

SAVE THE CHILDREN/US

**BANGLADESH FIELD OFFICE
CHILD SURVIVAL 8 ANNUAL REPORT FY 1993**

Cooperative Agreement No. FA0-0500-A-00-2034

YEAR ONE

**Save the Children
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GLOSSARY

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
BFO	Bangladesh Field Office
BRAC	Bangladesh Rural Advancement Committee
CDC	Community Development Coordinators
CDD	Control of Diarrheal Diseases
CDO	Community Development Organizers
CHO	Community Health Organizers
CPPBF	Campaign for Protection and Promotion of Breastfeeding
CPR	Contraceptive Prevalence Rate
CS	Child Survival Project
CSSP	Child Survival Support Program
DIP	Detailed Implementation Plan
EPI	Expanded Program for Immunization
FHV	Family Health Volunteers
FP	Family Planning
FS	Field Staff
GOB	Government of Bangladesh
GV	Group Volunteer
HIS	Health Information System
HKI	Helen Keller International
IAC	Impact Area Coordinator
IAM	Impact Area Managers
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IEC	Information, Education, Communication
IG	Income Generating Activities
IPHN	Institute of Public Health and Nutrition
JHU	Johns Hopkins University
K&P	Knowledge and Practice
LGS/SSS	Molasses + Sugar/Sugar + Salt Solution
MOH	Ministry of Health
NMW	Nurse Mid-Wife
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
FMIS	Program Management Information System
PNC	Pre-Natal Care
SC	Save the Children
SES	Socio-Economic Status
TBA	Traditional Birth Attendant
TMP/SMX	Trimetropin-Sulfametoxazol
TOT	Training of Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children Fund
USAID	US Agency for International Development
VHW	Village Health Worker
WHO	World Health Organization
WSG	Women's Savings Group

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I. OVERVIEW OF YEAR ONE

A. Comparison of Actual Accomplishments with Goals and Objectives for Reporting Period:

1. Expansion and Community Preparation

Extension into four unions is the major accomplishment of year 1. This expansion into the four unions follows approval for an expansion in the project area of CS8. Thus the BFO is implementing its plan to cover all seven unions in Nasirnagar thana and continue working in the four villages of Rangunia which had been included in CS4: the seventh union of Nasirnagar will be included in the second phase of this CS8 project.

As part of the expansion into the four new unions, the following steps were taken:

- establishment of linkages with the communities;
- identification of local GOB facilities and formal discussions with local GOB health authorities in preparation for setting up organizational structure
- orientation of community leaders;
- dissemination of information to community about SC's mission, goal and objectives

As a result of the above steps, community support has been elicited and an office established. Such key professional staff as community development coordinators (CDCs) and community development organizers (CDOs) have been recruited and are now working.

Table 1. Achievement of Interventions

Intervention (area)	Status as of 31 May 1993	Remarks
Immunization (Rangunia/ Nasirnagar, old areas)		
U1 year	33.8%	PMIS
12-23 mos	55.0%	PMIS
TT2	80.0%	PMIS
CPR (Rangunia/Nasirnagar, old areas)	18.0%	PMIS
FP Training (Rangunia/ Nasirnagar)	85% female 68% male	monthly manual impact area report
Pregnancy monitoring (ANC attended)	74.0%	PMIS
TBA training (Rangunia/Nasirnagar, old areas)	73.0%	manual field record
ORT training (Rangunia/Nasirnagar)	50.0% female 31.0% male	monthly manual impact area report
Training on Weaning Food	80%	monthly manual impact area report
Distribution of high potency Vitamin A (Nasirnagar, old area)	93%	computer roster

B. Training activities for project staff:

The following training activities have been accomplished:

TOT: All field staff, along with program staff from Dhaka Office, were trained by a trainer from BRAC. The CDCs, IAM, IAC and Dhaka staff were trained in preparing modules for FHV training.

Training sessions for FHVs on CS8 objectives were organized at the union level. Women's Savings Group volunteers from two unions (Buriswar and Bholakot) were oriented on WSG curriculum. All field staff of Kunda and Gokarna unions received training on CS8 objectives and methods of communication.

SURVEY TRAINING: A Knowledge and Practice (K&P) survey was carried out in the four new unions of Nasirnagar Thana of Brahmanbaria District. The objective of the survey was to obtain baseline information on the health knowledge and practices of mothers with children below two years of age. Technical assistance for the survey was obtained from Mr. David Newberry (Survey Trainer, Child Survival Support Program,

JHU) and Dr. Loren Galvaõ (Home Office, SC). The survey trainer and Dr. Galvaõ provided training to the health team members at the BFO. In the field, all FS supervisors and interviewers were trained in field testing of the questionnaire, and in collecting and tabulating data. Fifteen interviewers and 10 supervisors (including Dhaka staff) participated in the survey.

TRAINING ON FAMILY REGISTRATION IN EXPANSION AREA: The CDOs and CDCs were trained in household enumeration and family enrollment, area mapping, and data collection. They in turn trained community volunteers to conduct a complete census. A complete census of all families in the CS8 project area has been completed.

The family registration form used in this census was reviewed in December 1992 with technical assistance from Ms. Gita Pillai (Home Office); at that time, BFO indicators for socioeconomic classification were reviewed and simplified. Household enrollment forms contain the following identifying and socioeconomic information:

- identification of family and household members
- identification of para (neighborhood) and village in which household is located
- classification of household by SES

Field supervisors were trained in HIS methods and in determining socioeconomic status according to three indicators. After the census was completed, data were analyzed to identify the target population according to age and SES.

All of the household enrollment forms will be sent to the Dhaka office for entry into PMIS (the computerized data management system used by the BFO).

RECRUITMENT AND TRAINING OF FHVs: The FHVs were identified and selected from the community volunteers who had conducted the community census: they were selected on the basis of literacy and their interest in development work. After receiving CS8 activity training from FS, the FHVs will train mothers in protective behaviors during home visits.

WORKSHOP ON MIS AND REVISION OF HIS: A subregional monitoring and evaluation workshop was held at the BFO in Dhaka. Technical assistance during the workshop was obtained from Dr. Nirmala Murthy (Foundation for Research in Health Systems): she advised the BFO on establishing sentinel surveillance sites and on selecting a sentinel population of the appropriate size. Reporting and monitoring forms used in the HIS were simplified.

SUMMARY OF TRAINING ACTIVITIES:

- TOT of FS and Dhaka staff at BRAC
- TOT of FS on CS8 objectives
- Training of FHVs on CS8 activities
- Orientation of field staff and communities in new area
- Training of FS and FHVs in household enumeration and family enrollment
- Revision of HIS during workshop
- Development and field testing of WSG curriculum and manual
- Training of Dhaka and FS on K&P survey techniques

C. Technical Support

HIS	Revision of indicators for S/E classification.	Ms. Gita Pillai <i>Home Office</i>
IEC material development	For developing maternal nutrition IEC strategy development.	Kim Winnard <i>MotherCare Project, JSI</i>
K&P Baseline Survey for CS8	To assess the baseline information for the new expansion area of new 4 unions in <i>Nasirnagar Thana</i> .	Dr. Loren Galvaõ <i>Health Unit of Home Office</i> Mr. David Newberry <i>Survey Trainer, CSSP of Johns Hopkins University</i>
DIP-CS8 and MotherCare	Provide technical assistance for DIP-CS8 and MotherCare mid-term process evaluation.	Dr. Katherine Kaye <i>Health Unit, Home Office</i>
Final Evaluation	Technical assistance for preparation of final evaluation and project follow-up.	Ms. Karen LeBan <i>Health Unit Manager</i>
HIS	Technical assistance in designing sentinel area monitoring and evaluation system.	Dr. Nirmala Murthy <i>Foundation for Health Research in Health System</i>
Training	TOT for village Volunteers. Development and design of module for village volunteers' training.	Communica <i>Local organization</i>

D. Report on Number and Work of Community Health Committees

No community committee has been formed for implementation of CS8 activities during the reporting period. Instead of working through community committees, we are now organizing and strengthening WSGs.

BFO has developed a series of implementation procedures which require a high level of community involvement. Women's Savings Groups (WSG) have been organized and

provided with training on bookkeeping, management, leadership, awareness training, and training in income generating activities (IG), such as poultry and livestock, pisciculture, sericulture, etc. The WSGs have also been provided with a training of trainers (TOT) course on child protective behaviors. It is expected that the WSG leaders will mobilize and motivate the members of the community in adopting changed health behavioral practices.

The WSGs numbered 381 groups as of September 1993, for a total membership of 6816 members. Each WSG met once a month from July through September 1993, for a total of 1143 meetings in the three month period.

E. Linkages between Project and MOH and other Health and Development Groups

EPI: CS project staff have met frequently with local EPI GOB authorities in order to strengthen the project's linkage to services. As the BFO does not provide immunization services directly, such linkage is essential for attaining the expected objectives (e.g., high immunization coverage of children U1 year and women aged 15-45 years).

FP: Project staff have met frequently with FP/MOH officials to discuss how GOB might strengthen its provision of FP services to project beneficiaries (e.g., through demarcation of CS8 project area).

Breastfeeding: As promotion of exclusive breastfeeding is one of the CS8 project objectives, SC(US) has communicated with the Campaign for Protection and Promotion of Breastfeeding (CPPBF). CPPBF promotes exclusive breastfeeding from birth until the age of five months, and supports continued breastfeeding up to 24 months along with introduction of weaning food between the age of 4-6 months.

CDD (GOB)/ ARI (GOB)/ IPHN: As control of diarrheal disease and acute respiratory infection and promotion of vitamin A are objectives of CS8, project staff have met with GOB personnel from the CDD, ARI and IPHN projects to obtain technical support in the form of training and IEC teaching/supervisory materials.

F. Professional staff who joined the organization after the submission of DIP for CS-8:

1. NAME: A.B.M. SHAMSUDDIN MAHMUD

DESIGNATION: Computer System Analyst

DATE OF JOINING: 21.3.1993

EDUCATION: B.Sc. Engineering

EXPERIENCE: Five years of experience in the following fields:

- a) Information System Management
- b) Computer Programming
- c) System Analysis

JOB RESPONSIBILITIES: He is responsible for population based database program maintenance, programming, analysis and information system maintenance.

2. NAME: DWIJENDRA LAL SUTRADHAR

DESIGNATION: Child Survival Coordinator

DATE OF JOINING: 1.4.1984

EDUCATION: B.Sc. Diploma in Medical Assistant.

EXPERIENCE: Before joining SC (US) he worked as a Medical Assistant in GOB Family Welfare Center for one year.

JOB RESPONSIBILITIES: The CS Coordinator will work with the Impact Area Manager of Nasirnagar to ensure achievement of the target CS objectives. The activities include implementation, supervision, monitoring of the CS activities a field level. He will also provide technical support in terms of training of the volunteers at the field level.

3. NAME: SHAMSUN NAHAR

DESIGNATION: Community Development Coordinator

DATE OF JOINING: 1.4.1993

EDUCATION: M.A. in Social Science.

EXPERIENCE: She has three and half years working experience as community Program Manager in Christian Commission for Development in Bangladesh rural development program.

JOB RESPONSIBILITIES: Responsible for coordinating all program activities within a union to ensure they are meeting program goals and objectives particularly strengthening WSGs. The CDC provides supervision and support to the village-level staff and volunteers and coordinates activities involving technical staff to ensure that program objectives and targets are meet.

4. NAME: SYLVIA D' COSTA

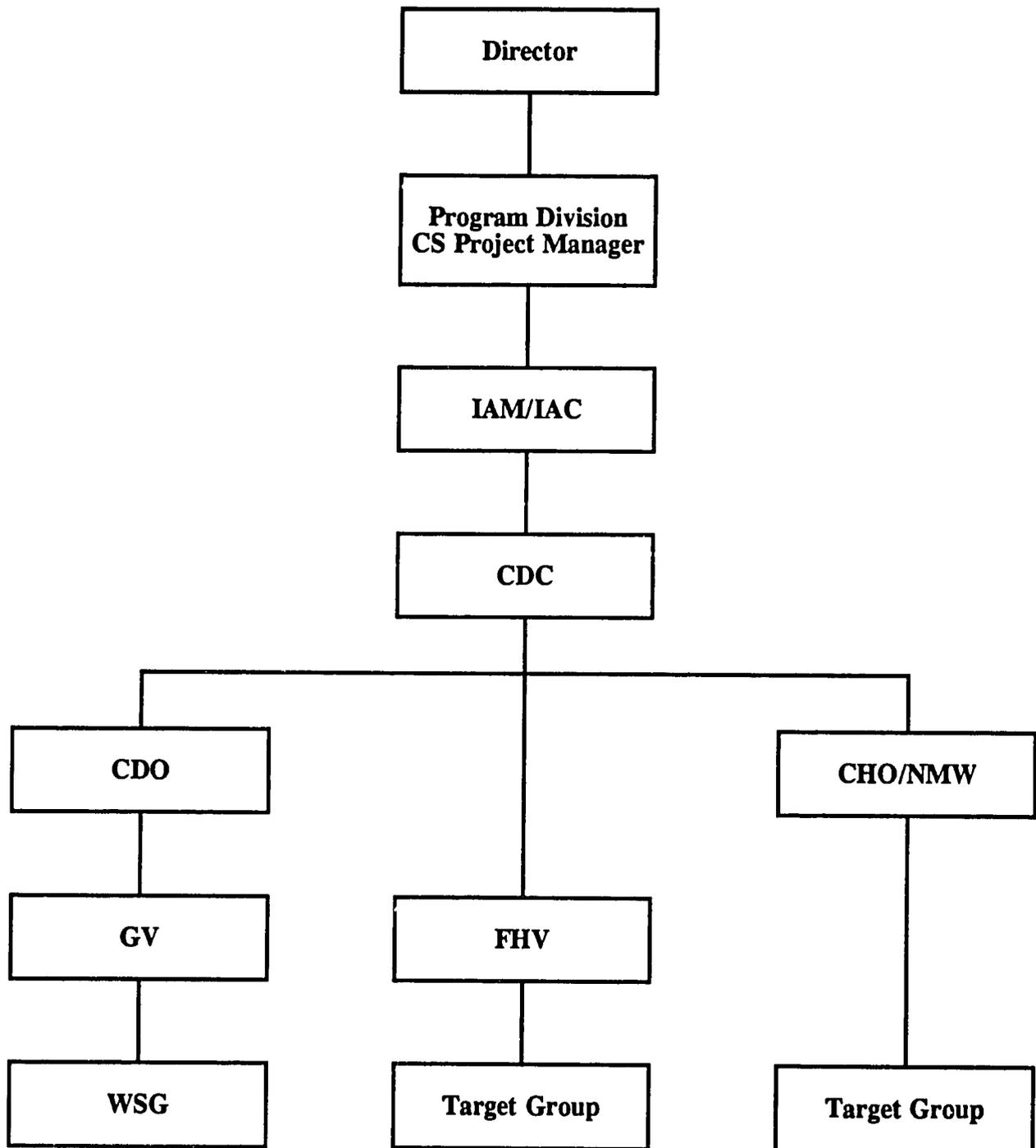
DESIGNATION: Nurse-Midwife

DATE OF JOINING: 8.8.1993

QUALIFICATION: Diploma in Nurse-Midwifery

EXPERIENCE: She has 2 years working experience in CCDB as a Nurse-Midwife.

JOB RESPONSIBILITIES: The main job responsibilities include TBA training with the aim to reduce neonatal and maternal mortality and morbidity through safe delivery. She will provide technical supervision to the family health volunteers and also will contribute to other activities as per program needs. The nurse-midwife will also assist TBAs in complicated deliveries whenever called and also will take responsibilities of in referring the patient to appropriate facilities if needed.



II. CHANGES IN PROJECT DESIGN

A. Measurable Objectives

Please see Appendix 1 for a comparison of present project objectives to those presented in proposal and in DIP. As indicated in this comparison, the following changes from DIP objectives have occurred; reasons for these changes are given in section VI:

1. The percentage of mothers attending PNC has been decreased to 40%; (actually, this is a change from the proposal, where the objective was 60%).
2. The percentage of fertile couples who use FP will increase at least 10% above baseline.
3. Objectives for the WSG functions and sustainability have been set.

B. Type or Scope of Child Survival Interventions

There have been no changes in type or scope of CS interventions.

C. Location and Number of Project Beneficiaries

In the original proposal, CS activities were proposed for eight unions--six in Nasirnagar and two in Rangunia. Permission was received from USAID to change the area of project implementation to 7 unions in Nasirnagar and four villages in Rangunia: a copy of the amendment is included as Appendix 2.

D. Budget

No significant changes have been made in project budget. However, because of delays in expanding into new areas, the project is under-spent for its first year.

III. CONSTRAINTS, UNEXPECTED BENEFITS AND LESSONS LEARNED

A. Identification of constraints

1. In June, 1993, there was a flash flood which delayed implementation of project activities.
2. Because the literacy rate in the new area is very low, it was difficult to find qualified family health volunteers.
3. Community organization in new areas has taken longer than expected.

B. Strategies to Overcome Constraints

SC has no control over natural disasters, and has learned that a longer time is needed to organize communities for project implementation in an entirely new area. To deal with the problem of low literacy in the new area, staff had to select some FHV's who were illiterate: these FHV's will receive more training and in-service supervision than usual.

C. Facilitation of Implementation

Some project staff had been involved in implementing a MotherCare Project in four villages of Nasirnagar: the purpose of this project was to reduce maternal, perinatal and neonatal mortality and morbidity. Experience in developing the IEC materials and case management protocols used in this project facilitated development of the maternal health strategy used in this CS project.

It is expected that "streamlining" the HIS through simplifying forms and computerizing data only for the sentinel population will make the BFO's monitoring and evaluation system more useful.

D. Lessons Learned

The delays encountered by project staff in implementing CS8 activities in new areas emphasized the need to be more realistic when establishing time schedules for future activities: in Bangladesh, it is important to take into account the occurrence of possible natural disasters. Although the sentinel surveillance system is not yet functioning, some lessons have been learned in how to establish such a system: e.g., how to select sites, how to determine total population which should be included.

V. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

A. Characteristics and effectiveness of project HIS

Reaching the target families who are in greatest need of project interventions depends on efficient use of the HIS. SC (US) has maintained an HIS during previous CS projects. Recently, simplification of HIS forms and the classification system for SES was accomplished, with technical assistance from Dr. Nirmala Murthy and Ms. Gita Pillai. On the basis of this technical assistance as well as encouragement from Home Office, the BFO is also moving toward a computerized HIS which contains longitudinal data only for the sentinel population rather than for the entire project population. Socioeconomic classification of families is now done manually by field supervisors, using three indicators.

To summarize, the manual and computerized health information systems are as follow:

- manual records (enrollment forms and rosters) are prepared, maintained and used in the field.
- computerized records consist of baseline census data for the ENTIRE project population and longitudinal health data (derived from continuously updated manual rosters) only for the SENTINEL population (approximately 50,000 people)

B. Collection and Utilization of HIS Data

The Family Health Volunteers (FHV's) collect information on a few different forms. As described earlier, a complete census of all families in the project area has been completed. The family enrollment forms which were used in this census are bound into books according to paras (neighborhoods); these forms are the main source of demographic and socioeconomic information for the entire project population. The family enrollment form contains the following information for a single household:

- identity of household by para and village
- household members by name, age marital status, occupation and education
- designation of household head

For each married woman in the household, the enrollment form contains the following information:

- identification by name and "serial number" within family (by individual and couple)
- father's place of residence
- status with regard to contraception and pregnancy
- outcome of any pregnancy during last two years (stillbirth or live born)
- information about any deaths of infants born to that woman (date and cause of infant death, age at death in days or months)

Information is also recorded in the following records and rosters:

1. birth register - Newborns are assigned a serial number and are identified by name and sex, date of birth, household number, socioeconomic status, mother's name and age at time of birth, and history of pregnancy (in terms of prenatal care) and delivery (complications and information about who conducted delivery).
2. death register - contains date of death and for children under five years, cause of death and age (in months or days, if younger than one month)
3. roster of 0-2 year olds - contains name, serial and household numbers, socioeconomic class, date of birth and columns to record immunizations and dates
4. roster to record TT immunization status of women aged 15 to 45 years
5. roster of fertile couples and their status regarding family planning
6. roster of pregnant women and their attendance at prenatal care sessions

The FHV's update the family registration forms and other manual records. Information on vital events (births, deaths, in/out migration) is updated quarterly; information on immunization status is updated monthly. Each FHV has a daily activity plan and record book where activities are planned in advance and completion of activities is recorded. FHV's prepare monthly activity reports which are reviewed by their supervisors in the field.

All persons involved in the project, from grass roots to field office, help ensure the quality of data collected. The impact area supervisors review and analyze data collected by FHV's and compile reports; they monitor data quality by conducting spot checks to compare data reported by FHV's to conditions actually existing in households and also by using Lot Quality Assessment techniques. The CHO's also conduct supervisory spot checks to determine whether mothers and other family members have understood messages communicated to them by FHV's. A monitoring officer based in Dhaka checks data which are to be computerized, during the coding process.

The HIS is useful and effective in identifying and directing services to the high risk targeted population. For example, the HIS allows program managers to know the total number of pregnant women and the percentage of those who are attending prenatal care, as well as the number of sessions they have attended. Project managers use the manual data and computer generated reports for the following:

- monitoring program activities
- planning next activities
- supervision
- identification of problems and development of solutions
- identifying needs for training support
- reporting and documentation
- program evaluation
- performance evaluation
- sharing experience
- raising community awareness and involvement

C. Need for Further Refinement of HIS

During the midterm evaluation, we will review data collected in the sentinel system. If there are problems with data quality or if the system proves difficult to maintain, we will consider revisions in the system.

V. BUDGET AND EXPENDITURES

Please see appendix 3 for pipeline analysis.

VI. FOLLOW UP OF DIP REVIEW

Please see Appendix 4 for detailed comments to all comments made by DIP reviewers.

VII. Action Oriented Work Plan: FY 93-94

Project Objective at the end of project	Target for FY 93-94	Planned Activities	Persons Responsible	Time Frame: October 1993 - September 1994			
				Quarter I Oct-Dec	Quarter II Jan-Mar	Quarter III Apr-Jun	Quarter IV Jul-Sep
1. Immunization:							
80% of children 12-23 months will be completely immunized.	65%	Identify target women and children and prepare rosters.	FHV, WSG	<----->			
		Updating immunization status from card or GOB register.	CDO	<----->			
	60%	Identify the high risk group (any child incompletely immunized after the age of 12 months and all pregnant women) and prepare a roster.		<----->			
		Updating of Roster		<----->			
80% of Women aged 15-45 years immunized for TT2 (24 TTs).	60%	Assist MOH/EPI with immunization campaign as follows: FHV's inform mothers of children due for immunization to bring them to EPI Camps.	FHV, CDO, CHOs, IAM	<----->			
80% of mothers will know the correct age for measles immunization	60%	Train FHV's, CHOs, NMW's on HIS WSG's, importance schedules and procedures and target identification.	CS PM, TC, Tech Asst.	<----->			
80% mothers will know importance of TT immunization	40%	FHV's train mothers and WSG leaders on immunization importance and procedures.	CDO, CHOs	<----->			
		All these activities are a continuous process.					
2. Diarrhea Management:							
50% of mothers will use ORS and manage diarrhea correctly when their children have diarrhea.	20%	Training of FHV, CDO, GV, CHO	CS PM & TC	<----->			
50% of mothers will know about continued and increased fluid and food intake during diarrhea episodes and convalescence		Train all target mothers and WSG members during home visits or the organized group session.	FHV, CDO, GV	<----->			
		Preparation of ORS ORT - (use of ORS)		<----->			
		Dietary management during diarrhoea (e.g. continued and/or: more breast feeding continued and/or more fluid and food intake.		<----->			
		Danger signs of dehydration due to diarrhea and when and where to refer					

VII. Action Oriented Work Plan: FY 93-94

Project Objective at the end of project	Target for FY 93-94	Planned Activities	Persons Responsible	Time Frame: October 1993 - September 1994			
				Quarter I	Quarter II	Quarter III	Quarter IV
				Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep
		Increased food and fluid intake during convalescence.					
		Preventive measures for diarrheal diseases: e.g. proper disposal of excreta, hand washing.					
		Keeping records of training in manual register.	FHV, CDC, GB, CDO	<----->			
		Follow-up of training and update records.	FHV, CDC, GB, CDO	<----->			
		Monitoring and supervision	CDC, CS Cord, IAM, PM	<----->			
3. Nutrition Intervention:							
30% mothers will know that they should eat more during pregnancy.	30%	Prepare a roster of pregnant mothers and maintained by FHV/CHO.	FHV, CHO	<----->			
		FHV, CDO, WSG, GV will be trained	FHV	<----->			
		Train target groups on FHV/CHO.	FHV, CHO	<----->			
70% of mothers breast-feed, 30% of mothers breast-feed exclusively (4-6 months).	40%	FHV, CDO, WSG, GV will be trained.	CS PM, TC, Tech Asst.	<----->			
		Prepare a roster of pregnant mothers and mothers of U-6 months.	FHV, CHO	<----->			
		Train target groups	FHV, CHO	<----->			
		A roster for pregnant women will be maintained by the FHVs in order to identify newborns with problems.	FHV, WSG	<----->			
		Arrange for training in group sessions.		<----->			
		Training provided to mothers of U-5 months, pregnant mothers and all women of reproductive age during home visit.	FHV, WSG, GV	<----->			
50% mothers will know correct weaning practice.	30%	FHV, CHO, CDO, GV trained.	CS PM, TC, Tech. Asst.	<----->			

VII. Action Oriented Work Plan: FY 93-94

Project Objective at the end of project	Target for FY 93-94	Planned Activities	Persons Responsible	Time Frame: October 1993 - September 1994			
				Quarter I	Quarter II	Quarter III	Quarter IV
				Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep
		FHV will prepare a roster of mothers of U-5 months.	FHV	----->			
		Train the mothers during home visit.	FHV	----->			
		Arrange for training in group sessions.	FHV, CDC	----->			
4. High Potency Vitamin A (200000 Iu):							
60% children will be fully covered with high potency Vitamin A every 6 months.	40%	Training of CHO, CDO, CDC, FHV.	CS PM, TC, Tech Support	<----->			
		Identify target.	FHV, CDC				
		Enumeration of 6 months - 6 years and make a manual roster.	FHV, CDC	<----->			
		Update the new targets.	FHV				
		Contact local GOB authority for supply of high potency VAC and information to avoid duplication.	IAM, IAC, CDC	<----->			
		training of mothers of 6 months - 6 years on importance of Vitamin A during home visit.	FHV	----->			
		Training to mothers on vegetables rich in Vitamin A.	FHV				
		Training on night blindness and how prevented.	FHV	----->			
		Outreach for the drop out cases.	FHV	<----->		<----->	
		Reporting.	FHV, CDC				
5. MALARIA							
60% of all village doctors trained on management of malaria.	30%	Identification of local village practitioners.	CS PM, TC, Tech Support	<----->			
		Make linkage with the local GOB health authorities.	FHV, IAM, IAC, CDC, FC	<----->			
		Arrange for training and provide training to the village practitioners.	CHO, CS PM, Tech Support, IAM, IAC	<----->			
Train the mothers on use of bednets		Train the FHV's on malaria.	CHO, CDC	<----->			

VII. Action Oriented Work Plan: FY 93-94

Project Objective at the end of project	Target for FY 93-94	Planned Activities	Persons Responsible	Time Frame: October 1993 - September 1994			
				Quarter I	Quarter II	Quarter III	Quarter IV
				Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep
		Identify the household and prepare a roster.	FHV, CDC	<----->			
		Train the mothers on importance of using bednets in prevention of malaria.	FHV, CDC	<----->			
6. Maternal Health:							
60% mothers will attend 2 ANC sessions during pregnancy.	20%	Training of CHO, CDC, FHV, CDOs	CS PM, TC, Res. Person	<----->			
		Identify the pregnant mothers during home visit and make a roster.	FHV, CHO	<----->			
		Train the mothers on importance of ANC	FHV, CHO, NMW				
		Arrange for training in group sessions.	FHV, CHO, NMW				
		Motivates for TT immunization and inform when and where to go.	FHV, CHO				
		Link with the trained TBAs.	FHV, CHO				
80% TBAs will be trained.	40%	Identify the TBAs from birth form and make list.	FHV, CHO	<----->			
		Motivate the TBAs for training.	FHV, WSG, CDO	<----->			
		Arrange for training of TBAs.	FHV, WSG, CHO	<----->			
		Follow-up of training and refreshers.	CHO, CS	<----->			

**Comparison of Present Project Objectives to
Those Given in Proposal and DIP**
(All objectives are to be accomplished by end of project.)

Intervention	Proposal	DIP	Present
Immunization	80% of 12-23 mo children fully immunized	same as proposal	80% of 12-23 mo children fully immunized
	80% of 15-45 yr. women appropriately immunized with TT	same	80% of 15-45 yr women to have 2 or more TT
	80% of mothers will have correct knowledge of measles and TT vaccines	same	
ORT	50% of mothers will use ORS & manage diarrhea correctly	same	same
Nutrition	70% of mothers breastfeed; 30% of mothers breastfeed exclusively (to 4-6 mos)	same	same
	50% know correct weaning practice	same	same
	60% of children under 6 yr. will be covered with Vitamin A	same	60% of children 6-60 mo will be covered w/ Vit A
ARI	70% of mothers will recognize danger signs	same	same
	80% of these will seek treatment	same	same
	90% of those seeking treatment will receive appropriate care	same	same: 90% of those treated at SC clinic...

Intervention	Proposal	DIP	Present
MaternalCare	30% of mothers will know that they should eat more during pregnancy	same	same
	60% of mothers will attend at least 2 PNC sessions during pregnancy	40% of mother will attend at least 2 PNC sessions during pregnancy	same as DIP
	80% of TBAs to be trained	same	same
	70% of mothers to be delivered by trained TBAs	same	same
Family Planning	20% of all fertile couples practice FP	30% of all fertile couples practice FP	% of fertile couples who use FP will increase at least 10% above baseline
Malaria	60% of all village MDs trained in management	same	same
	all households to be trained in use of bednets	same	same
	30% of families will use bednets	same	removed
Sustainability/ WSGs	70% of eligible women to be in WSGs	same	same
			90% WSG leaders trained in management
			90% WSG leaders trained in health
			80% of WSGs are "mature" by index
			70% WSGs use some funds for health care
			K&P of WSG members will be 10% higher than in general community
			80% of TBAs practice safely

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14/2/93
Nancy O
Brig



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

APR 2 1993

APR 2 1993

Mr. James J. Bausch
President
Save the Children
54 Wilton Road
Westport, CT 06881

Subject: Cooperative Agreement FAO-0500-A-00-2034-02
Amendment No.: 02

Dear Mr. Bausch:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, and the Federal Grant and Cooperative Agreement Act of 1982, as amended, the Agency for International Development hereby amends the subject Agreement in (SCF)/Bangladesh to shift two unions from the Rangunia Thana project area (Chittagong District) to the Nasirnagar Thana project area (Brahmanbaria District).

The specific changes are as follows:

A. Program Description, SAVE THE CHILDREN/BANGLADESH, CHILD SURVIVAL 8 rev. 4/92.

1. Section A. SUMMARY DESCRIPTION OF PROJECT: Delete the first sentence and insert the following:

"The Bangladesh Field Office of Save the Children proposes, to improve child survival among the poorest segments of a significantly large population consisting of seven multiple government administrative units in the Nasirnagar Thana project area (Brahmanbaria District).

Except as amended herein, all other terms and conditions of the Cooperative Agreement, as amended, remain unchanged and in effect.

Please acknowledge receipt of this amendment by having an authorized official sign all copies, keep one copy for your files, and return the remaining copies to this office.

Sincerely,



James A. Jeckell
Agreement Officer
FAO Branch, Division A
Office of Procurement

ACCEPTED BY:

SAVE THE CHILDREN

BY: Terrence R. Meersman

TYPED NAME: Terrence R. Meersman

TITLE: Executive Vice-President

DATE: April 20, 1993

FISCAL DATA

PIO/T No.:	938-0500-2685005
Project No.:	938-0500
Appropriation No.:	72-112-1021.7
Allotment No.:	247-38-099-00-76-21
Budget Plan Code:	EDCA-92-16850-KG11
Agreement Amount:	\$2,997,805
Total Amount Obligated:	\$2,997,805
Technical Office:	FHA/PVC/CSH:JHenriquez
Negotiator:	Benjamin C. Vogler

COOPERATIVE AGREEMENT FAO-0500-A-00-2034

21-Oct-93

CHILD SURVIVAL VIII: BANGLADESH

YEAR 1: EXPENSES VS. PLANNED BUDGET

LOG: CUMULATIVE EXPENSES VS. TOTAL GRANT

	EXPENSES 07/31/93	PLANNED BUDGET	BALANCE	% SPENT	BUDGET YEAR 2	BUDGET YEAR 3	CUMULATIVE ACTUAL	TOTAL BUDGET	BALANCE	% SPENT
Evaluation	0.00	1,050.00	1,050.00	0.0%	9,700.00	5,800.00	0.00	16,550.00	16,550.00	0.0%
Personnel	54,042.43	98,000.00	43,957.57	55.1%	143,300.00	166,200.00	54,042.43	407,500.00	353,457.57	13.3%
Travel	2,249.13	5,800.00	3,650.87	38.1%	11,100.00	12,500.00	2,249.13	29,500.00	27,250.87	7.6%
Communications	622.27	2,000.00	1,377.73	31.1%	2,000.00	2,000.00	622.27	6,000.00	5,377.73	10.4%
Facilities	0.00	0.00	0.00		0.00	0.00	0.00	0.00		
Other direct	103.92	34,810.00	34,706.08	0.3%	47,700.00	53,550.00	103.92	136,060.00	135,956.08	0.1%
Procurement										
Supplies*	8,046.52	13,700.00	5,653.48	58.7%	14,800.00	6,800.00	8,046.52	35,300.00	27,253.48	22.8%
Consultants	1,100.00	3,000.00	1,900.00	36.7%	3,000.00	0.00	1,100.00	5,000.00	3,900.00	22.0%
Services		0.00	0.00		0.00	0.00		0.00		
sub-total Procurement	9,146.52	16,700.00	7,553.48	54.8%	17,800.00	6,800.00	9,146.52	40,300.00	31,153.48	22.7%
Total Direct	66,164.27	158,460.00	92,295.73	41.8%	231,600.00	246,850.00	66,164.27	635,910.00	569,745.73	10.4%

Year 1 = Sept.30,1992 - Sept. 30, 1993

Year 2 = Oct. 1, 1993 - Sept. 30, 1994

Year 3 = Oct. 1, 1994 - Sept. 30, 1995

Budgets revised to Amendment 3

*Supplies are individually under \$500 per item.

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Appendix 4. RESPONSE TO DIP REVIEW COMMENTS

Immunization:

Re: Cold chain monitoring: The project will promote immunization coverage through motivating the mothers and other family members and assisting and supporting the MOH immunization team in organizing immunization campaigns and sessions. Vaccines are being stored and supplied and vaccinators are being provided by the MOH EPI department. Cold chains are also maintained and monitored by the EPI department following the WHO protocol; the MOH/EPI team receives much support from UNICEF. SC is not directly involved in vaccine delivery, either in camps or in antenatal clinic. Thus, there is no need or scope for SC to monitor the cold chain or to develop a written protocol.

Re: Focus on children under the age of one year for completing immunization: With respect to immunization, we had written in section 5a.3 that "while immunization objectives are stated in terms of 12-23 month old children, children under one year will be targeted"; if the immunization objective is to be measured in terms of under-one coverage, it should be lowered to 60% of the denominator. Since a child cannot be completely immunized until he receives the measles vaccine at 9 months of age, the denominator for calculating one year coverage should be children aged nine through eleven months or children having their first birthday within a specified period of time. For the purpose of this project, we will continue to use the indicator based objective of 12-23 months.

Re: appropriately immunized and completely immunized with respect to TT immunization. There is apparently some confusion over our use of the term "appropriately immunized" with respect to TT immunization of pregnant women: by this we mean the administration of two TT immunizations before or during the first pregnancy, and one TT (up to five) for every subsequent pregnancy; whether a woman is fully immunized depends on the number of pregnancies she has had, so we will determine the proportion of "appropriately immunized" women aged 15-45 years according to whether they have received at least two TTs. There had been a question in the DIP Review about how we could aim for having 80% of mothers immunized with TT when we aimed for a lower percentage to attend at least two prenatal care sessions: this is possible because monthly immunization camps provide TT vaccines, not the antenatal clinic.

Re: Strategy for dealing with drop out cases: The Project promotes immunization coverage through motivation of the target women and the family decision-makers. Two to three days before the monthly EPI session, VHWs list all the target children and women eligible for the specific EPI shots. They visit the target households to counsel families and give them "identity slips" which list the vaccine and dose for each household member and remind families of the date, time and place of EPI sessions; "identity slips" are brought by families to EPI sessions. If the targeted child or woman does not show up at the EPI session, the VHW returns to the target house (or sends a volunteer) to remind family members and bring them to the camp. If the VHWs are unable to motivate the targeted families, they seek assistance from their supervisors or influential persons in the community. Additional motivation for pregnant women is provided through counseling at the antenatal clinics.

Control of Diarrheal Disease:

Re: Mothers who use ORS will know how to prepare it correctly: By this statement we wanted to emphasize that all the mothers (or at least one member of each family) will be trained about proper preparation of the ORS, so that when they use it, they prepare it properly. The BFO does not consider this to be an unrealistic objective; in fact, considering the damage

basis by FHVs. The quality of data included in these manual records will be monitored by annual lot quality assessments conducted by field supervisors. A consolidated objective-based report will be prepared at the field level by the supervisors and sent to the central office for regular monitoring of progress by the program managers. For the purpose of evaluation, objective-based K&P surveys will be conducted during the final evaluation.

Human Resources:

Re: FHV turnover: If consistent with past experience, the turnover rate for FHVs in the CS8 project area is expected to be less than 10% per year. One reason for such low drop out rates is that CS projects are based in communities where there are few other opportunities for paid employment.

Re: Communication between WSG leaders and FHVs: The responsibilities and the work of FHVs and WSG leaders are not quite parallel. FHVs counsel community members through house to house visits while WSG leaders communicate health messages to WSG members and motivate them to practice protective behaviors. However, we will organize quarterly health meetings between FHVs, group volunteers, WSG leaders, and their supervisory staff.

Sustainability:

Re: objectives: Objectives for monitoring the sustainability of WSGs were presented earlier. It should be clear, however, that because the use of WSGs as part of a strategy to increase sustainability of health practices is new, the development of measurable and time-limited objectives regarding activities conducted through the groups can be guided only by conjecture about what MIGHT be realistic in this environment. The knowledge/practice indicators which were listed under each health intervention may also reflect sustainability, as they will presumably result in sustainable behavior change. Another objective for sustainability is that by the end of the project, 80% of trained TBAs will be practicing safely (as indicated by responses on postnatal questionnaires administered as part of the final evaluation). As part of the midterm evaluation, the BFO intends to study patterns of service utilization within project communities; this study will be repeated during the final evaluation, at which time project staff hope to see an increase in self-motivated service utilization (as evidence of sustainability).

* It should be noted that two of the indicators which were listed as measures of sustainability in a communication to USAID from SC Home Office (dated 9/30/93) have been dropped: percentage of families who pay for folic/Fe tablets and contraceptives and percentage of FHVs still making home visits or consulted by community people. The first indicator was dropped because BFO thought it might undermine efforts of government FWAs to promote/distribute Fe/folic acid and contraceptives. The second was dropped because it cannot truly be assessed until some time after project has ended.

Re: Involvement of community leaders: Thorough discussion with community leaders and formal community orientation occurred in the new areas: project staff considered ideas expressed by community leaders as the DIP was prepared.

Re: Community endowment fund: WSGs will be encouraged to established emergency health care and referral funds. The project managers now consider this more limited perspective to be more realistic and sustainable than the broad concept of community endowment funds.

that can result from improperly mixed ORS, the BFO considers this objective necessary in view of the imperative to "do no harm".

Re: 'Half hearted effort': The project emphasizes training mothers on appropriate management of diarrhea, not only the promotion of home fluid or ORS packets. The WHO and MOH CDD protocols recommend home fluids (for example, LGS/SSS or molasses+sugar/sugar+salt solutions) for cases of diarrhea with no apparent dehydration. Thus, project staff will train mothers to prepare these home-made solutions to manage cases without dehydration. According to WHO and MOH CDD protocols, ORS packets should be used for cases who DO show some signs of dehydration: the MOH rationale for this is that the packets contain potassium and bicarbonate. As demonstrated in the baseline survey, these ORS packets are available and are being used in the project area. Thus, although project staff will not actually distribute ORS packets, they will certainly train mothers on the preparation and proper use of packets for cases showing some dehydration. We hope this convinces reviewers that our CDD intervention is not "half hearted" but rather a thoughtful attempt to strengthen management of diarrhea according to WHO/GOB protocols.

Re: Technical Assistance: The BFO is quite clear on the difference between home-available fluids and pinch/scoop sugar/ salt solutions. On page nine of the DIP, we mention that we plan to consult with ICDDR,B on the use of such traditional HAFs as barley water+salt. The project managers/staff are regularly in contact with and are active in tapping available resources. In this regard, SC is taking technical assistance from the CDD program of MOH, as well as ICDDR(B).

Re: Referral Criteria: The WHO and MOH CDD protocols include a list of referral criteria: we use this list for training workers and mothers. (Please see appendix for protocols.) Mothers are advised to seek treatment in cases of persistent or bloody diarrhea and for severe dehydration. Dehydration is described using symptoms which mothers can easily understand: minor signs of dehydration are given as lack of tears and dryness of mouth; major signs are lethargy, thirst and poor skin turgor. Thus, reduced urine output in the presence of diarrhea is not the only criterion used for referral.

Nutrition:

Re: Why growth monitoring program was deleted: The BFO's past experience with growth monitoring has demonstrated it to be an extremely staff-intensive activity, one that in all likelihood would be difficult to sustain. The BFO is currently in the process of investigating whether or not its previous supplementation/education programs for children who were moderately to severely malnourished or growth faltering did in fact alter individual survival and growth; the prevalence of malnutrition on a community level did not significantly change during those projects. All nutrition activities in the present project are educational in nature: again, in the interest of sustainability, the BFO has opted NOT to do nutrition supplementation for the following reasons:

1. In CS-8 we emphasize programs which are sustainable in the long run and of low cost for replicability.
2. From previous experience, we learned that the growth monitoring program was staff intensive and, therefore, expensive.
3. As growth monitoring is not currently a GOB priority, it would not be replicated or sustained at that level.

4. Growth monitoring without food supplementation (and sometimes curative health care) is usually NOT effective: families are unlikely to participate in or sustain a nutrition intervention which consists only of growth monitoring.
5. There was no community-wide reduction in the prevalence of malnutrition as a result of the generalized growth monitoring program.

However, based on findings from current investigations of previous growth monitoring and supplementation activities, the BFO may seek funding from other sources to conduct operations research on effective nutrition interventions.

Re: Materials for nutrition training/education: BFO is seeking advice from other organizations involved in nutrition education--e.g., Campaign for Promotion and Protection of Breastfeeding (CPPBF), Institute of Public Health Nutrition (IPHN), Helen Keller International (HKI). Project staff will use materials which they have developed and which have been proven effective.

ARI:

Re: objective on ARI: DIP section 5e.7 refers to objectives to be achieved by the end of project.

Re: drugs: Amoxicillin/ampicillin will be used for treating children younger than two months (since about 50% of the children are born under weight) and TMP/SMX will be used for treating children older than two months. This follows the WHO protocol. Regarding the project objective that "90% of those who seek care will receive appropriate care": we can only ensure that those who seek care at SC clinics will receive appropriate care; project staff have no direct control over care provided at hospitals or by private MDs.

Maternal Care & Family Planning:

Re: updating pregnant mothers list: During their routine quarterly home visits to fertile couples, FHV's will collect information on menstrual history and other information relating to pregnancy as well as on the couple's contraception status. From this information, pregnant mothers will be identified on a quarterly basis. We expect this strategy to enable 40% of pregnant women to attend PNC clinic at least twice during their pregnancy.

Re: TBA Training: The pregnant mothers will be encouraged and motivated to use trained TBAs, and in every community all active TBAs--i.e., those who deliver at least three infants each year--will be trained. Through this two-pronged approach it is expected that 70% of the deliveries in the project area will be attended by trained TBAs. Training those TBAs who perform less than three deliveries a year is beyond the resources of this project.

Malaria control:

Re: Further assessment of local resources: Government health workers (health assistants) are assigned to collect blood slides during their home visits if they come in contact with any cases of febrile illness. FHV's will strengthen the efforts of government workers in educating families and in raising their level of knowledge about malaria control. A training program for village doctors will be organized with the cooperation of the local MOH doctors from the thana health complex: this training program will include information on managing malaria.

Re: Limited component: The four villages where this intervention will be implemented comprise the only region in the project area in which malaria is endemic.

Re: follow up: The project managers will review the effectiveness of these training sessions through discussions with the FHV's, MOH doctors and trained village doctors, and through checking treatment of some cases (e.g., by reviewing prescriptions). Mosquito control measures will be explored and incorporated in the training as appropriate.

Womens Savings Groups:

Re: Measurable objectives: Objectives to monitor the establishment, function, sustainability and health promotion ability of Women's Savings groups are as follow:

By the end of the project:

90% of WSG leaders will be trained in WSG management

90% of WSG leaders will be trained in health activities

80% of WSGs will score adequately on maturity index (see Appendix for example of index)

70% of WSGs will be using some of their funds for health care of their members

The level of health-related knowledge and practice among WSG members who have belonged to a savings group for at least one year will be at least 10% higher than that in the general community; indices of knowledge/practice will be as presented for each health intervention.

Re: Number of WSGs and members: As stated in DIP Section D.3, by the end of the project 70% of eligible women (i.e. those in the lowest socioeconomic class, 70% of total) are expected to belong to WSGs. The projected total project population is now 158,000; the estimated population of eligible women is 32,700. If 70% of those eligible participate, WSG membership will be approximately 22,100. With 20 members per group, we may expect a total of roughly 1,100 groups. This is now our target output.

Re: Lower than expected participation rates: CS activities will be promoted through the FHV's, who will visit ALL targeted households in the community. WSG-based activities will reinforce health messages imparted by FHV's for the poorest women, who along with their families are most vulnerable to some of the adverse health conditions addressed by SC interventions.

Re: Literacy training for WSG members: Literacy training is beyond the financial scope of this project; moreover, literacy training has not been articulated as a need by women in the communities in which we work. WSGs, however, will include training in such practical skills as household and small business financial management, and child rearing.

Monitoring and evaluation:

Concern about sustainability, cost and relevance to program interventions persuaded the BFO to streamline its HIS. The BFO will computerize data from some randomly selected sentinel points spread over the whole project area: these points will include a population of about 45-50,000. Computerization of data from sentinel points will maintain a longitudinal data base for use in analysis of program impact and trends. In the entire project area, manual records of demographic data, target population and service coverage will be kept updated on a regular

basis by FHVs. The quality of data included in these manual records will be monitored by annual lot quality assessments conducted by field supervisors. A consolidated objective-based report will be prepared at the field level by the supervisors and sent to the central office for regular monitoring of progress by the program managers. For the purpose of evaluation, objective-based K&P surveys will be conducted during the final evaluation.

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