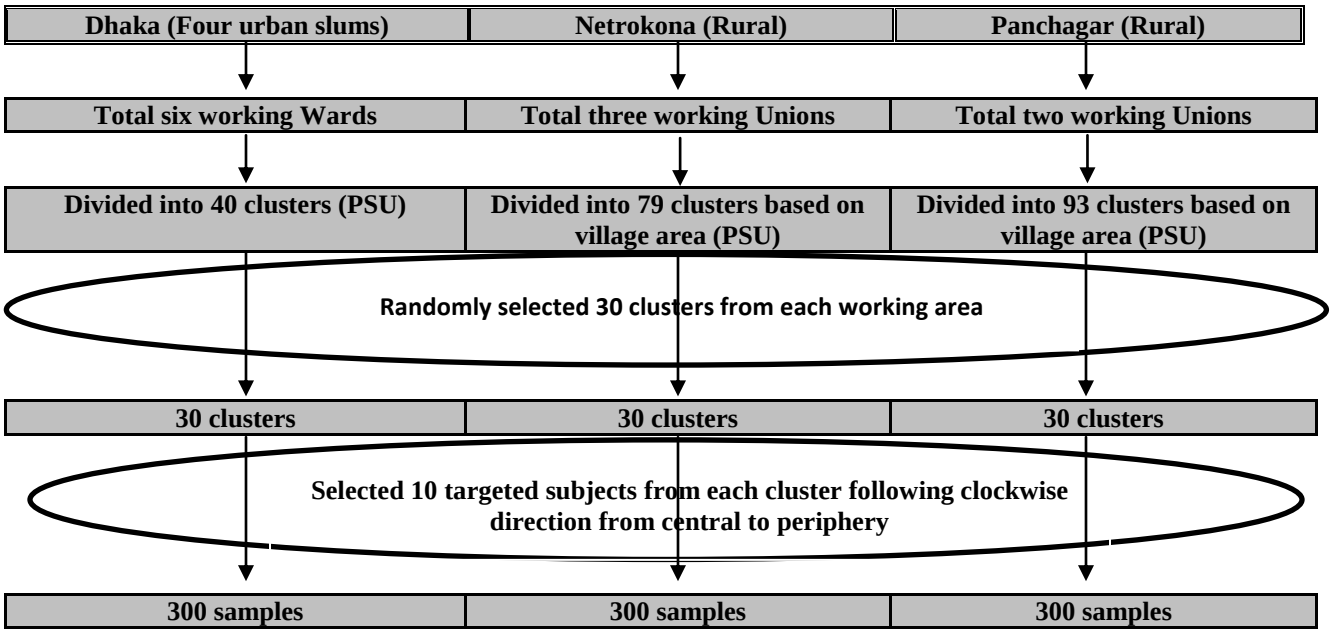
An intensive two-day follow-up training for the data collectors and supervisors was conducted in Dhaka. A third day field practicum in non-working area urban slums was also added. CRWRC also worked on the training design to update it and make it more participatory using dialogue education. The CSP Program Officer and CRWRC staff conducted the training. The training consisted of sessions on sampling strategy, selection of target respondents, data collection techniques and field management during the survey period. The draft questionnaire was discussed thoroughly and the interviewers and supervisors received adequate knowledge on important aspects of each variable. They were taught the detailed techniques of measuring weight and height of the mothers and children using the weighing scale and height measurement board.

An interviewer field guide was also prepared in Bangla, which consisted of a definition and a detailed explanation of each variable in the questionnaire. The field guide was used by each of the surveyors to ensure that they followed the protocol for conducting the survey. The guideline was also translated into English for office use as needed. The Program Manager, Program Specialist, Data Management Officer, volunteers and other CSP staff, visited each of the project sites for quality control during the data collection phase of the final KPC survey.

Data was cross checked by the surveyors thoroughly at the project offices. Data editing/entry operators performed data editing, coding and data transformation before entering into entry software. Three data entry operators were selected based on their experience and computer literacy. These data entry operators were staff members from SATHI, PARI, SUPOTH and/or CRWRC. After computer entry, data cleaning was done and internal consistencies were checked by a professional Data Management Specialist under the direct supervision of the Data Management Officer. Database developed and entered with CSPro3.2. Data was cleaned by a programmer from Mitra and Associates as he was subcontracted for this purpose. If any missing or erroneous data was found, it was collected by revisiting the respondent as much as possible.

Nutritional status of mothers and children was calculated using ANTHRO software (developed by Center for Disease Control and recommended by WHO). All other data were analyzed using SPSS 12.5 for Windows software. Data analysis was carried out by the ICDDR,B Child Health Unit and additional analysis done by the CRWRC Project Manager and Data Management Officer.

Figure 1: Sampling frame and sample size (300 from each working area)



Results of the Final KPC Survey

Results of the final KPC surveys are shown in Tables 1 and 2. Table 1 depicts the comparison of final against baseline figures for key indicators from the Monitoring and Evaluation Plan. The mid-term survey results are also presented in Table 1, but not compared with the final results. Table 2 depicts the results for all indicators collected during the final KPC survey in all three working areas. Table 2 also gives the numerator and denominator for each indicator.

Given the background described above, the indicators presented here are combination indicators from the baseline KPC survey, the new revised Rapid CATCH 2006 indicators and nutritional surveillance indicators. It is important to note that there are not baseline figures for Rapid CATCH 2006 indicators. In analyzing data, the tabulation plan

(Numerator/Denominator/relevant questions and responses) on how to calculate the indicators provided by the CSTS+ was strictly followed.

Discussion on the findings

The discussion on the key indicators of the final KPC can be found in the main narrative of the Final Evaluation Report on pages 12 to 21.

Limitations

The major limitation of this survey was the design itself. The adequacy design has no control group, thus to causally link the observed changes solely with the intervention is subject to debate. Comparative analysis was done between baseline and final survey results from the same area. The observed improvements/changes could also be related to other contextual factors, such as improved socio-economic status, education, communication, and other vertical programs by NGOs or government.

Further discussion

In some areas there has been much improvement since midterm survey and some of the indicators achieved commendable success (e.g. exclusive breastfeeding, appropriate complementary feeding). Description and discussion of measures taken to improve the situation will be important findings and will help the Government or other NGOs working in Bangladesh to emulate the success achieved by CRWRC.

Table 1: Results of the final KPC survey presented against the baseline

D=Dhaka N=Netrokona P=Panchagor

Intervention area	Indicators	Work Area	Base-line %	Mid-term %	Final %	Difference Base Vs Final Diff (95% CI)
Strategic Objective I: Improve Maternal and Neonatal Care						
Delivery by Skilled health personnel (Not including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel not including TTBAs.	D	14	22	35	
		N	15	11	15.3	
		P	8	10	8.3	
Delivery by Skilled health personnel (including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel including TTBAs.	**D***	35	76	96	61 (53 to 69) **P<0.0001**
		N*	21	31	95	74(67 to 81) **P<0.0001**
		P*	18	61	95	77 (70 to 84) **P<0.0001**
Antenatal care rate	Percentage of mothers who had at least 4 prenatal visits from a skilled attendant prior to the birth of her youngest child less than 24 months of age.	**D***	36	58	71	35 (28 to 44) **P<0.0001**
		N*	6	9	86	80 (75 to 86) **P<0.0001**
		P*	31	76	87	56 (48 to 64) **P<0.0001**
Tetanus Toxoid (TT)	Percentage of mothers who received at least two tetanus toxoid injections	**D***	59	66	94	35 (26 to 43) **P<0.0001**

Intervention area	Indicators	Work Area	Base-line %	Mid-term %	Final %	Difference Base Vs Final Diff (95% CI)
	before the birth of the youngest child less than 24 months of age (protected against Tetanus).	**N***	62	61	98	36 (28 to 44) **P<0.0001**
		P*	80	49	96	16 (9 to 23) **P<0.0001**
Knowledge on Maternal Danger signs/symptoms	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and post natal period.	**D***	37	71	99	62(54 to 70) **P<0.0001**
		N*	31	62	100	69 (62 to 76) **P<0.0001**
		P*	33	66	100	67 (59 to 75) **P<0.0001**
Strategic Objective II: Prevent and properly treat Diarrheal Diseases						
ORT use during Diarrheal episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF).	D	55	67	76	21 (-12 to55) P=0.1872
		N	56	54	68	13 (-8 to 33) P=0.2326
		P	64	46	77	13 (-16 to42) P=0.3576
Increased Fluid and Continued Feeding During an illness	Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food	D	94	95	97	3 (-13to18) P=0.7117
		N	64	75	61	3 (-24to17) P=0.7429
		P*	57	56	90	33 (5 to 61) **P=0.0098**
Zinc treatment	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness.	**D***	9	41	62	53 (29 to 77) **P=0.0027**
		N*	11	48	87	76 (62to 90) **P<0.0001**
		P*	14	33	84	70 (47to 92) **P<0.0001**
Availability of soap for hand washing	Percentage of mothers of children age 0-23 months that have soap readily available for hand washing.	**D***	37	98	100	63 (55 to 70) **P<0.0001**
		N*	15	90	93	78 (71 to 84) **P<0.0001**
		P*	53	98	96	43 (34 to 51) **P<0.0001**
Strategic Objective III: Detect ARI and Make Appropriate Referral						
Appropriate care seeking for pneumonia	Percentage of children aged 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider.	D	63	61	75	12 (-26 to 51) P=0.508
		N	8	19	61	53 (28 to 78) **P=0.0019**
		P*	29	14	93	63 (45 to 82) **P<0.0001**
Maternal knowledge of child danger signs/symptoms	Percentage of mothers of children age 0-23 months who report at least two child danger signs/symptoms.	**D***	62	91	97	35 (27 to 43) **P<0.0001**
		N*	73	80	99	26 (19 to 33) **P<0.0001**
		P*	70	82	99	29 (21to 36) **P<0.0001**

Intervention area	Indicators	Work Area	Base-line %	Mid-term %	Final %	Difference Base Vs Final Diff (95% CI)
Strategic Objective IV: Improve Child Nutrition						
Underweight	Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median weight-for –age (WA) of the WHO/NCHS reference population.	**D***	39	27	22	16 (7 to 25) **P=0.0003**
		N*	41	37	26	15 (5 to 24) **P=0.0017**
		P*	38	26	27	11 (2 to 20) **P=0.0153**
Exclusive breastfeeding[17]	Percentage of children aged 0-5 months that were exclusively breastfed milk during the last 24 hours.	**D***	64	67	84	19 (5 to 34) **P=0.0068**
		N	74	63	87	13 (1 to 28) P=0.0509
		P	88	74	86	-2 (-1 to 11) P=0.7781
Appropriate complementary feeding practice	Percentage of infants aged 6-9 months who received semisolid or family foods in the last 24 hours.	D	55	79	76	21 (-4 to 46) P=0.0865
		N*	14	75	80	65 (48 to 87) **P<0.0001**
		P*	27	47	81	54 (59 to 80) **P=0.0002**
Vitamin A coverage	Percentage children aged 6-23 months who received a vitamin A dose in the last six months.	**D***	53	77	85	33 (22 to 44) **P<0.0001**
		N*	61	84	76	15 (4 to 26) **P<0.0001**
		P*	62	74	81	19 (8 to 29) **P=0.0002**
Strategic Objective V: Reduce Morbidity and Mortality from Vaccines						
Complete Immunization Coverage	Percentage of children aged 12-23 months received all doses of vaccination (fully immunized) with 1 dose each of BCG and measles; and 3 doses each of DPT and polio.	**D***	28	82	90	62 (49 to 75) **P<0.0001**
		N*	32	74	96	64 (52 to 76) **P<0.0001**
		P*	57	92	94	37 (25 to 49) **P<0.0001**
Strategic Objective VI: Increase awareness of HIV/AIDS						
Maternal knowledge of HIV risk reduction	Percentage of mothers of children aged 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV.	**D***	51	84	100	49 (41 to 57) **P<0.0001**
		N*	13	58	99	86 (80 to 91) **P<0.0001**
		P*	12	59	99	87 (82 to 92) **P<0.0001**

* Difference between baseline and endline is statistically significant ($p<0.05$)

[17] Baseline data for this indicator was not collected. The baseline data presented in this table was collected during the September 2005 Nutritional Surveillance.

Table 2. Results of the Final KPC Survey

(Final KPC was conducted in March 7th to 21st march 2009)

Bold = Indicators that are in the Program Monitoring Plan

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
A. Maternal and Newborn Care				
Delivery by skilled health personnel (not including TTBAs)	Indicator-1 Percentage of children aged 0-23 months whose births were attended by skilled health personnel. Numerator : D: 105 N: 46 P: 25 Denominator: D: 300 N: 300 P:300	35.0	15.3	8.3
Delivery by skilled health personnel (including TTBAs)	Indicator-2 Numerator : D: 289 N: 284 P:285 Denominator: D: 300 N: 300 P:300	96.3	94.7	95.0
Delivery at Parental home	Indicator-3 Percentage of children aged 0-23 months whose delivery occurred at parental home of the mother. Numerator : D: 13 N: 32 P 20 Denominator: D: 300 N: 300 P:300	4.3	10.7	6.7
Clean cord care	Indicator-4 Percentage of children aged 0-23 months whose cord was cut with new rezor Numerator : D: 260 N: 277 P:297 Denominator: D: 300 N: 300 P:300	86.7	92.3	99.0
Maternal health card possession	Indicator-5 Percentage of mothers with a maternal health card (interviewer-confirmed) for the youngest child less than 24 months of age. Numerator : D: 157 N: 265 P:279 Denominator: D: 300 N: 300 P:300	52.3	88.3	93.0
Prenatal Care Coverage	Indicator-6 Percentage of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24 months of age. Numerator : D: 293 N: 300 P:299 Denominator: D: 300 N: 300 P:300	97.7	100.0	99.7
Antenatal Care rate	Indicator-7 Percentage of mothers who had at least 4 prenatal visits from a skilled attendant prior to the birth of her youngest child less than 24 months of age. Numerator : D: 228 N: 259 P:261 Denominator: D: 300 N: 300 P:300	76.0	86.3	87.0
Tetanus Toxoid (TT)	Indicator-8 Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age (protected against Tetanus Numerator : D: 281 N: 295 P:288 Denominator: D: 300 N: 300 P:300	93.7	98.3	96.0
Iron supplementations	Indicator-9 Percentage of mothers who received/ bought iron supplements while pregnant with the youngest child less than 24 months of age Numerator : D: 276 N: 294 P:294 Denominator: D: 300 N: 300 P:300	92.0	98.0	98.0

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
Post-partum Vitamin A supplementation	Indicator-10 Percentage of mothers who received/bought a high dose of vitamin A supplementation during the first six weeks of delivery of the youngest child less than 24 months of age. Numerator : D: 287 N: 295 P:291 Denominator: D: 300 N: 300 P:300	95.7	98.3	97.0
Maternal Vitamin A coverage	Indicator-11 Percent of mothers who received a vitamin A dose in the last six months Numerator : D: 116 N: 200 P: 95 Denominator: D: 300 N: 300 P:300	38.7	66.7	31.7
Maternal De-warming Supplementation	Indicator-12 Percent of mothers who received a de-worming dose in the last six months. Numerator : D: 28 N: 127 P:177 Denominator: D: 300 N: 300 P:300	9.3	42.3	59.0
Dietary Practice during pregnancy	Indicator-13 Percentage of mothers who ate a greater amount of food while pregnant with the youngest child less than 24 months of age. Numerator : D: 183 N: 177 P:215 Denominator: D: 300 N: 300 P:300	61.0	59.0	71.7
Mothers Under nutrition	Indicator-14 Percentage of mothers with Body Mass Index < 18.5. Numerator : D: 84 N: 127 P:112 Denominator: D: 296 N: 293 P:297	28.4	43.3	37.7
Dietary caring practice among adolescent girls	Indicator-15 Numerator : Percentage of households of mothers of children age 0-23 months with adolescent girls offered extra food to the adolescent compared to other family members. Numerator: D: 14 N: 33 P: 2 Denominator: D: 38 N: 56 P: 26	36.8	58.9	7.7
Knowledge maternal danger sign/symptoms	Indicator-16 Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and post natal period Numerator : D: 297 N: 300 P:300 Denominator: D: 300 N: 300 P:300	99.0	100.0	100.0
Post-partum visit for the mother	Indicator-17 Percentage of mothers of children age 0-23 months who received a post-partum visit from an appropriately trained health worker within three days after the birth of the youngest child. Numerator : D: 173 N: 70 P: 98 Denominator: D: 300 N: 300 P:300	57.7	23.3	32.7
Post-partum visit to check on the Newborn	Indicator-18 Percentage of children aged 0-23 months who received a post-partum visit from an appropriately trained health worker within three days after birth. Numerator : D: 174 N: 283 P:278 Denominator: D: 300 N: 300 P:300	58.0	94.3	92.7

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
Colostrums feeding	Indicator-19 Percent of children aged 0-23 months who received colostrum Numerator : D: 298 N: 297 P:296 Denominator: D: 300 N: 300 P:300	99.3	99.0	98.7
B. Community Integrated Management of Childhood Illness (IMCI): Diarrhea and ARI				
Period prevalence of diarrhea	Indicator-20 Percentage of children 0-23 months who had one or more episodes of diarrhea in the previous two weeks according to mother's perception. Numerator : D: 30 N: 43 P: 34 Denominator: D: 300 N: 300 P:300	10.0	14.3	11.3
ORT use during diarrheal episode	Indicator-21 Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF). Numerator : D: 22 N: 26 P: 24 Denominator: D: 29 N: 38 P: 31	75.9	68.4	77.4
Care-seeking for diarrhea	Indicator-22 Percent of children aged 0-23 months with diarrhea in the last two weeks whose mother sought advice or treatment for the illness. Numerator : D: 27 N: 37 P: 28 Denominator: D: 29 N: 38 P: 31	93.1	97.4	90.3
Breastfeeding continuation during a diarrheal episode	Indicator-23 Percentage of children aged 0-23 months with diarrhea in the last two weeks who continued breastfeeding during the illness. Numerator : D: 29 N: 38 P:28 Denominator: D: 29 N: 38 P: 31	100.0	100.0	90.3
Zinc treatment	Indicator-24 Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness. Numerator : D: 18 N: 33 P: 26 Denominator: D: 29 N: 38 P:31	62.1	86.8	83.9
Period prevalence of ARI	Indicator-25 Percentage of children aged 0-23 months who experienced fast or difficult breathing with or without cough in the previous two weeks. Numerator : D: 20 N: 23 P: 14 Denominator: D: 300 N: 300 P:300	6.7	7.7	4.7
Appropriate care-seeking for pneumonia	Indicator-26 Percentage of children aged 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider. Numerator : D: 15 N: 14 P: 13 Denominator: D: 20 N: 23 P: 14	75.0	60.9	92.9

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
Maternal knowledge of child danger signs/ symptoms	Indicator-27 Percentage of mothers of children age 0-23 months who report at least two child danger signs/symptoms. Numerator : D: 292 N: 297 P:297 Denominator: D: 300 N: 300 P:300	97.3	99.0	99.0
Mother as decision maker of a sick child	Indicator-28 Percentage of mothers of children age 0-23 months who made the decision to seek medical advice during sickness of the child. Numerator : D: 114 N: 29 P: 48 Denominator: D: 300 N: 300 P:300	38.0	9.7	16.0
Availability of soap for hand washing	Indicator-29 Percentage of mothers of children age 0-23 months that have soap readily available for hand washing. Numerator : D: 299 N: 279 P:287 Denominator: D: 300 N: 300 P:300	99.7	93.0	95.7
Safe drinking water	Indicator-30 Percentage of households with drinking water from tubewell source or covered well. Numerator : D: 300 N: 259 P:295 Denominator: D: 300 N: 300 P:300	100.0	86.3	98.3
Sanitary excreta disposal	Indicator-31 Percent of households with access to a flush toilet. Numerator : D: 297 N: 239 P:289 Denominator: D: 300 N: 300 P:300	99.0	79.7	96.3
Point of use (Safe drinking water)	Indicator-32 Percentage of households of children aged 0-23 months that treat water effectively (only for Dhaka domain-boiling). Numerator : D: 174 N: 0 P: 0 Denominator: D: 300 N: NA P: NA	58.0	NA	NA
Appropriate hand washing practices	Indicator-33 Percentage of mothers of children aged0-23 months who live in a household with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the last 24 hours. Numerator : D: 298 N: 279 P:287 Denominator: D: 299 N: 279 P:287	99.7	100.0	100.0
Increased fluid and continued feeding during an illness	Indicator-34 Percentage of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food. Numerator : D: 28 N: 23 P: 28 Denominator: D: 29 N: 38 P: 31	96.6	60.5	90.3
C. Child Nutrition				
Underweight	Indicator-35 Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median weight-for –age Numerator : D: 66 N: 76 P: 79 Denominator: D: 293 N: 291 P:295	22.5	26.1	26.8

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
Wasting	Indicator-36 Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median weight-for –height (WH) of the WHO/NCHS reference population. Numerator : D: 26 N: 18 P: 27 Denominator: D: 293 N: 291 P:295	8.9	6.2	9.2
Stunting	Indicator-37 Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median height-for –age (HA) of the WHO/NCHS reference population. Numerator : D: 82 N: 87 P: 75 Denominator: D: 293 N: 291 P:295	28.0	29.9	25.4
Growth monitoring card possession	Indicator-38 Percentage of children aged 0-23 months who have a growth monitoring card (interviewer-confirmed). Numerator : D: 294 N: 294 P:246 Denominator: D: 300 N: 300 P:300	94.7	98.0	82.0
Immediate breastfeeding of newborn	Indicator-39 Percentage of children aged 0-23 months who were breastfed within the first hour after birth. Numerator : D: 220 N: 269 P:274 Denominator: D: 300 N: 300 P:300	73.3	89.7	91.3
Continued breastfeeding	Indicator-40 Percentage of children aged 0-23 months who are still breastfeeding. Numerator : D: 294 N: 297 P:296 Denominator: D: 300 N: 300 P:300	98.0	99.0	98.7
Exclusive breastfeeding	Indicator-41 Percentage of children aged 0-5 months who were exclusively breastfed milk during the last 24 hours. Numerator : D: 70 N: 71 P: 60 Denominator: D: 77 N: 79 P: 67	90.9	89.9	89.6
Appropriate complementary feeding practices	Indicator-42 Percentage of infants aged 6-9 months who received semisolid or family foods in the last 24 hours. Numerator : D: 35 N: 39 P:30 Denominator: D: 46 N: 49 P: 37	76.1	79.6	81.1
Bottle-feeding rate	Indicator-43 Percentage of children aged 0-23 months who were ever introduced to bottle –feeding. Numerator : D: 25 N: 6 P: 53 Denominator: D: 300 N: 300 P:300	8.3	2.0	17.7
Pre-lacteal feeding rate	Indicator-44 Percent of children aged 0-23 months who were introduced to pre-lacteal substance. Numerator : D: 28 N: 7 P: 13 Denominator: D: 300 N: 300 P:300	9.3	2.3	4.3
Vitamin A coverage	Indicator-45 Percentage children aged 6-23 months who received a vitamin A dose in the last six months. Numerator : D: 175 N: 162 P:180 Denominator: D: 205 N: 213 P:222	85.4	76.1	81.1

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
De-worming supplementation	Indicator-46 Percentage of children 12-23 months who received de-warming medicine in the past six months. Numerator : D: 20 N: 33 P: 44 Denominator: D: 131 N: 130 P:136	15.3	25.4	32.4
Iodine coverage rate	Indicator-47 Percentage of surveyed households consuming packet salt. Numerator : D: 299 N: 299 P: 294 Denominator: D: 300 N: 300 P:300	99.7	99.7	98.0
Consumption rate of homestead produced vegetable	Indicator-48 Percentage of households of mothers of children aged 0-23 months consuming homestead produced vegetables. Numerator : D: NA N: 201 P:111 Denominator: D: NA N: 202 P:120	NA	99.5	92.5
Home gardening practice rate	Indicator-49 Percentage of households of mothers of children aged 0-23 months practicing home gardening. Numerator : D: 0 N: 201 P:120 Denominator: D: 0 N: 209 P:133	NA	96.2	90.2
Immediate and exclusive breastfeeding rate of newborn	Indicator-50 Percentage of children aged 0-23 months who were breastfed within the first hour after birth and did not receive pre-lacteal feeds. Numerator : D: 210 N: 265 P:262 Denominator: D: 220 N: 269 P:274	95.5	98.5	95.6
D. Child Immunization				
Possession of vaccination card rate	Indicator-51 Percentage of children aged 0-23 months who have a vaccination card (interviewer-confirmed). Numerator : D: 239 N: 282 P:217 Denominator: D: 300 N: 300 P:300	79.7	94.0	72.3
Complete immunization coverage	Indicator-52 Percentage of children aged 12-23 months received all doses of vaccination (fully immunized) with 1 dose each of BCG and measles; and 3 doses each of DPT and polio. Numerator : D: 82 N: 119 P:113 Denominator: D: 91 N: 124 P:120	90.1	96.0	94.2
Incomplete immunization rate	Indicator-53 Percentage of children aged 12-23 months received any vaccination among BCG, measles any doses of Polio, or any doses of DPT. Numerator : D: 9 N: 5 P: 7 Denominator: D: 91 N: 124 P:120	9.9	4.0	5.8
Measles vaccination	Indicator-54 Percentage of children aged 12-23 months who received a measles vaccination. Numerator : D: 84 N: 119 P:113 Denominator: D: 91 N: 124 P:120	92.3	96.0	94.2

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
Health system performance regarding immunization services	Indicator-55 Percentage of children aged 12-23 months who received DPT3 vaccination before they reached 12 months Numerator : D: 87 N: 124 P:118 Denominator: D: 91 N: 124 P:120	95.6	100.0	98.3
Access to immunization services	Indicator-56 Percentage of children aged 12-23 months who received DPT 1 vaccination before they reached 12 months. Numerator : D: 89 N: 124 P:120 Denominator: D: 91 N: 124 P:120	97.8	100.0	100.0
E. Family Planning				
Pregnancy rate of adolescent age	Indicator-57 Percentage of mothers of children aged 0-23 months who experienced first pregnancy between age 10-19 years. Numerator : D: 242 N: 205 P:226 Denominator: D: 300 N: 300 P:300	80.7	68.3	75.3
Contraceptive use rate	Indicator-58 Percentage of women aged 15-49 of children aged 0-23 months using/ever used pill, IUD, injection, norplant, vaginal method, ligation, condom and vasectomy for birth control. Numerator : D: 253 N: 243 P:239 Denominator: D: 300 N: 300 P:300	84.3	81.0	79.7
Adequate birth interval between youngest survival children	Indicator-59 Percentage of children aged 0-23 months who date of birth is at least 36 months after the previous surviving child. Numerator : D: 119 N: 151 P:130 Denominator: D: 164 N: 238 P:205	72.6	63.4	63.4
Child spacing	Indicator-60 Percentage of children aged 0-23 months who were born at least 24 months after the previous surviving child. Numerator : D: 145 N: 201 P:170 Denominator: D: 164 N: 238 P:205	88.4	84.5	82.9
F. Malaria, Dengue, HIV/AIDS				
Household bed net possession rate	Indicator-61 Percentage of children whose mothers report the presence of bed nets in the house. Numerator : D: 279 N: 297 P:298 Denominator: D: 300 N: 300 P:300	93.0	99.0	99.3
ITN use	Indicator-62 Percentage of children aged 0-23 months who slept under a bed net the previous night (Currently there is no practice of insecticide treated bed net use in Bangladesh). Numerator : D: 268 N: 295 P:293 Denominator: D: 279 N: 297 P:298	93.1	99.3	98.3
Maternal knowledge of HIV risk reduction	Indicator-63 Percentage of mothers of children aged 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV. Numerator : D: 296 N: 295 P:292 Denominator: D: 296 N: 298 P:294	100.0	99.0	99.3

Intervention area	Indicator	Dhaka	Netro-kona	Pancha-gor
G. Nutritional Surveillance				
Serial food consumption	Indicator-64 Percentage of children aged 6-23 months who consumed either rice or bread everyday for the last four days. Numerator : D: 180 N: 160 P:200 Denominator: D: 203 N: 211 P:218	88.7	75.8	91.7
Vegetable and fruit consumption	Indicator-65 Percentage of children aged 6-23 months who consumed either green leafy vegetables or yellow/orange fruit/vegetables every day for the last four days Numerator : D: 55 N: 61 P: 84 Denominator: D: 203 N: 211 P:218	27.1	28.9	38.5
Fish ,Meat, Egg or lentil consumption	Indicator-66 Percentage of children aged 6-23 months who consumed either fish or egg or lentil or meat every day for the last four days Numerator : D: 129 N: 58 P: 48 Denominator: D: 203 N: 211 P:218	63.5	27.5	22.0

Annex 8: Evaluation Team Members and their Titles

-Dr. Frank Baer, Independent Consultant, Baertracks (team leader)
-Mrs. Elsie Hasdak, Head of Training, LAMB, Bangladesh
-Mr. Will Story, CS & Health Tech. Advisor, CRWRC/US
-Mrs. Stephanie Sackett, Assoc. Dir. for Grants, CRWRC/US
-Ms. Nancy TenBroek, Development Consultant, CRWRC/BD
-Ms. Kohima Daring, DC & Country Team Leader, CRWRC/BD
-Ms. Prity Lata Biswas, Data Mgmtt Officer, CRWRC/Bangladesh
-Dr. Shahnaz Parveen, Program Specialist, CRWRC/Bangladesh
-Mr. Doyal Chandra Paul, Executive Director, SUPOTH
-Mr. Rezaul Karim, Health Coordinator, SUPOTH
-Mr. Apurbo Ghagra, Executive Director, SATHI
-Ms. Shireen Akhtar, Health Coordinator, SATHI
-Ms. Catherine Rina Guda, Assistant Director, SATHI
-Mr. Gabriel Rozario, Executive Director, PARI
-Mr. Prafulla Chandra Hajong, Health Coordinator, PARI

Back: Gabriel Rozario, Apurbo Ghagra, Frank Baer, Doyal Chandra Paul, Stephanie Sackett Rezaul Karim, Will Story, Catherine Reina Guda, Nancy TenBroek, Front: Prafullo Chandra Hajong, Prity Lata Biswas, Shahnaz Parveen, Elsie Hasdak, Kohima Daring, , Shireen Akhtar,

Annex 9: Evaluation Assessment Methodology

The Final Evaluation took place June 6-17, 2009. The 15-person evaluation team included an external consultant team leader, staff of CRWRC/Bangladesh and CRWRC/US, the head of training from LAMB hospital, and representatives from the three implementing partners (PARI, SATHI AND SUPOTH). The evaluation process answered six questions (AMPLOS):

A: What were the project Achievements?

M:Were the implementation Models and approaches effective?

P: What are some Promising Practices initiated by this project?

L: What are the Lessons Learned from this project?

O: What Opportunities exist for scaling up or replication?

S: How can the project achievements be Sustained?

The evaluation team reviewed a list of possible stakeholder groups (see table below) to interview as during the final evaluation and selected 12 groups as priorities.

Prioritized List of Groups to Interview	Selected
Super CHVs	OK
Trained Traditional Birth Attendants	OK
Village Doctors	OK
Peoples' Institution	OK
PI Health Sub-committee	OK
Health Center staff (e.g. FWC, SSF)	OK
Local Government (Union)	OK
Local Government (District)	OK
Training Institutions (LAMB, Joyramkura, Radda Barnen)	OK
Partner Staff	OK
CRWRC Staff	OK
USAID Mission	OK
Community Health Volunteers	
Community-based Local Leaders	
Community Theater Team	
Community Central Committee (CCC)	
Primary Group	
Child Weighing	
Women of Reproductive Age	
Adolescent Group	

Using the six AMPLOS questions as a framework, the evaluation team developed a specific list of questions for each group to be interviewed. In some cases, the questions were similar for several groups. The questionnaires by group are shown below:

Questions for Group Interviews

I. Questions for USAID Mission

1) From USAID/Bangladesh's point of view, what are the most important achievements of CRWRC's Child Survival Project? In what ways does this project contribute toward the achievement of USAID's own health objectives for Bangladesh?

2) What interesting innovations and/or promising practices have you noted in this project. How might the Mission use these to inform the activities of the mission?

3) How has CRWRC's Child Survival Project complemented the Mission's bilateral programs?

4) In what ways have CRWRC and USAID/Bangladesh collaborated in the past 4-5 years? How has CRWRC added value to what the Mission is doing? And how has the Mission added value to CRWRC's Child Survival Project? Please give some specific examples.

5) How do you see CRWRC's Child Survival Project strengthening efforts and policies by Bangladesh's Ministry of Health?

6) What components of the program (strategies, models, etc) do think were most effective in promoting health?

7) What opportunities do you see for scaling up strategies from CRWRC's CSP at the country level in Bangladesh?

8)What possibilities do you see for components of the CSP to be sustained, continued or supported by the USAID Mission or bi-lateral program after the CSHGP funding ends?

II. Questions for National IMCI Office:

1) From your point of view, what are achievements has the CRWRC Child Survival Project?

2) In what ways does this project contribute toward the achievement of your IMCI objectives for Bangladesh?

3) What interesting innovations and/or promising practices have you noted in this project? How could these reinforce your work?

4) What opportunities do you see for scaling up strategies from CRWRC's Child Survival Project at the regional or country level?

5)What possibilities do you see for the C-IMCI components of CSP to be sustained, continued or supported by the National IMCI Office after the end of the project?

III. Questions for District, Upazila, and Health Facility Level:

1) From your point of view, what are achievements has the CRWRC Child Survival Project?

2) In what ways does this project contribute toward the achievement of your health objectives for your district/upzilla?

3) What interesting innovations and/or promising practices have you noted in this project? How could these reinforce your work?

4) What opportunities do you see for scaling up strategies from CRWRC's Child Survival Project at the regional or country level?

5)What possibilities do you see for the components of CSP to be sustained? How might your group contribute to this process?

6) Do you have any other comments, question, or any recommendation for this project?

IV. Questions for training institutions

1) As per planned, what were the achievements of this project within your organization?
   a. How did your work help to achieve the overall objectives of the project?
   b. Tell us a story or event about your biggest success and explain your role in making it happens.

2) What is your opinion about the implementation model/process/strategies used by this project?

3) What are the best/promising practices of this project? What were some of the innovations you used in the trainings that you think was a promising practice?

Were there any new ways of training, or types of training you used that you think is a promising practice?

4) What are the lessons learned from this project?

5) During the course of the grant, what things did you change? What would you do differently next time? What things didn't work, that you had to change/adapt in order to achieve the objectives?

6) What are the opportunities of the existing health system for scaling up? Do you think anything from your training could be used with other organizations? For scaling up or used by the Government?

7) What is your opinion about the sustainability of the achievements of this project and how will your organization contribute to sustainability? Do you think that the work of the CHVs and TTBAs will sustain? How do you think your part in the project will contribute for continued good health in the community?

V. Questions for PI and PI health sub team

1. Achievements: Do you think the project achieved the objectives of Improvement of Maternal and child health?
   a) Tell us a story or event about your biggest success and explain your role in making it happens.
   b) What changes you have observed among the community people due to your work of CSP?
2. Model: Do you think the approach and strategies of this project was appropriate? Why?
   a) How do you think about the strategy to build relationship with health facilities?
3. Promising practices: Can you identify some of the promising practices that will keep the project on-going?
   a) Which activity do you think that your team is doing well? Why? What results you want see?
4. Lessons learned: What lessons did you achieve from this project? Can you share some of those?
   a) What would you like to do differently in future to promote/in order to improve mothers and child health? How?
5. Opportunities: What opportunities do you find to expand this project in new area or include in the health system?
   a) What opportunities do you think exist should continue work for the community?
6. Sustainability: Do you think your health activities (Ma o Shishu) will continue for a long time or forever? Why?
   a) Share something about your good work that your team capable to continue without support of SATHI/PARI/SUPOTH.
   b) What is your plan to continue this program without support of outsider/ SATHI, PARI, SUPOTH?
7. Is there a proverb or religious quote that exists in your community which illustrates the work of this project?

VI. Questions for CHVs, TTBAs and Village Doctors

1. What have you learned or achieved from this project? Tell us a story or event about your biggest success and explain your role in making it happen.
2. What were the objectives of the training that you participated in? Did you achieve these objectives?
3. What did you particularly like about 'the way' that this training was conducted?
4. What are some of the new practices related to your work that have brought good results for the community?
5. How do you relate to the personnel in the health facility? Has this changed during the project?
6. How do you relate to the Peoples Institutions? Has this changed during the project?
7. Do you think the things that the project has achieved or started will last in the community? How will you take part in keeping these things running/practicing/lasting?
8. Is there a proverb or religious quote that exists in your community which illustrates the work of this project?

VII. For NGO Partner Staff:

1. What were the main objectives of this project? Which objectives do you think the project achieved?
2. What were the strategies you used in this project? What strategies did you like/ and think worked in this project? Why?
3. What were some of the innovations or promising practices that you think emerged in this project? OR
   a) What were some of the things that were most successful in this project, and different from other organization
4. What lessons did you learn during the Project? What changes did you make during the project?
   a) Or, what things didn't work that you changed and did differently after the midterm?
   b) Or, if you were doing this project again, what did you learn that you would do differently next time?
5. What parts of the model/strategy do you think can be used in other areas, or used by the Government?
6. Do you think that the PIs can sustain the work? How?
   a) What more can your organization do (with PIs) to ensure the sustainability of the project?
7. What were the key elements to the success of this project that could be adapted and implemented by other CRWRC partners?

VIII. Questions for CRWRC Staff

1) Describe how this project achieved the objectives that you planned?

2) What were the primary implementation models/approaches/strategies used by this project? Were they successful in achieving your project objectives? How do you know?

3) What promising practices can you identify?

4) What lessons learned can you identify?

5) What opportunities are there to scale-up or mainstream this project? What aspects of this project could be used to influence scale-up at the national level? What aspects could be or have been incorporated into other CRWRC health programs?

6) Are the project achievements sustainable? How will CRWRC contribute to sustainability? What factors do you believe will be most critical for the long-term success of the outcomes achieved by this project?

7) What policy and evidence based advocacy activities did the grantee engage in? With which stakeholders and partners?

Field Visits were organized to interview as many groups as possible. A total of 37 groups were interviewed during the final evaluation.

The evaluation team divided into two teams for field visits to project areas (see schedule). The teams conducted almost 40 group interviews with Super CHVs, Trained TBAs, Village Docs, Peoples Institutions (PI), PI Health Sub-teams, health facility staff, MOH authorities, local government leaders, training institutions, NGO partner staff, CRWRC staff, and USAID.

Following field visits, findings were compiled and discussed to answer the six key evaluation questions. Preliminary lists of promising practices, lessons learned, opportunities and potential for sustainability were developed and discussed.

A consensus was established on project achievements, promising practices, lessons learned, opportunities, and potential for sustainability. These results were prepared into an Executive Summary and PowerPoint presentation for review and discussion with stakeholders. The evaluation results were presented and discussed with stakeholders during a meeting on June 17.

Overview of the Final Evaluation Schedule

Sat June 6	Eval process, Update since MTE, KPC findings, Finalize selection and schedule of groups to interview	
Sun June 7	Develop field instruments, staff interviews, Meet with USAID PHN Program Officer (late PM)	
Mon June 8	National IMCI Division of MOHFW First field visit with two teams to Dhaka	
June 9 – 12	Two teams visit Panchagor and Netrokona	
	Team A:	Team B:
Tue 9	Travel (LAMB, Supoth)	Travel (District/Pari)
Wed 10	PI, SCHV, TTBA,	Field visits (PI, CHV,
Thr 11	VDocs, FWC, Union	VDocs, FWC, Union)
Fri 12	Return to Dhaka	Joyramkura Return to Dhaka
Sat June 13	DAY OFF	
Sun June 14	Reporting, Compile findings, Review achievements and KPC table, Begin draft	
Mon June 15	Discussion of findings and listing of promising practices, lessons learned, opportunities, and potential for sustainability.	
Tue June 16	Establish consensus on executive summary and list of PP, LL and opportunities, prepare for presentation to stakeholders.	
Wed June 17	Official presentation to stakeholders.	

Annex 10: List of persons interviewed and contacted

Dr. Mosaddeque Ahmed, Program Manager for IMCI

Dewan Emdadul Hoque, Deputy Project Coordinator, ICCDR,B

Mr. Kishnapada Chakraborty, Advisor of Population, Health and Nutrition, USAID/Bangladesh

Staff of CRWRC/Bangladesh:
- Ms. Nancy Ten Broek, Development Consultant (Director of CSP)
- Ms. Kohima Daring, Development Consultant and Country Team Leader

Directors and Trainers from the three training institutions contracted for TTBA/CHVs trainings:
- Radda Barnen (Dhaka)
- Joyramkura (Netrokona)
- LAMB Hospital (Panchagor)

In Dhaka, SATHI's project area, the following individuals and groups were interviewed:
- SATHI staff (2)
- Members of the "Ottaran" People's Institution in Maniknagar (19)
- TTBAs in Maniknagar (20)
- Super CHVs in Maniknagar (16)
- Clinic Director and other staff at the Smiling Sun Clinic in Sutrapur
- Members of the People's Institution Health Sub-Team in Sutrapur (16)
- Training Coordinator and TBA Trainers from Radda Barnen, Mirpur
- Health facility staff at Urban Health Center Project (funded by Dhaka City Corp.) in Lalbagh
- Members of the People's Institution Health Sub-Team in Mirpur (15)
- TTBAs in Mirpur (15)
- Super CHVs in Mirpur (12)

In Netrokona, PARI's project area, the following individuals and groups were interviewed:
- PARI staff (4)
- Civil Surgeon and Deputy Director of Family Planning
- 15 Members Mukta Society (PI) and 5 members of the Health Sub-Team from Kullagora Union
- Union Chairman, Union Council members (9), and other elites (12) in Kullagora Union
- Super CHVs in Gopalpur Union (17)
- CSBAs, FWV, FWA, Medical Assistant, and Assistant Health Inspector, Durgapur
- Village doctors from various communities in Durgapur (16)
- Members of Zhinuk Society (People's Institution) and Health Sub-Team in Gopalpur Union (18)
- Acting Upazila Health & Fam. Plan. Officer, Health Inspector, & EPI Tech. at Durgapur
- Medical Assistant, Asst. Health Inspector, & Health Assistant at Lengura Family Welfare Center
- Clinic Manager of Smiling Sun Clinic (operated by JTS) in Lengura Union
- TTBAs in Durgapur (18)

In Panchagor, SUPOTH's working area, the following individuals and groups were interviewed:
- SUPOTH staff (6)
- Super CHVs from Chaklahat and Kamatkazaldighi Unions (16)
- People's Institution members (13)
- TTBAs from Chaklahat and Kamatkazaldighi Unions (15)
- Civil Surgeon, DDFP, UHFPO, UFPO, Med. Officer, and Jr. Ed. Officer, Panchagor District
- PI Health Sub-Team members (9)
- Family Welfare Center staff in Chaklahat Union (9)
- Village Doctors from Chaklahat and Kamatkazaldighi Unions (13)

Annex 11: Special Reports - Community Case Management

Community Case Management of Diarrhea and Pneumonia Through Community Health Workers in Rural Northern Bangladesh

(Excerpts from the full report)

Background

The Christian Reformed World Relief Committee (CRWRC) received funding from the USAID Child Survival and Health Grants Program in the Entry category for a five-year program in Bangladesh that seeks to achieve and sustain improved health and rates of survival for children under age five and women of reproductive age.

The program targets two rural districts (Panchagarh and Netrokona) and one urban district (Dhaka) in Bangladesh where rates of under five child mortality (88 deaths/1,000 live births) and maternal mortality (322 deaths/100,000 live births) are very high (NIPORT, 2003; NIPORT, 2005). The six strategic objectives for CRWRC's Child Survival Project (CSP) are:

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

In order to achieve these objectives, CRWRC works with three partner organizations: Pari (Netrokona), Sathi (Dhaka) and Supoth (Panchagarh). Over the life of the project, CRWRC and its partners hope to directly benefit 5,072 children under five and 11,468 women of reproductive age (WRA).

CRWRC incorporated the strategic objectives into the three components of the C-IMCI resulting in the following key intervention activities:

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

CCM was integrated into on-going C-IMCI activities by improving the quality and availability of treatment for diarrhea and pneumonia through CHVs. CRWRC has a Health Coordinator and several Health Animators established within each partner organization who are responsible for many of the child survival program activities including the training of CHVs. The addition of diagnosis and treatment protocols for pneumonia and diarrheal disease were easily integrated into the current child survival activities. The study was conducted in the Panchagarh district.

Hypothesis

CHVs can be used to properly diagnose and treat diarrhea and pneumonia at the household level with proper training, supervision, and monitoring. The number of suspected cases of severe diarrhea and pneumonia that receive proper treatment will increase using CCM when compared to the basic management and verbal referral of diarrhea and pneumonia by CHVs.

Objectives

General

To Develop a CCM Strategy through CHVs to diagnose and properly treat diarrhea and pneumonia at house hold level.

Specific

To adapt simple clinical criteria and algorithms for CHVs to diagnose and treat pneumonia and diarrhea among the children under 2.

1. To train CHVs to use the clinical criteria and algorithms for community case management, including:
   i) Early identification of sick children
   ii) Treatment for pneumonia with oral co-trimoxazole (2-23 months of age) and diarrhea with oral rehydration solution and zinc
   iii) Appropriate referral for severe cases

2. To provide supervision to CHVs who are implementing CCM.
   i) Create a supervisory tool for use with CHVs
   ii) Use existing health animators and IMCI trained doctors to supervise CHVs
   iii) Use community based organizations (a community group/committee) to monitor, support and ensure referral mechanism for the CCM
      a) To establish a sustainable system for monitoring and evaluating CCM
      b) To incorporate the treatment algorithms, training protocols, supervisory tool, and monitoring system for the CCM of diarrhea and pneumonia into the C-IMCI strategy for the GOB for rapid scale-up

Methods

Study Design

A quasi-experimental study design was used to determine the impact of CCM for diarrhea and pneumonia by CHVs compared to basic management and verbal referral of diarrhea and pneumonia by CHVs. The design is shown diagrammatically in Figure 1.

Figure 1. Study Design

	TIME →		
Intervention Group	O_1	X	O_2
Control Group	O_3		O_4

Where:

X = community case management of diarrhea and pneumonia

O_1, O_3 = measures of diarrhea and pneumonia-specific diagnosis, treatment, and Mortality prior to the intervention and control groups.

O_2, O_4 = measures of diarrhea and pneumonia-specific diagnosis, treatment, and Mortality following the intervention and control groups.

Study Area

The intervention groups are selected from 2 unions, Chakalarhat union and Kamatkajal deghi union in the Sadder Thana of the Panchagarh district in Northern Bangladesh. The control group is chosen from two other unions like Harivasha and Hafijabad in the Sadder Thana of the Panchagarh district in Northern Bangladesh.

Study Population

The target population was children 0 months to 59 months of age, focusing on children from 1 day up to 2 months of age and 2 months up to 5 years of age**.**

Operational Definitions

Diarrhea: Based on WHO definition.

Pneumonia: Defined as the combination of at least two of the following symptoms: cough, difficulty breathing, rapid breathing (>40 breaths per minute), chest in drawing, or fever within preceding 30 days.

Community Case Management: The assessment and treatment of children under two with diarrhea or pneumonia by a CHV (UNICEF/WHO, 2006).

- Assessment: The CHV performs a targeted physical examination, including detection of chest in drawing, determination of respiratory rate using a watch, stopwatch or timer for pneumonia, and dehydration. The CHV may use a classification algorithm to make treatment decisions. Treatment decisions are based on the respiratory rate and signs of severe disease.
- Treatment: The CHV both prescribes and dispenses cefprozil or cotrimoxazole for pneumonia and oral rehydration solution (ORS) and zinc for diarrhea. The CHV may also monitor response to treatment by following up on the child in the home.
- Referral: CHVs are trained to recognize the signs of severe pneumonia and diarrhea that require referral to a health facility for treatment and monitoring beyond what can be provided in the community by the CHV. Referral cards were used by CHVs to monitor referral outcomes.

Basic Management and Verbal Referral: Communication and awareness creation about prevention and treatment of diarrhea and pneumonia through CHVs (UNICEF/WHO, 2006).

- Assessment: There is little assessment of children by the CHV beyond detection of dehydration and fever, and no use of algorithms.
- Treatment: CHV activities may include providing such treatments as vitamins, antihelminthics, or ORS. CHVs do not sell or provide antibiotics.
- Referral: If a sick child is identified as requiring treatment with antibiotics, the CHV will refer the child verbally to an existing health facility. The CHV also promotes care-seeking from health facilities through education during household visits.

Selection, Training, and Supervision of CHVs

Existing CHVs who work for the CSP were trained in CCM of diarrhea and pneumonia. CCM training was given to the CHVs in addition to basic training on key family practices and safe deliveries. Specific criteria were used to select CHVs for training in CRWRC's CSP, and a

summary of the training previously received by the CHVs (CRWRC, 2005) was reviewed. Additional training on diarrhea and pneumonia case management also followed UNICEF and WHO guidelines (UNICEF/WHO, 2006; WHO, 2002) and included topics such as classification of ARI and diarrheal diseases, analysis of the causes and factors that contribute to these infections, examination of diarrhea and pneumonia case studies, counting respiration rate, advice on patient care, and use of referral card. The Bangladesh Field Office of Save the Children-USA has been implementing CCM for ARI and diarrhea through CHVs in rural communities since 2004 through its NGO Service Delivery Program. CRWRC was able to adapt the training materials used by Save the Children to provide the additional training on CCM.

Findings

This one year pilot project of Community Case Management (CCM) along with its research operation an operation research was aimed at developing community capacity in the area of childhood illnesses management, especially diarrhea and pneumonia. CCM included the activity of further developing skills of the existing Community Health Volunteers (CHV) in diagnosing, managing and referring the children with diarrhea and pneumonia. These CHVs had already been selected and working as volunteers in the two unions of Panchagor District where the CSP has been operating.

The operations research had an objective to determine the effectiveness and outcome of CCM project activities. At the end of the project the findings show that there has been considerable improvement in the capacity of community health volunteers in early diagnosis and management of diarrhea and ARI at the community level. In 64% of cases, CHV s were able to diagnose and treat diarrhea and ARI correctly, and in 21% more cases they performed well after they received advanced training. Only in 15% of cases of diarrhea and ARI did they not perform satisfactorily. CHV s provided advice and treatment for 60.43% of cases and 39.56% cases they referred to a local health facility for better care.

Through the CCM project, government doctors were provided training on Community IMCI with the purpose that they would better manage the severe and complicated cases of childhood illness referred to the hospitals by the CHV s. In cases of referrals the system did not work properly. In almost all referred cases it was found that there was no documentation preserved or of referral slips use. Most of the cases were referred verbally and the health care providers at the hospital did not keep any record of those referred cases. Only 23% of mothers actually received care for their sick child from hospital after being referred by the CHV s and the rest did not follow the advice.

Among all the cases of childhood illness managed by CHV s, 25% presented with ARI, 72% with diarrhea and 3% with both diarrhea and ARI. 11% of the cases were diagnosed by the CHVs as having danger signs. It indicates that the symptoms of those children with severe illness could have led to serious complications or even death if the CHVs were not able to classify and treat at the household level or referred immediately to the hospital by the CHV s.

The community survey regarding the acceptance and satisfaction level with CCM shows that the CHV s got more acceptance and appreciation from the mothers when they provided direct care to the sick children than when they provided only advice and health lessons. 23% of mothers expressed that there should be more frequent communication with the CHVs, 20% want Supoth to establish their own clinic, 16% of mothers want CHV s to travel with them to the hospital when they are referred to, 14% suggested to continue the CCM for a longer period of time and

11% of mothers suggested that the CHVs should be given training on other diseases as well so that they can manage a wider range of ailments at the community level. 51% of mothers expected CHVs to provide zinc and ORS for the sick children whenever necessary, 11% of mothers expected nutritional supplements from the CHVs and 8% expected all other necessary medicines from CHVs and 17% want the presence of the CHVs while visiting a doctor for health care.

The effectiveness of CCM could not be determined and tested because of some technical issues of the operation research that were as follows:

- There were no CHVs working in the regular program of CSP or with the Government or other NGOs in the control areas selected for the research, so a comparison could not be done.
- Similar data from the control area could not be collected for the same reason mentioned above.
- Referral data was not available in GOB facility because they did not preserve any referral information. They practice a verbal referral system. We used referral slips and the patients received care but the referrals were not recorded in the GOB facility. We used referral slips and patient get care but no referral was recorded in GOB facility.

Project Level Recommendations

1. To give more emphasis in the overall CSP project for case assessment, classification, treatment, and referrals on ARI and Diarrhea according to C-IMCI protocol by CHV.
2. To arrange training of other diseases like fever, ear problem, malnutrition and anemia according to C-IMCI protocol for CHV.
3. To improve Health Care management in Health Facility like- FWC, H & FWC and Panchagarh Sadder Hospital.
4. To provide continue Tab Co-trimoxazole in the community from government, and also try to provide Zinc and ORS in future.
5. To maintain strong networking with the government
6. To arrange a transport from a Thana Federation in severe cases, and then immediately referred to a health facility.
7. To improve more communication of CHVs with the community
8. To incorporate CCM into the Child Health and Survival program.

Policy Level Recommendations

After one year of interventions, in spite of some limitations, the CHV gets higher rates (85%) of good treatment and more community people are satisfied by CHV services (91%). Community people have greater expectations about some other services, but overall they are satisfied with the service they get from CHVs. One notable expectation is the provision of But one noticeable thing is that they expect Zinc/ORS (51%) like Cotrimoxazol. CCM is successful in achieving higher treatment rate without compromising quality, so we strongly recommended that the GOB should include CCM (Diarrhea and pneumonia) in its on-going C-IMCI strategy. We also recommend that the government approve and support written referral records and child treatment

records at the clinic level. With these interventions and changes, we will be able to save millions of children's lives and prevent serious illness.

Conclusion

Training of the Community health volunteers (CHV) demonstrated a significant increase in the effective treatment by the CHVs of Pneumonia and Diarrhea. CHVs were able to manage basic treatments for pneumonia and diarrhea. Community people were also satisfied by the CHV services and expect continuation of services. As CHVs made mistakes assessing symptoms, classifying illnesses, and prescribing correct doses of medications, ongoing training and support of CHVs would strengthen this program. The health subcommittees of the People's Institutions can be instrumental in ensuring that the Government clinics and CHVs are working well together in diagnosis and treatment and referrals of pneumonia and diarrhea cases.

Annex 12: Project Data Form

Updated and printed from www.childsurvival.com/projects/dipform/login.cfm.

Child Survival and Health Grants Program Project Summary

Jun-25-2010

Christian Reformed World Relief Committee (Bangladesh)

General Project Information

Cooperative Agreement Number:	GHS-A-00-04-00010-00
CRWRC Headquarters Technical Backstop:	Alan Talens
CRWRC Headquarters Technical Backstop Backup:	Stephanie Sackett
Field Program Manager:	Nancy TenBroek
Midterm Evaluator:	Franklin C. Baer
Final Evaluator:	Franklin Baer
Headquarter Financial Contact:	Stephanie Sackett
Project Dates:	9/30/2004 - 3/31/2010 (FY04)
Project Type:	New Partner
USAID Mission Contact:	Sukumar Sarker
Project Web Site:	

Field Program Manager

Name:	Nancy TenBroek (Development Consultant)
Address:	3/13 Iqbal Road Mohammedpur , Dhaka Bangladesh
Phone:	88-02-8119171
Fax:	88-02-8115076
E-mail:	ntenbroek@crwrc.org
Skype Name:	

Alternate Field Contact

Name:	(Development Consultant)
Address:	 Bangladesh
Phone:	
Fax:	

E-mail:

Skype Name:

Grant Funding Information

USAID Funding: $1,098,152 **PVO Match:** $475,201

General Project Description

CRWRC seeks to achieve and sustain improved health and rates of survival for children under age five and women of reproductive age in Bangladesh. The six strategic objectives for CRWRC's Child Survival Project are: 1) improve maternal and neonatal care; 2) prevent and properly treat diarrheal disease; 3) detect ARI and make appropriate referrals; 4) improve child nutrition; 5) reduce mortality and morbidity from vaccine preventable diseases; and 6) increase awareness about HIV/AIDS. In order to achieve these objectives, CRWRC works with three partner organizations: Pari (Netrokona), Sathi (Dhaka) and Supoth (Panchagor). Over the life of the project, CRWRC and its partners hope to directly benefit 5,072 children under five and 11,468 women of reproductive age (WRA). CRWRC incorporated the strategic objectives into the three components of the Community/Household Integrated Management of Childhood Illness (C-IMCI) resulting in the following key intervention activities: 1)Improve networking with health facilities in order to refer complicated pregnancies and severe childhood illnesses. 2)Increase the quality and availability of pre-natal, natal and post-natal care through training of traditional birth attendants (TBAs). 3)Promote key family practices critical for child health and nutrition through training community health volunteers (CHVs) and forming primary groups.

Project Location

Latitude: 26.33	**Longitude:** 88.57
Project Location Types:	Urban Rural
Levels of Intervention:	Health Center Health Post Level Home Community
Province(s):	--
District(s):	Dhaka District: slum areas of Lalbag, Sutrapur, Maniknogar, and Mirpur. Netrokona District: Kolmakanda and Durgapur Thanas. Panchagarh District: Sadar Thana
Sub-District(s):	--

Operations Research Information

OR Project Title:	Community Management of Diarrhea and Pneumonia through Community Health Workers in

	Rural Northern Bangladesh
Cost of OR Activities:	$29,238
Research Partner(s):	PARI in Netrokona, SATHI in Dhaka and SUPOTH in Panchagarh
OR Project Description:	The OR is to determine whether the CHVs can be used to properly diagnose and treat diarrhea and pneumonia at the household level with proper training, supervision and monitoring. A quasi-experimental design was used to determine the impact of Community Case Management (CCM) for the above diseases. The conclusion: Training of CHVs showed significant increase in effective treatment by CHVs of diarrhea and pneumonia. CHV s were able to manage basic treatment for these 2 diseases and the communities were satisfied by the services and expected continuation. Ongoing supervision will strengthen the program. The health subcommittee of the People's Institution (PI) can be instrumental in ensuring that government clinics and CHVs are working well together in diagnosis and treatment and referral cases (diarrhea and pneumonia). Recommendation is for the GOB to include CCM of pneumonia and diarrhea with its C-IMCI strategy, and that it approve and support written referral records and child treatment records at the clinic level. With CCM and the recommended changes, projects could save million lives of children and prevent serious illnesses.

Partners

Pari Development Trust (Sub grantee)	$90,000
Sathi (Sub grantee)	$87,500
Supoth (Sub grantee)	$115,000

Strategies

Social and Behavioral Change Strategies:	Group interventions Interpersonal Communication
Strategies for Enabling Environment:	Advocacy for policy change or resource mobilization
Tools/Methodologies:	BEHAVE Framework Sustainability Framework (CSSA) Rapid Health Facility Assessment LQAS

Participatory Rapid/Rural Appraisal

Capacity Building

Local Partners:

Local Non-Government Organization (NGO)
Pharmacists or Drug Vendors
Dist. Health System
Health CBOs
Other CBOs
Faith-Based Organizations (FBOs)

Interventions & Components

Immunizations (10%) - Classic 6 Vaccines - Vitamin A - Mobilization - Measles Campaigns - Community Registers	IMCI Integration	CHW Training HF Training
Nutrition (25%) - ENA - Gardens - Complementary Feeding from 6 months - Hearth - Continuous BF up to 24 months - Growth Monitoring - Maternal Nutrition	IMCI Integration	CHW Training HF Training
Vitamin A (5%) - Supplementation - Post Partum - Integrated with EPI	IMCI Integration	CHW Training HF Training
Micronutrients (15%) - Iodized Salt - Iron Folic Acid in Pregnancy	IMCI Integration	CHW Training HF Training
Pneumonia Case Management (10%) - Recognition of Pneumonia Danger Signs	IMCI Integration	CHW Training HF Training
Control of Diarrheal Diseases (10%) - Water/Sanitation - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counseling - POU Treatment of water - Zinc	IMCI Integration	CHW Training HF Training
Malaria	IMCI Integration	CHW Training HF Training
Maternal & Newborn Care (15%) - Emergency Obstetric Care - Neonatal Tetanus - Recognition of Danger signs	IMCI Integration	CHW Training HF Training

- Newborn Care
- Post partum Care
- Integration. with Iron & Folic Acid
- Normal Delivery Care
- Home Based LSS
- Emergency Transport

Healthy Timing/Spacing of Pregnancy	IMCI Integration	CHW Training HF Training
Breastfeeding (5%) - Promote Exclusive BF to 6 Months	IMCI Integration	CHW Training HF Training
HIV/AIDS (5%) - Behavior Change Strategy - ABC	IMCI Integration	CHW Training HF Training
Family Planning	IMCI Integration	CHW Training HF Training
Tuberculosis	IMCI Integration	CHW Training HF Training

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health
748 (510 TTBA and 238 CHVs)
Number of People Trained in Child Health & Nutrition
748 (510 TTBAs and 238 CHVs; Training contents were maternal, newborn , Child Health and Nutrition)
Number of People Trained in Malaria Treatment or Prevention
Not Applicable

Locations & Sub-Areas

Netrokona	89,068
Dhaka	45,445
Panchagor	35,290
Total Population:	169,803

Target Beneficiaries

	Netrokona	Dhaka	Panchagor	Total
Children 0-59 months	0	0	0	0
Women 15-49 years	23,603	12,043	9,352	44,998
Beneficiaries Total	23,603	12,043	9,352	44,998

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster

Underweight Children

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	61	150	40.7%	12.9
Dhaka	58	150	38.7%	12.6
Panchagor	57	150	38.0%	12.6

Birth Spacing

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	88	110	80.0%	18.3
Dhaka	70	86	81.4%	20.8
Panchagor	73	99	73.7%	19.0

Delivery Assistance

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	23	150	15.3%	8.5
Dhaka	21	150	14.0%	8.2
Panchagor	11	147	7.5%	6.1

Maternal TT

Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	92	149	61.7%	14.8
Dhaka	88	150	58.7%	14.6
Panchagor	100	125	80.0%	17.2

Exclusive Breastfeeding

Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breast milk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	34	46	73.9%	27.9
Dhaka	34	53	64.2%	25.1
Panchagor	29	33	87.9%	33.9

Complementary Feeding

Description -- Percentage of infants age 6-9 months receiving breast milk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breast milk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	2	14	14.3%	27.0
Dhaka	11	20	55.0%	39.1
Panchagor	4	15	26.7%	34.4

Full Vaccination

Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	21	66	31.8%	17.6
Dhaka	15	54	27.8%	18.4
Panchagor	42	74	56.8%	20.5

Measles

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	0	0	0.0%	0.0
Dhaka	0	0	0.0%	0.0
Panchagor	0	0	0.0%	0.0

Bed nets

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bed net the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	127	142	89.4%	16.4
Dhaka	123	132	93.2%	17.0
Panchagor	126	139	90.6%	16.6

Danger Signs

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits

Netrokona	109	150	72.7%	15.4
Dhaka	93	150	62.0%	14.8
Panchagor	105	150	70.0%	15.3

Sick Child

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	3	44	6.8%	10.7
Dhaka	3	11	27.3%	40.6
Panchagor	1	14	7.1%	19.4

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	20	150	13.3%	8.0
Dhaka	76	150	50.7%	13.9
Panchagor	18	150	12.0%	7.6

Handwashing

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	22	150	14.7%	8.3

Dhaka	56	150	37.3%	12.5
Panchagor	80	150	53.3%	14.2

Rapid Catch Indicators: Mid-term

Sample Type: 30 Cluster

Underweight Children

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	100	269	37.2%	9.3
Dhaka	78	288	27.1%	7.9
Panchagor	75	285	26.3%	7.8

Birth Spacing

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	234	300	78.0%	11.0
Dhaka	258	300	86.0%	11.2
Panchagor	264	300	88.0%	11.2

Delivery Assistance

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	33	300	11.0%	5.2

Dhaka	67	300	22.3%	7.1
Panchagor	30	300	10.0%	4.9

Maternal TT

Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	179	294	60.9%	10.5
Dhaka	195	295	66.1%	10.7
Panchagor	148	300	49.3%	9.8

Exclusive Breastfeeding

Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	60	95	63.2%	18.7
Dhaka	57	85	67.1%	20.1
Panchagor	67	91	73.6%	19.8

Complementary Feeding

Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	21	28	75.0%	35.9
Dhaka	26	33	78.8%	33.3
Panchagor	17	36	47.2%	27.7

Full Vaccination

Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	59	80	73.8%	21.1
Dhaka	68	83	81.9%	21.2
Panchagor	70	76	92.1%	22.4

Measles

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	60	80	75.0%	21.2
Dhaka	72	83	86.7%	21.3
Panchagor	72	76	94.7%	22.5

Bednets

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bed net the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	248	277	89.5%	11.7
Dhaka	270	275	98.2%	11.8
Panchagor	207	290	71.4%	11.0

Danger Signs

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs

listed in B through H of Rapid CATCH Question 20
Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	240	300	80.0%	11.1
Dhaka	272	300	90.7%	11.3
Panchagor	245	300	81.7%	11.1

Sick Child

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23
Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	143	191	74.9%	13.7
Dhaka	189	199	95.0%	13.9
Panchagor	78	139	56.1%	14.9

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25
Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	107	184	58.2%	13.1
Dhaka	241	286	84.3%	11.4
Panchagor	128	218	58.7%	12.1

Handwashing

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26
Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	269	300	89.7%	11.3
Dhaka	295	300	98.3%	11.3
Panchagor	295	300	98.3%	11.3

Rapid Catch Indicators: Final Evaluation

Sample Type: 30 Cluster

Underweight Children

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	76	291	26.1%	7.7
Dhaka	66	293	22.5%	7.2
Panchagor	79	295	26.8%	7.8

Birth Spacing

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	201	238	84.5%	12.6
Dhaka	145	164	88.4%	15.2
Panchagor	170	205	82.9%	13.5

Delivery Assistance

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	46	300	15.3%	6.0
Dhaka	105	300	35.0%	8.6
Panchagor	25	300	8.3%	4.5

Maternal TT

Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	295	300	98.3%	11.3
Dhaka	281	300	93.7%	11.3
Panchagor	288	300	96.0%	11.3

Exclusive Breastfeeding

Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	71	79	89.9%	21.9
Dhaka	70	77	90.9%	22.2
Panchagor	60	67	89.6%	23.8

Complementary Feeding

Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	39	49	79.6%	27.4
Dhaka	35	46	76.1%	28.1

Panchagor	**30**	**37**	**81.1%**	**31.6**

Full Vaccination

Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	**119**	**124**	**96.0%**	**17.6**
Dhaka	**82**	**91**	**90.1%**	**20.4**
Panchagor	**113**	**120**	**94.2%**	**17.9**

Measles

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	**119**	**124**	**96.0%**	**17.6**
Dhaka	**84**	**91**	**92.3%**	**20.5**
Panchagor	**113**	**120**	**94.2%**	**17.9**

Bednets

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	**295**	**297**	**99.3%**	**11.4**
Dhaka	**268**	**279**	**96.1%**	**11.7**
Panchagor	**293**	**298**	**98.3%**	**11.4**

Danger Signs

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	297	300	99.0%	11.3
Dhaka	292	300	97.3%	11.3
Panchagor	297	300	99.0%	11.3

Sick Child

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	23	38	60.5%	29.2
Dhaka	28	29	96.6%	36.4
Panchagor	28	31	90.3%	35.0

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	295	298	99.0%	11.4
Dhaka	296	296	100.0%	11.4
Panchagor	292	294	99.3%	11.4

Handwashing

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after

defecation, and after attending to a child who has defecated
Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26
Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Netrokona	279	300	93.0%	11.3
Dhaka	299	300	99.7%	11.3
Panchagor	287	300	95.7%	11.3

Rapid Catch Indicator Comments

Bed nets: None of the bed nets are treated in Bangladesh. These numbers represent the number of children 0-23 months who slept under a bed net the previous night. Hand washing: A new indicator was used; number of households with ready access to soap for hand washing.

Annex 13: Activities and Final Results for Six-Month No Cost Extension Period October 2009- March 2010

The data after the 6-month extension period showed that CSP reached most of the end of project targets for number of PIs formed, beneficiaries served, and number of TBAs and CHVs trained (see table below).

Beneficiaries, Group Formation, People Trained by CSP through March 2010

Particulars		Dhaka		Netrokona		Panchagor		TOTAL	
		Actual	EOP Target	Actual	EOP Target	Actual	EOP Target	Actual	EOP Target
Primary Groups		165	227	203	203	225*	225	593	655
Primary Group Members		3,645	3,750	3,267	3,248	4,493	4,470	11,372	11,468
Adolescent Group	Girls	50	40	7	6	12	12	69	58
	Boys	21	20	4	4	12	10	37	34
Adolescent Group Member	Girls	525	400	143	115	325	325	993	840
	Boys	208	240	80	82	270	270	558	592
Peoples' Institutions		15	15	3	1	1	1	19	17
Children under 5		1,861	1,810	2,473	1,662	1,657	1,600	5,991	5,072
CHVs Trained		187	166	203	203	120	120	510	489
TBAs Trained		85	88	74	75	79	75	238	238

*Two (2) groups were consolidated into one which resulted in the total numbers of groups going down by one.

Below are the results of the project activities during the 6-month extension period after the Final Evaluation (June 2009).

Activity	Oct,09	Nov,09	Dec,09	Jan,10	Feb,10	Mar,10	Comments
People's Institution (PI) health sub team communication and networking with health centers.	X	X	X	X	X	X	PIs had regular twice monthly meetings with health centers.
PI Health sub team monthly meeting with Super CHVs, TTBAs and theater team members.	X	X	X	X	X	X	Took place in all three areas – led by sub teams.
Emergency health fund management by the health sub team and the PI chairperson supervised and received a monthly report	X	X	X	X	X	X	Monthly reports were consistent in all three areas.

Activity	Oct,09	Nov,09	Dec,09	Jan,10	Feb,10	Mar,10	Comments
Regular Meetings of Super-CHVs, TTBAs, Government and NGO health workers.	X	X	X	X	X	X	Monthly meetings were conducted. These were initiated with the help of the PI sub teams.
PI leaders participation in health center meetings quarterly	X			X		X	In Dhaka, these took place monthly. The other two areas were quarterly.
Training/orientation for PI leaders on supportive supervision for CHVs and TTBAs with monthly meetings	X	X	X				Completed during grant extension.
Action plan development with Pi leaders on seed fund(small grants)and health fund management	X						Completed. PIs now develop their own yearly action plans.
MOU development with PI and health center authorities.	X						Completed
CHV and TTBA leaders' selection for report collection.	X						Completed – and ongoing.
Development of health teaching center in the community where Super CHVs and TTBAs provide health education among women of reproductive age, pregnant and lactating mothers and adolescents.	X						These took place at the PI locations in the communities
PI leaders ensure the NID program reached the community.	X	X	X	X	X	X	This occurred regularly. PI sub teams were responsible for this.
Community action plan development by PI leaders ,and school teachers	X						Action plans were in place in all 3 areas.
Gender-based committee development in the PI	X	X	X	X	X	X	PI s ensures that sub team has gender balance.

Annex 14: Summary of Major Project Accomplishment

Project Objective #1: Improve Maternal and Newborn Care			
Project Inputs	**Activities**	**Outputs**	**Outcome**
Trainers Training materials and supplies Record Books for CHVs and TTBAs	Train TBAs Train CSP staff and CHV on Kangaroo mothers Care (KMC) Ensure TBAs perform their duties according to DIP Participation of CRWRC as member of the National Neonatal Health strategy development team (CRWRC was part of committee that drafted the National Neonatal strategy)	238 TBAs trained. Refresher courses completed by training institutions 1,022 safe deliveries by skilled personnel 776 deliveries referred to health facilities. GOB Neonatal Health strategy endorsed and signed by MOH. Trained CSP Staffs and CHVs –on home-based care for KMC	-Increase percentage of children 0-23 whose births were attended by skilled health personnel. (159%)* -Increase in percentage of mothers who had at least 4 prenatal visits prior to the birth of her youngest child less than 24 months of age. (141%)* -Increase in percentage of mothers who received at least two tetanus toxoid (TT) injections before the birth of the youngest child less than 24 months of age. (105%)* - Increase in percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/ symptoms during the prenatal, natal and postnatal. (161)* *Percent (%) of target reached
Project Objective#2: Prevent and Properly Treat Diarrheal Disease			
Project Inputs	**Activities**	**Outputs**	Outcome
Trainers Training materials and supplies Referral Cards	Train CHVs Ensure CHVs are performing their duties according to the DIP	510 CHVs trained in three project areas 526 cases of severe diarrhea referred to an appropriate health center. 687 cases of diarrhea treated with ORS at hoe	-Increase in percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluid. (93%)* -Increase in percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more. (129%)* -Increase in percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness. (95%)* -Increase in percentage of mothers of children age 0-23 months that have soap readily available for hand washing. (136%)*

Project Objective #3 Detect ARI and Make Appropriate Referrals			
Project Inputs	**Activities**	**Outputs**	Outcome
Trainer **Training supplies and materials.** **Referral Cards**	Facilitate workshop on ARI following IMCI module approved by MOH Ensure CHV are performing their duties according to DIP. Provide training on C-IMCI village doctors and pharmacist Community Case Management (Research)	146 village doctors trained in all project areas (3). 422 sever cases of ARI referred to an appropriate health center. Training of 20 CHVs in CCM	-Increase in Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health. (144%)* -Increase in percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms. (112%)* -Increase in treatment of referrals for ARI and diarrhea. (abstract submitted and presented to ICDDRB ASCON XII (Annual Scientific Conference 2009) *Percent (%) of target reached
Project Objective #4 Improve Child Nutrition			
Project Inputs	**Activities**	**Outputs**	Outcome
Trainers Training Materials Growth Monitoring Supplies (scales, GM Cards for mothers, Record books for PIs.	Develop growth monitoring (GM) groups and ensure proper GM techniques Sub teams weighing children monthly Implement PD Hearth Distribution of Vitamin A , iron tablets and anthelmintics with Ministry of health	Almost 600 GM groups formed in 3 project areas – doing monthly monitoring Weighing scales purchased by PIs GM cards used Over 1000 community children added as new clients. 11 PD Hearth sessions completed and followed up Vita A and anthelmintic distribution on NIDs (National	-Increase percentage of children aged 0-23 mother who are more than 2 SD below the median weight-for-age (WA) of WHO/NCHS reference population. (71%)* -Increase percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours. (98%)* -Increase percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours. (122%)* -Increase percentage children aged 6-23 months who received a Vitamin A dose in the past six months. (96%)* *Percent (%) of target reached

		immunization days) CHVs trained on Vitamin A , anthelmintic and iron tab distribution (35 Panchagor, 23 Netrokona and 20 in Dhaka)	
Project Objective#5 Reduce Morbidity and Mortality from Vaccine Preventable Diseases			
Project Inputs	**Activities**	**Outputs**	Outcome
Training supplies Record books for vaccine	Coordination with GOB Expanded program on Immunization for better coverage (CHV motivating people , doing street theater , coordinate with GOB and other NGOs) Awareness raising on vaccination by Theater team	CHVs who have participated in the GOB campaigns and NID programs PI involved in NID and regular immunization programs	-Increase percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio. (110%)* *Percent (%) of target reached
Project Objective#6 Increase Awareness of HIV/AIDS			
Project Inputs	**Activities**	**Outputs**	**Outcome**
Flip charts for trainings	HIV/AIDS awareness activities by PIs health sub teams	All the PI recognize and participate at the World AIDS day (Dec 1) yearly	-Increase percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV. (142%)* *Percent (%) of target reached
Cross cutting intervention #1 Community –Integrated Management of Childhood Illnesses			
Project Inputs	**Activities**	**Outputs**	**Outcome**
Flip charts Trainings Supervision in Community Case Management (CCM)	Selection and Training of super CHV Creation and use of the Emergency Health Fund (EHF)	95 Super CHVs trained out of 510 CHVs (each responsible for 4-6 CHVs. The Super CHVs meet together monthly EHF is now over $3500 USD and has a 75% usage	Improved Health Outcomes – Project Objectives #1-6 (above)

		rate- for under-5 and mothers. Funds are managed by PI with each PI holding a separate bank account.	
Project Objective #2 Child Survival Sustainability Assessment			
Project Inputs	**Activities**	**Outputs**	**Outcome**
Staff time Training Templates for CSSA	Use of dashboard to monitor sustainability semi-annually for each project area. Training of Partner NGO staffs in sustainability planning	Nine PI carrying out CSSA with minimal assistance –doing their own entry of results Training models developed by partners for use of the PIs. Trained community leaders on sustainability	Improved Health Outcomes – Project Objectives #1-6 (above)
Project Objective #3 Behavior Change Communication (BCC)			
Project Inputs	**Activities**	**Outputs**	**Outcome**
	Conducting Doer/Non-Doer Formative analysis Use BEHAVE Framework to address behavior that has been difficult to change Perform community dramas to communicate health messages	Doer and Non-Doer analysis in year 4 (carried out in year 4 and 5) BEHAVE Framework carried out for ARI care seeking, ANC and complementary feeding. Dramas set out in the 3 project areas.(Volunteers teams continue to develop new drama per request of the PIs)	Improved Health Outcomes –Project Objectives #1-6 (above)

*Percent (%) of target reached

Annex 15: Learning Exchange Reports

The Learning Exchange was an opportunity for partner organizations and CRWRC staff to learn about new innovations in maternal and child health through the Bangladesh CSP (Page 36). There were a total of 23 participants from 9 countries (Ecuador, Uganda, Laos, Cambodia, Tanzania, Zambia, Senegal, Nigeria, and Niger) and North America who benefited from this organizational capacity building activity. The participants went back to their respective countries with ideas on CSP implementation and the community mobilization model- the People's Institution. Below are 2 samples of the reports describing how the learning had enriched the participants and how this was applied to the country they work in.

A. Report from Tanzania: Impact of the Bangladesh Child Survival Program Learning Exchange to Tanzania.

Cross-Regional Exchange - Tanzania and Bangladesh
February, 2006
Trip Report

Submitted by
Steve Michmerhuizen, Program Consultant (CRWRC Mwanza, Tanzania)

Background for the Visit

"Capacity" has defined as the 'ability to deal with problems and administer work'. Tied to this definition is the idea that things need to be fixed because they are broken. CRWRC has discovered through partnership with churches and non-governmental organizations around the world that more than just fixing things, capacity can also mean the ability to discuss ideas, chart pathways, and strengthen an organization around a self-determined future.

Various indicators need to be developed and then used to measure the progress of an organization in their capacity areas. Essentially, this is an internal measurement or introspection. Indicators imposed from an external source may be rejected or ignored within the organization. Thus, effective indicators will be those that are generated from within an organization or community. Furthermore, the methods used to generate those ideas will greatly determine the actual effectiveness of the indicators. In general, methods that include participants, that give voice to people, that draw from local knowledge, and that use local resources will be effective. Participatory rural appraisal (PRA) methods are tools that can provide the right learning conditions mentioned. PRA methods also can allow organizations and community groups to develop and measure organizational capacity indicators (OCI) or community capacity indicators (CCI) and generate indicators that closely reflect organization or community interests and needs. CRWRC Bangladesh has used PRA methods with partners to determine OCI and CCI areas.

The objective of this exchange visit was to allow the Tanzanian visitors to observe and reflect on the PRA processes used by partner organizations and communities in Bangladesh in order that

they can replicate those methods with Tanzanian partner organizations and community groups. Each time a group works with PRA the activity is "real". So "just a practice PRA" with a community or organizations is not possible. The energy and enthusiasm during the PRA exploration can be very dynamic and genuine. It is possible to learn how to conduct PRA by observing and reflecting with objectives and questions to develop understanding. For these reasons, it the ideal learning environment for the Tanzania team will be observing actual PRA sessions.

Reflecting on this level of maturity among the Bangladesh partners it was proposed that a visit should be made to allow CRWRC partner staff from Mwanza, Tanzania to witness first hand the work of CCI and OCI. Also the intention was to expose the Tanzanian visitors to the potential for community organization in development programs and participation.

Participants:

from Tanzania:

Evarest Pamba, Development Officer, ELVD Tanzania, Buhumbi Parish
Joseph Shigulu, Development Officer, Sengerema Informal Sector Association
Steve Michmerhuizen, CRWRC Field Staff

from Bangladesh:

Kohima Daring, CRWRC Bangladesh
Nancy TenBroek, CRWRC Bangladesh
Apurba Ghagra, Project Director SATHI
Catherine Rina Guda, Assistant Project Director SATHI
Dayal Chandra Paul, Executive Director SUPOTH
Objectives for the Visit

1) Objective: to learn about the Bangladesh development partners and programs.
2) Objective: to learn about the origin and use of PRA methods in community development work.
3) Objective: to learn about OCI and CCI as used by CRWRC, partner organizations, and communities.
4) Objective: to learn about the process whereby partners and communities in Bangladesh began to use PRA in determining their own OCI and CCI.
5) Objective: to observe PRA sessions where partners and communities are using PRA methods to measure their OC and CC progress and/or to develop new OCI and CCI measures.
6) Objective: to reflect, to discuss, and to plan how these methods could be used by partner organizations and communities in Tanzania for the same purposes.

Activities during the Visit

Time Frame	**Activity**	**Venue**
Wednesday, February 1		
Morning	Arrival in Bangladesh	Dhaka
"	Rest at Viator Guesthouse	Viator
Noon	Visit and Lunch at CRWRC Office	CRWRC

Afternoon	Debriefing with Kohima at CRWRC Office	"
"	Presentation of SATHI by Apurba and Catherine	"
Evening	Dinner at Viator with Kohima	Viator
Thursday, February 2		
Morning	Breakfast and depart from Viator	Viator
"	Meet and depart from CRWRC office with Sathi	CRWRC
"	Shuki Women's Savings Meeting	Mirpur
"	Tailoring Shop	"
"	Working Children's Class	"
"	Plastic Press Business Program	"
Noon	Lunch at Maniknagar Field Office	Maniknagar
Afternoon	Computer Class	"
"	People's Institution Meeting	"
"	Comm. Health Worker and People Inst. Meeting	"
Evening	Dinner at Viator	Viator
Friday, February 3		
Morning	Breakfast and Depart for CRWRC office	Viator
"	Meet and depart from CRWRC office with Sathi	CRWRC
"	Suvetcha Graduated Men's Group	Begunbari
"	Adolescent Girls Class	"
"	People's Institution Meeting	"
Noon	Lunch out	Dhaka
Afternoon	Return to Viator for rest	Viator
"	Church with Nancy	Dhaka
Evening	Dinner with Nancy, Alana, and Kohima	"
Saturday, February 4		
Morning	Breakfast and depart from Viator	Viator
"	Travel to Supoth in northwest Bangladesh – all day	Road
Afternoon	Presentation at Supoth Office by Dayal	Birgonj
Evening	Men's Group with rice mill	"
Sunday, February 5		
Morning	Breakfast and depart for Panchagor	Birgonj Mission
"	Panchagor Thana Federation School	Panchagor
"	Panchagor Thana Federation Meeting	"
"	Rice Mill	"
"	Women's Meeting	Nilphamari
Noon	Lunch	"
Afternoon	Travel to Border and Sightsee	Panchagor
Evening	Return to Birganj	Birganj
Monday, February 6		
Morning	Breakfast and depart for Kaharole	Birganj
"	Meeting at Kaharole Office with Taarika	Kaharole

"	Women's Meeting	Kaharole
"	Travel to Saidpur Biman flight to Dhaka	Road
Afternoon	Travel to Dhaka with Biman arrive at 6:00	Air
Evening	Dinner out with friends	Dhaka
Tuesday, February 7		
Morning	Breakfast and depart Viator for Grameen Bank visit	Dhaka
"	Travel to Gazipur	Road
"	Meeting in Grameen Branch Office with Manager	Gazipur
"	Meeting with Women's Village Bank	"
"	Return to Dhaka and CRWRC office	Road
Afternoon	Work at CRWRC office	Dhaka
"	Return to Viator	"
Evening	Dinner with Nancy and Kohima	"
Wednesday, February 8		
Morning	Breakfast and depart for airport	Dhaka
"	Morning flight to Dubai	"
Afternoon	Arrive Dubai	Dubai

Analysis of Learning

1) **What was the context of the programs visited, and how do these compare to the context each visitor comes from?** The visit was split between two sites: one urban and one rural. The rural site was more comparable to the reality of Mwanza area than the urban work in Dhaka. That notwithstanding the urban visit was very powerful given the clear development of the partner maturity and organization. A detail description of Bangladesh is found in Appendix 2 on page 26.

2) **What are the goals of the programs visited?** The goals for each partner programs are detailed below.

SATHI (Sustainable Association for Taking Human Development Initiatives)
Program Goals *– from SATHI Annual Report 2004-2005*

Group Formation and Community Leadership Building Program
Goal: Men and women establish a value based society by acquiring necessary life oriented learning through functional education and practicing acquired knowledge in their daily and social life.

Income Generation Program
Goal: The groups and Peoples Institutions create funds through regular savings, invest them in the income generating projects (IGA, ME, SME), and create permanent employment opportunities by proper monitoring and effective utilization of fund and local

recourses which brings financial solvency and positive changes in family as well as in society.

Community Based Primary Health Care Program

Goal: The participants acquire primary health care knowledge and practicing their learning through the Peoples Institutions and ensure good health at all levels of the community.

Justice and Rights Program

Goal: The participants become aware of their own culture, rights and gender equity by acquiring knowledge, practicing those in their personal life and thus ensure value base good governance in family and society.

Adolescent Development Program

Goal: Adolescents become aware of their rights, receive necessary directions and are able to make decisions for their life, developing as dignified and self-dependent persons.

SUPOTH (Scheme for Underprivileged People to Organize Themselves)

Program Goals *– from SUPOTH Annual Report 2004*

Group Formation and Development for Institution Building Program

Goal: *The aim of the Thana Federation is to create enormous interest and awareness, and the build strong faith and confidences among the participants which would empower them for their own poverty alleviation and would establish a strong, sustainable and independent community organization.*

Functional Education Program

Goal: *To empower the participants with analytical skills, knowledge and positive attitude changes for their betterment.*

Income-Generation Activities and Micro-enterprise Program

Goal: *The aim of these two aspects is to encourage agriculture-based projects as income generating activities and to encourage a savings and loan program.*

Community-Based Health Care Program

Goal: *The goal of this program is to increase overall community health through multiple components such as health education, traditional birth attendant training, growth monitoring and promotion, family planning education, kitchen gardening and agriculture, water and sanitation, and social forestry.*

Gender and Justice Program

Goal: *The aim is to support an understanding and increasing exercise of one's rights and responsibilities, awareness and action in support of gender and justice, and assistance in the validation and appreciation of specific communities' cultures, history, and languages.*

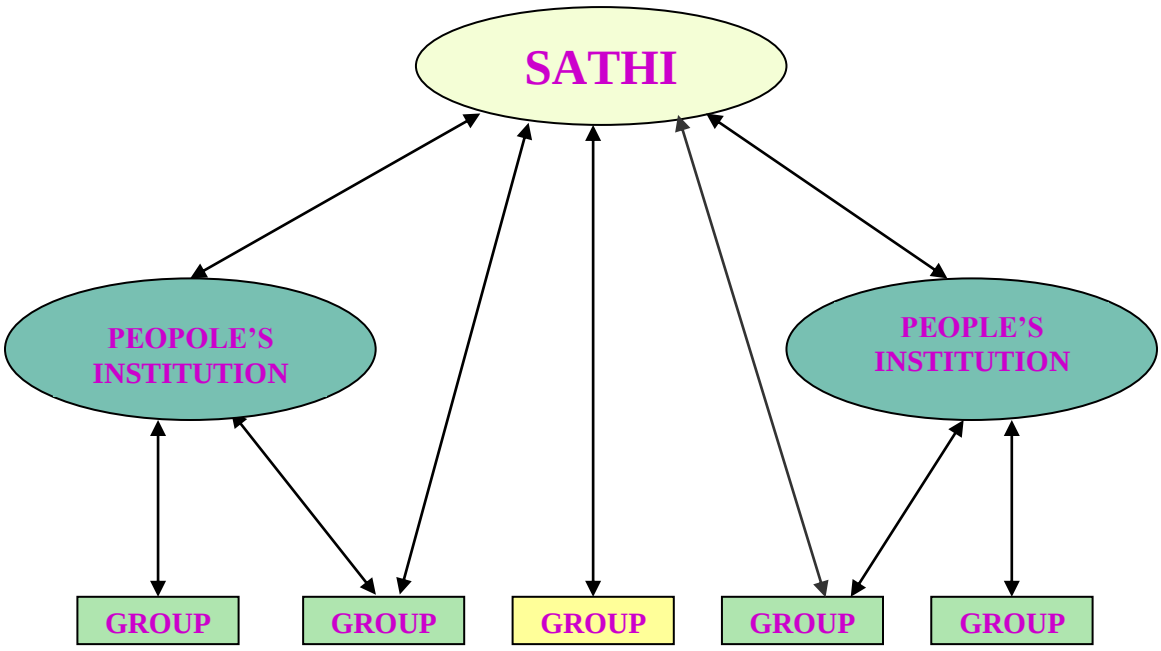
Human Resource Development Training Program

Goal: *The human development training helps the group members and SUPOTH workers to develop a sense of the collective efforts and to realize the need for organization*

building as well as the importance of involvement of women participants in the development process.

(3) **What are the main methods and approaches used?** The main method used in Bangladesh is the self-help promotion method with community-based leadership which draws heavily upon community development and organization.

a. **SATHI** - The figure below illustrates how SATHI works with communities to organize them into a two-tier system. The first level of leadership is the primary group generally formed by 12-15 people. Men and women form separate groups at this level. Participants meet usually once weekly for meetings, at which time they contribute to their savings accounts as well as attend to other business of the groups. Men tend to meet at night; women tend to meet during the day. Group members determine their own progress in several skill areas including leadership and management, financial, technical, good governance, and networking. Capacity is measured on a semi-annual basis by using PRA methods and charts such as are illustrated later in the achievements section. Primary groups eventually become Graduated Groups after 3-5 years. A sub team for each technical area is also formed within first level of organization. Primary groups, Graduated Groups and Technical Groups made from primary group members participating in a particular program all come together in a larger geographical area and form a People's Institution. Currently there are 15 People's Institutions, 145 Primary Groups, and 22 Graduated Groups working with SATHI.



SATHI Community Development Philosophy

"SATHI aims to facilitate a process of change in which people are not merely the objects of development efforts but rather are themselves the prime movers, planners, implementers, and evaluators of their own development. SATHI has adopted a participatory, integrated community development approach in the urban slums that encourages all participants in the programs to contribute to the setting of their own goals. Therefore all organizational interventions reflect the community's aspirations for positive change.

To establish their future goals, SATHI follows the Participatory Rural Appraisal approach: slum dwellers participate in the assessment of their situation, are led to discover solutions, and enabled to implement necessary changes. SATH staff members generally live near the intervention area and work with needy slum dwellers to solve their problems. Together they worked and planned to achieve self-sufficiency and independence. This approach is like a weaving in which different strands of community development processes are drown upon at different times, in conversation with community members, according to expressed needs.

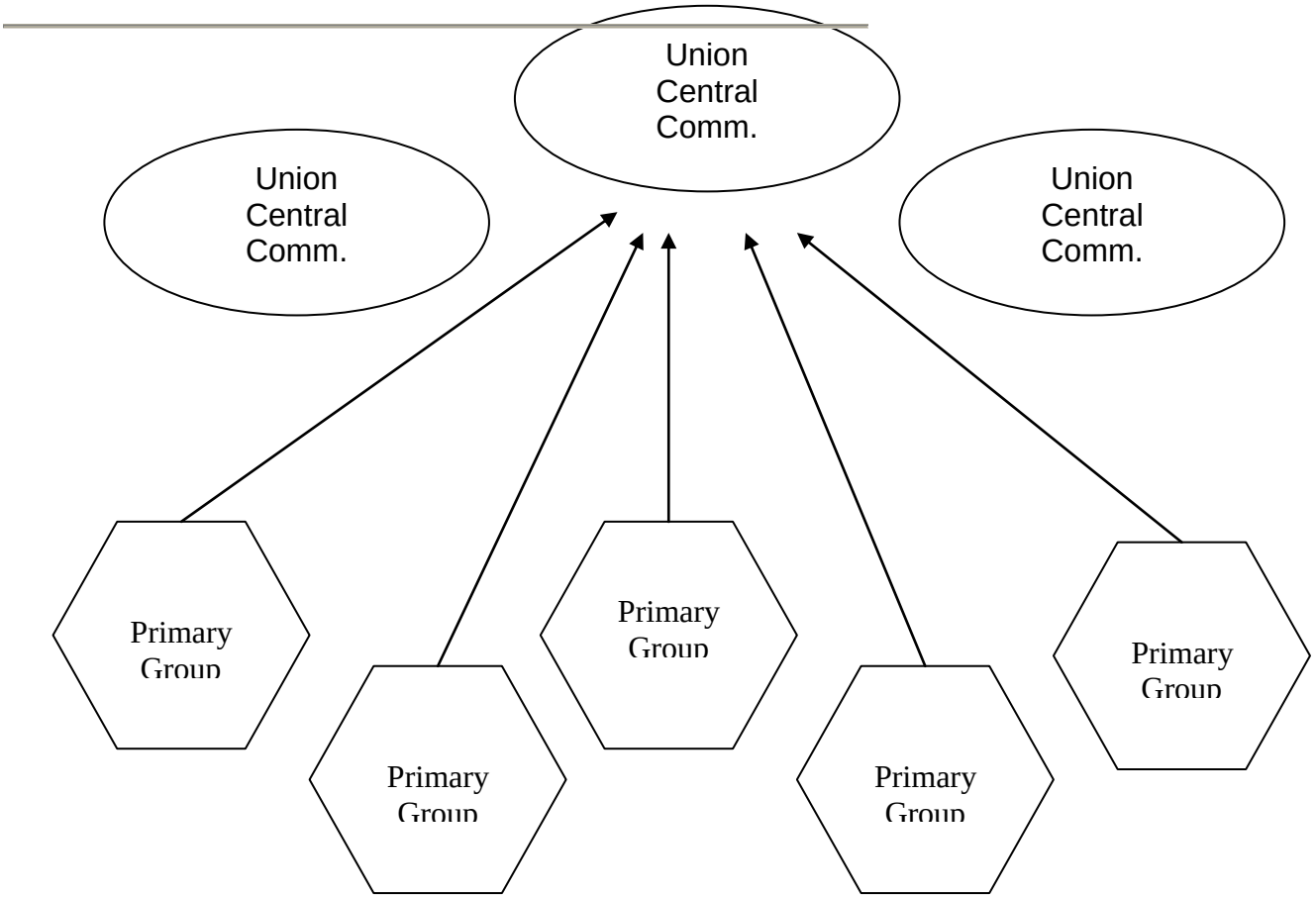
To effectively implement its development initiatives, SATHI follows the integrated community development strategy for sustainable community empowerment. This particular approach is considered the best means of strengthening the community in an integrated way within a short period of time. On this basis, SATHU promotes the following development strategies:

- A *graduation criterion*: SATHI supports the primary groups to increase their capacity through training and motivation, in order that, after three to five years, they graduate from regular field staff support and continue as self-sustained groups.
- A *People's Institution model*: SATHI promotes a two-tier system consisting of primary groups and People's Institutions. The latter is a collective of all primary groups in a particular are. The primary groups elect representative from among their members to the people institutions. People institutions are coordinating bodies that support the groups and enable collaboration of groups on larger projects. The people institutions are establish sub-teams to provide additional motivation and training in such areas as literacy, income generation and micro enterprise, and health and justice issues.
- *Development of leadership bodies* at all group levels who establish teams to address various component of their intervention.
- Supporting technical development and developing expertise through training in technical areas and organizing staff and *group technical teams*.
- *Community "from within"* planning which, in turn, nurtures shared leadership and drives overall organizational planning.
- A "*savings-first, savings-focused"* model by which communities are encouraged to develop consistent savings habits, good financial management, and sufficient savings to begin productive investments prior to provision of credit.
- Facilitate participatory, six-month group financial audits and *community capacity self-assessments* at the primary and intermediary group (people's institution (levels, at which targets are also set for the following six-month as well as yearly period.

- *Development of small business* activities as the "third window" in an approach that begins with income generation, followed by micro-enterprise, then by small and medium enterprise development.
- Encouraging small businesses by networking through different business development forums and *interacting with the intermediary groups and business forums*.
- *Strengthen community capacity and establish strong community based health program* where health services and facility are available for the entire community, but especially for pregnant mothers, children and adolescents.
- *Organize and create opportunity for adolescents* to be represented at the People Institution and initiate development activity for their benefit.
- *Facilitate groups to be change agents*, so that as the wider community becomes involved in development, stronger and more inclusive community bodies will take responsibility for their own development.

To effectively integrate the above mentioned strategies in the developmental process, SATHI facilitates, organizes, animates, motives, and encourages community to be active participate in their own development. This is especially the case regarding democratic decision making, planning, economic solvency, empowerments, and leadership development, all of which are necessary for sustainability."

SUPOTH Three-tier System



SUPOTH – The figure on the preceding page illustrates the three-tier system that SUPOTH uses for all its community development work. Similar to SATHI, the first level of leadership is the Primary Village Group with 15-20 individuals, with men and women in separate groups. Representatives from Primary Groups are sent to the second level of leadership – the Union Central Committee (*Anusoghothon*). This level in turn sends representatives to the Thana Federation. As with SATHI, these Primary Village Groups also send representatives to technical sub teams such as literacy, gender, justice, health and agriculture. As of December 2004, there were 359 Primary Village Groups formed, also 43 Union-based Central Groups, and 9 Thana-Federations. These Thana Federations had begun to leverage successfully for services and support from local government offices and non-governmental organizations.

SUPOTH Community Development Philosophy

"SUPOTH is a grassroots development organization, which assists community groups of men and women belonging to landless (owning less than 0.5 acres of land), poor or marginalized families. It seeks to build awareness and skills among the beneficiary participants and to strengthen the capacity of community organization through integrated programs such as group formation, human resource development, functional education, health and nutrition, agriculture, in come generation projects (IPG's), micro-enterprise promotion and gender and justice program.

SUPOTH emphasizes the improvement of the quality of life of the target population through productive IGA's. SUPOTH's primary focus is on empowering the poorest communities though formation and development of indigenous or primary groups and central groups that are Union-based federation of primary groups, and ultimately establishment of Federations or People's Organizations. Organizing landless, poor, underprivileged and marginalized men and women into groups and encouraging their participation in their own development are therefore considered crucially important goals for SUPOTH. SUPOTH organizes and facilitates training for human resource development and imparts awareness raising education on people's own rights and available opportunities. Moreover, SUPOTH seeks to assist the participants of the northern districts to gain access to and control over resources by encouraging capital generation through savings.

Development Strategy

- *SUPOTH endeavors to engage in long-term rather than short-term community development. SUPOTH sacrifices quick or easy short-term results for the sake of real long-term sustainable improvement in the well being of the target population.*
- *SUPOTH strongly feels that with proper motivation, organization and management, the formation of villagers into groups is important in a resource-poor people of our country Bangladesh. Working together tin groups, SUPOTH helps community members to identify and share their problems and allows them*

to pull together their resources, both tangible and intangible, and collectively to overcome many of the factors that cause and aggravate poverty.

- *SUPOTH wishes to develop the skills of the poor. SUPOTH encourages our target groups' participation and involvement in the development process.*
- *SUPOTH has only a temporary influence in the lives of community members. Therefore, SUPOTH takes all possible measures and steps to encourage groups toward self-reliance and not dependency on SUPOTH as an organization.*
- *SUPOTH discourages and minimizes giving loans and relief materials (except in the case of severe national disaster) and will only supply those, which we feel, will eventually aid in the long-term development process.*
- *SUPOTH avoids those activities which may help a member of one group of people but which would eventually in some way harm others in the local areas or in the country as a whole.*
- *SUPOTH strongly believes that building good relations with the member of the community and the community leaders are essential. To this end, the grassroots-level workers of SUPOTH live in the rural areas with the community.*
- *To act as change agents for the development of the poor, SUPOTH staff members need to love and have compassion for the poor. SOPUTH staff member need to be highly/strongly motivated and committed to the development of poor people as change agents.*
- *For sustainable development, economic liberation is an essential condition. Therefore, SUPOTH encourages, and promotes IGA's which are locally appropriate and which will yield good financial returns to the community groups and target participants.*
- *SUPOTH strongly emphasizes technical and motivational support rather than material or economic (grant) support.*
- *SUPOTH is committed to promoting self-management and self-reliance at all levels for the sake of the true development and well being of its group members. We consider it vital to help develop local leadership from among the group members in order to sustain the development process. To foster and deepen development benefits, SUPOTH encourages a three "tier" system or organization building through which the target people can carry out development activities and build support, guidance, and solidarity among themselves.*
    - *The three tiers are as follows:*
        - *Primary village groups consisting of individual members (men and women in separate groups)*
        - *Union Central Committee (Anusongothon) consisting of representatives of primary groups*
        - *Thana Federation/People's Organizations consisting of the representative of the union central committee.*

SUPOTH promotes the following:

- *Graduation criteria: It supports the primary groups and assists them through training and motivation with a view to be graduated them after 3-5 years.*

- *Coordination and Federation Model: The formation of Union Committees and Thana Federations are seen as a vital part in the development process in SUPOTH. The aim is to build and strengthen the Thana Federations so that in time they replace the development organization.*
- *Participatory, six-month audits of the financial situations of the groups and community capacity self-assessments. At that time, the next six-monthly targets are also set.*
- *Community level planning from within, in turn, shares leadership and intuits overall organization planning.*
- *A savings-first/savings-focus model encourages the community to develop savings attitude and consistent thrift-savings habits. Moreover, the community is also encouraged to practice good financial management, generation of a sufficient pool of savings with which to begin productive investments prior to provision of credit.*
- *The Union Committees and Thana Federations establish Sub-Committees to provide additional motivation and training in literacy, agriculture, gender and justice issues, income generation, and health. The organization believes in establishment of the Sub-Committees for literacy, gender and justice, and advocacy as well as for health and agriculture at both the Union Committee and Thana Federation levels. The members of these Committees are given adequate support and guidance to make them equipped in implementation, monitoring and supervision of all program components within the groups." (excerpts from pp. 2-5)*

3) **What are the major achievements of the programs?** The photos below were taken during the visit and descriptions of each photo highlight and provide an example of the accomplishments of the various programs of SATHI and SUPOTH.

Left: A People's Institution (PI) holds a meeting in its own house in Maniknagar. There are 15 other PI's working with SATHI in six slum areas of Dhaka.
Left below: A People's Institution in Begunbari gathesr to discuss their capacity indicator.
Below: An adolescent girls group meets to discuss reproductive health and family planning. A total of 56 groups (both girls and boys) with 602 members meet each month for 60-lesson course on health, social and basic life skills.

Suvetcha Men's Graduated Primary Group from Begunbari performs a song to close this visit. After seven years of working closely with SATHI this group of 24 members graduated in 2002. They hold weekly meetings, conduct savings activities, respond to emergencies, and elect leadership on an annual basis. There are 38 other graduated groups conducting their own development as well.

Members of Shuki Women's Primary Group in Mirpur collect weekly savings during their meeting. They also are involved literacy classes, children under 5 health program, and income generation activities. There are another 101 women's primary groups with a total of 2412 members and 53 men's groups with 1057 members working with SATHI.

SATHI staff from the Mirpur Field regularly visit and monitor the progress of the primary groups within the slums of Dhaka. There are 47 total employees in SATHI, of whom five are field managers, two job creation officers, 22 field animators, and five peer educators, just to name a few. Each field manages information on program progress from each primary group and People's Institution.

A member of Shuki Women's Group proudly displays her shop to visitors in the Mirpur area. Her business was supported by visits from the SATHI jobs creation officer and technical field staff.

Kamal, the man on the right in both photos runs a successful small plastics molding shop in Mirpur. To give life to his project he sought the support of the jobs creation officer of SATHI and submitted a business plan requesting money for a loan. With the loan he rented another room, hired more workers, and expanded the dies he could use and the product line he could manufacture. Kamal is one of the seven primary group members who have worked to expand his business opportunities with the Micro-Enterprise program of SATHI. Currently, the ME program is the highest level of business development among the Primary Groups and has generated 21 new jobs. Two of the seven businesses are run solely by women, as seen above, which is a remarkable achievement for these women and their primary groups.

Our visit to Panchagor visit began at the Panchagor Thana Federation Center (top). One of nine federations in northern Bangladesh, Panchagor Thana has seen some great achievements such as the construction of their own school (above) which is staffed with government trained and Thana-paid teachers, a huge fish pond that will be used to produce fish for sale (above left), and the construction of their rice mill (below left) which has the capacity to employ 18 new permanent job openings and mill 25,000 100kg bags/high season and 50,000 bags total per year.

As with SATHI, the first level of leadership and organization is the Primary Village Groups, which we see here (above top and bottom). Once savings have been achieved members can, with approval enter into Micro-Enterprises as we see in the shop in the top picture. Kaharole Women's Group (bottom) has a fish-raising project in a large pond to generate income for the group. In 2004 there were 359 groups participating at the primary group level.
Project staff for the Child Health and Survival Program stand in their training center/offices located on the property of the Panchagor Thana Federation (middle right). The main goal of the project is to reduce mother and child mortality.

The geographical area where SUPOTH is working is a rural, agriculture-based area known for its rice growing. The high level of program integration in SUPOTH and the high level of coordination among primary groups, unions, and federations the 300 plus primary groups are engaged in programs that are neatly woven together to provide a strong net of protection and a realistic force for change in their lives. No one spoke about being a health program participant or a savings participant – instead, it was clear that the people of Bangladesh working with SUPOTH, and SATHI, were participants in their developing communities.

4) What are the major challenges the program still faces?

It could be said that there are two broad challenges that the partners and programs are still facing: those external and those internal. External challenges could be those which face the Bengali people as a population: pollution of air, soil and water, overcrowding of urban areas, landlessness in rural areas, lack of good governance, unemployment, undernourishment, and not enough income to cover basic human needs such as food, shelter and clothing.

These are challenges that still face participants within the programs. The difference is that they have organized themselves to alleviate some of their poverty and then build on that change. Internal challenges which face the partners and participants face are similar to those that present themselves to any community development organization: leadership, sustainability, transparency, financial administration, gender equity, democratic values and practice, and organizational management. These are challenges felt within SATHI and SUPOTH, as well as within the primary groups, central groups/unions, and people's institutions/Thana federations.

The current level of maturity and development of participants and their organizations has not occurred overnight; instead it has been a growing process where the partners, participants, and CRWRC have worked together to train, equip, prepare, and strengthen each person when the challenges arose. Obviously, these partners and participants have been trough many trails to have come so far and to be so strong in their development. Yet, that said, the kinds of internal challenges mentioned above still continue to face new groups as programs expand into new geographical area.

That is one of the major challenges in community development. The experiences of one village may have taught them much and they may have matured significantly in their organization. And, if the neighboring village wants to follow them in development, they can learn from the first village; however the process will be theirs and theirs alone. How they respond to challenges both internal and external may reflect what they have learned from others, and they may be able to avoid certain challenges and problems by following sound advice. However, it will not be possible to shortcut their learning process and speedup their development solely because they have learned so much from the other groups. There is a certain amount of growing pains that each groups needs to experience to become its own agent of change in community.

Each village or community will find their own challenges as they move towards development. It is not possible to predict what they will be, except to say that at the end of the day they will be their own.

What was learned? How can this improve programming? Were the objectives met?

1) What was learned? There were many things learned on this exchange. What I was most impressed with however is the maturity of organization of the groups into the tier system. This of course was a process that evolved and we can learn from that process and the end result.

2) How can this improve programming? I think that programming among the Mwanza partners will improve through an adoption and adaptation process of this tier system. A varying amount of reorganization will need to occur with each partner and the communities they serve. For the past two years we have been working in Mwanza to deconstruct a bit of the separate partner idea and look at the work of all three partners as interchangeable and mutual. Changes made in Mwanza over the past two years, such as monthly staff training with all partners, partner to partner exchanges of staff and participants, participant training and learning together were done with the goal of re-enforcing the idea that we are all learning and working together. Even if we consider the new perspective which the partners and participants now see their work in community development, they are, in general still thinking about program participation. Now will be the time to transform that from "program participant" picture to "community participant" picture. In other words, the emphasis should be on "community" as the basis for beginning and implementing all community development work. The goal will be to reorient people's thinking from "I live in such and such a place and am a health program participant" to thinking and perception that says, "I live in this community development and participate in a, b, c, and programs and have such and such leadership on this or that committee". This can happen and I think that the current government-based organization of rural Tanzania will assist, not hinder, the implementation of these significant changes. In the end, if this is effectively implemented it will transform the entire outlook and perspective of each community member.

3) Were the objectives met? Several of the objectives were met and exceeded expectations, while several others were derailed due to the immigration problems encountered and time constraints. For example, the "firsthand" aspect of the exchange of course did not meet expectations desired given that the Tanzanians were not present. In one case, the actual PRA session on OCI was not possible to witness due to time constraints and the need to continue with other groups. On the other hand the experience facilitated a rich and appreciative understanding of the community development work in Bangladesh by CRWRC, SATHI, and SUPOTH, the Primary Groups, Unions/Central Groups, and Thana Federations/People Institutions.

What is the Plan for Sharing/Using this learning?

The sharing and using of this learning has already begun here in Mwanza and will continue through informal and formal situations. Since arriving back in Mwanza the partner Development Officers were each given a copy of the Annual Reports from SATHI and SUPOTH. Both officers have informed me that they have finished reading those reports and have begun implementing a few changes already. In April of 2006 a formal presentation will be made by Steve Michmerhuizen at the Country Team Meeting for Tanzania to present the learning and make some proposals of where partner staffs believe that they could implement this learning. Likewise, a similar presentation will be made at the ESAMT meeting in November, 2006 to detail and challenge field staff regarding the learning from Bangladesh.

Action 1)
Once the full learning has been presented to Mwanza partner staff they will work in collaboration with community committee members to design the steps of change and a proposed timeline of implementation will be drawn up. For example, the communities and partners may decide to restructure their work based entirely on geographic location with new committees formed and implemented. This could then imply the initiation of a two or perhaps three tier system. It should be understood that the adoption and use of this learning by the community must be entirely their own decision and thus will not be mandated by CRWRC or partner staff.

Action 2)
One year after the process has been implemented with partners and communities they will make a short report of the changes and practices they have begun in their communities. A summary of this report will be submitted to CRWRC Bangladesh and to the Best Practices Coordinator.

Note regarding Tanzanian Participation during Exchange

This exchange was designed for the participation of one North American CRWRC field staff person working in Mwanza and two Tanzanian partner staff also working in Tanzania. In the end, as explained below, the Tanzanian staff was denied entry and thus did not participate.

Originally this exchange was planned for February 2005 but was postponed to allow CRWRC Bangladesh staff more time to implement relief work after the December 2004 Tsunami. In making preparations for the 2005 exchange the High Commission in Dar es Salaam and Nairobi were contacted regarding the status of Tanzanian citizens and their required visa procedures. Both Commissions stated on several occasions that Tanzanian citizens enjoyed the "Visa Upon Arrival" privilege and would only need to pay for the visa when it was stamped in at the airport. Later in 2005, when planning for the postponed exchange, this information was again verified with the High Commissions and was found to be consistent with earlier information. Thus we traveled under the given information detailed above. However, upon arrival the immigration officials stated that Tanzanians did not have that privilege; they were refused entry, and were returned to Tanzania on the very same day. Immediately upon realizing that they were going to be denied entry, the CRWRC office in Bangladesh was contacted and they tried without success to negotiate on behalf of the Tanzanian partner staff.

To avoid any such situation of this kind in the future it is the strong recommendation of this report that travelers obtain visas regardless of any information received from diplomatic authority. The exercise of this decision by the Bangladeshi authorities was not consistent with previously gathered information and was, in the experience of people consulted afterwards, not without precedent or frequency for other visitors to Bangladesh.

B: Report of the Visit to Bangladesh by the Nicaragua Group and the Impact of the Child Survival Learning Exchange

As part of the visit to CRWRC Bangladesh, we visited two organizations member of COMUNAD: an NGO called SUPOTH that works at the North of Bangladesh with groups of rural men and women around preventive health, farming and micro-credit for small business. The other organization member is SATHI and develops its social work in the urban and rural areas of the capital of the country (DHAKA). They work on the component health and credit for men and women.

We also visited the international center of diarrhea, a research center specialized in public health, which COMUNAD is carrying out an evaluation process with about the model promoted by them.

We also visited some governmental organizations that work in coordination with the above organizations in the places where they coincide. This means that they have been able to establish relations of cooperation that make easier to work as a network.

During the field visits to the groups of the organization members of COMUNAD, in Bangladesh it was noticeable the implementation of a model of work (methodology) especially to create development.

This model of work or methodology is the base of work of all the organizations members of COMUNAD in Bangladesh-India. This model has been applied for the last 15 years and has been valued and adjusted to the realities in any organization member of COMUNAD.

The model of development is based, according to my observations, in an adjustment of the model made by the Grameen Bank regarding the micro-credit.

The model of work to create development in the community is based on some fundamental premises:

1- The staff of the organization has to be very well selected to be able to implement the model taking into account the mission and vision of the organization. This means a selection and training process for the local staff has to be done, what in Nicaragua it would be local promoters.

2- Any primary group of the community gets together and proceeds to save money every week to fulfill their urgent necessities. These necessities could be around health, education, credit, communal houses, etc. The groups get together separately, men and women. Every person provides a weekly quota until they get enough money to open a group saving account. This money is used to solve the activities prioritized by the groups.

3- Every group has an incredibly group discipline, so that they get together once a week at the same hour, just like the Grameen methodology. Every member gives in his/her saving weekly-quota. Loans are taken from this fund for farming or business purpose. Health fund works in the same way.

4- Each group has been able to consolidate itself as a self-management communitarian group, since they have understood that the solution to their problems depends on everybody's contribution, what means discipline, time, self- respect, self-confidence and not depending neither on the organization nor on the government. In the creation of primary groups pre-selection and selection process are done what contributes to promote the union and solidarity of the group. Regarding credits, they use the solidarity group of 5 people who play the role of supportive guarantors, just like the Grameen model.

5- This working model has been successful with people in conditions of extreme poverty who don`t have any access to credit in formal banks and whose cultural level is low. Most people who started primary group were illiteracy people and learned how to read and write being in the group.

6- The creation and rotation of leadership is a very important key. Every member of the group is prepared to take any position in the group, since the positions of president, treasurer and secretary rotate every year. This permits the model is sustainable when any external support from any organization is over.

7- The way of organization is very important for the model's successful. In the case of SUPOTH organization, they create groups of women and groups of men who are called primary groups. They have an executive committee made up by three people who get together every week one hour. Every 10 primary groups make up one central group represented by 2 or 3 members of the central group and get together once a month. The third level is the Federation made up by 10 central groups and represented by 2 or 3 members of the central groups. They get together every month and keep coordination with non-governmental and governmental organizations to fulfill their needs. In the case of SATHI, another organization member of COMUNAD, they just have two levels of primary groups and the PEOPLE entities that functions like the Federation. PEOPLE entities are organized through various committees of work according to the negotiated projects. In this case they had health, justice and leadership committees. In the case of SUPOTH organizations, some of them have been able to set up as a community organization legally recognized by the government. They also have been able to sing collaboration agreements with the government, especially in health area with the Ministry of Health. These federations have been able to be sustainable holding up their economy and organization.

Personal assessments:
The model of work, since my point of view, is valuable and unique; I think there is no similar experience in Latin America, even in Bangladesh itself is novel due to the success achieved by CRWRC. Regarding the possibilities to copy the model, according to the CRWRC Bangladesh-India team, some other organizations have tried to copy it, but they have failed in the attempt. They don`t know the cause.

In the case of Latin America, it hasn`t been tried to be copied, yet. What is expected is that the organizations member of COMUNAD that knew the experience, try to copy it as a pilot experience. The political and program decision by the organizations to try to apply it, it hasn`t been defined with the representative of COMUNAD, yet.
Some possible obstacles to apply the copy of the model in Nicaragua:

1. Lack of confidence of the people from the communities.

2. There is no saving culture in Nicaraguan families.

3. The dependence of the families on the organizations like ours that promote development.

4. Lack of value to the people, little value to their own skills to solve their problems, situation solved by people from the primary groups in Bangladesh.

5. Lack of discipline by the working teams and community leaders.

I think the model presents many challenges in the national context, even so, I consider a pilot experience in the community has to be tried to be applied it, initiating a project with funds from CRWRC.

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