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Save the Children

Bangladesh Field Office

Child Survival 4

Final Evaluation Report

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SAVE THE CHILDREN/BANGLADESH
CHILD SURVIVAL IV FINAL EVALUATION
EXECUTIVE SUMMARY

The final evaluation of the Save the Children's Bangladesh Child Survival IV Program was conducted in August, 1993. Members of the Final Evaluation Team included a technical consultant Professor Emeritus from Columbia University, an Associate Professor from Dhaka Univeristy Department of Economics, an UNICEF Representative, a Senior Advisor to GTZ, and an EPI Technical Specialist. Evaluation methods included review of project documents and special studies, comparison of data collected in the Project Management Information System to KPC survey data, observation of project activities, and interviews focussing on sustainability with project staff, community residents, and representatives from government and non-government agencies.

The Bangladesh Field Office started implementing a Child Survival I project in 1985 in 4 areas of Bangladesh: this project enhanced the agency's ongoing community-based integrated rural development project with a large health component, which included EPI, ORT, GMP and MCH components; male and female workers were assigned as a team to cover approximately 200 to 250 households and, in collaboration with Medical Assistants and other Field Staff, provided health education and basic PHC services. The final evaluation of the Child Survival I project documented a decrease in under five mortality and positive changes in the adoption of child protective behaviors. Receipt of the CS4 grant (9/1/88) valued at $603,500 allowed the BFO to further promote successful interventions, to pilot health and development interventions through women's savings groups, and to increase population coverage to more than 75,000 individuals. The BFO maintained high levels of achievement of project objectives during the original four years of CS4, achieving almost all targets by the midterm evaluation of the project. The team concluded that the project handled financial matters competently and efficiently.

A no cost extension was requested for the fifth year, mainly for the implementation of strategies designed to improve sustainability of project activities: this required BFO and community-level staff to change from an orientation toward direct service provision and the achievement of ambitious quantitative objectives to one of facilitating the establishment of linkages between communities and other service providers. The new focus on sustainability coincided with the initiation, by the BFO in 1992, of an overall phaseover process in the Ghior, Mirzapur and Rangunia impact areas and a simultaneous expansion in the Nasirnagar impact area (which is by far the poorest of the four CS4 sites).

Bangladesh CS4 project staff were committed to measuring the impact of CS interventions on child mortality and morbidity. Longitudinal data contained in the project's on-going health information system complemented those provided by the KPC survey, which is now mandated in all AID-supported child survival projects: KPC data suggested positive trends over time, and **HIS data illustrated decreases in infant and under five mortality and fertility rates during the course of the project**, as well as increases in immunization coverage and participation in growth monitoring.

The Final Evaluation Team's main findings and recommendations centered on the following issues:

1. Value of a community-based longitudinal data management system

Data contained in the program's manual and computerized management information system were extremely useful for program evaluation and analysis. These data allowed evaluation of changes in health indices over time (particularly in mortality, fertility rates and children's nutritional status); such longitudinal analysis is difficult,

and often impossible, using survey data alone. The Program Management Information system should be maintained in the future, though given the large expansion of program population which will occur during the CS8 project, it may be best to confine PMIS to sentinel areas.

2. Value of focused studies

Implementing agencies such as Save the Children can gain much insight into program problems and accomplishments by commissioning studies focused on particular child survival issues. The three studies which were commissioned by Save the Children as the initial part of the final evaluation and conducted by the University Research Corporation of Bangladesh provided much information on the association between membership in Women's Savings Groups and health outcomes and practices; patterns of health care service use in Save the Children's program areas; and the impact on contraceptive practices of workshops held by Save the Children staff for community and religious leaders. These types of studies can benefit the Child Survival program and should be included in the future.

3. Importance of malnutrition

The continued high prevalence of malnutrition and high mortality among malnourished children argue for continued attention to nutrition interventions. Data collected in the PMIS should be used to analyze the effectiveness of nutritional interventions implemented during this CS4 project on the growth and survival of children who participated in the growth monitoring program. The results from such a study might inform the development of nutrition strategies undertaken as part of the World Bank's Bangladesh Integrated Nutrition Project.

4. Sustainability

Absolute poverty, on both the community and government levels, is the main barrier to sustaining child survival activities as they have been carried out in the past. The establishment of linkages between communities and government and non-government institutions (including mission hospitals) is essential to ensuring sustainability of service delivery: GOB health officials in the project area have expressed willingness to deliver services within the constraints of their budgets. It is important for SC to systematically assess all resources available in the project area that can be utilized for delivery of child survival services, and to identify ways in which SC can use its resources to help the GOB staff develop and test ways of delivering the priority interventions effectively and efficiently.

5. Value and limitations of KCP surveys

While KCP surveys afford a rapid means of program evaluation (especially in projects which do not collect longitudinal data), the insights they offer are limited by techniques used for sample size and selection as well as by construction of some questions (particularly those which elicit nutritional information): the absence of questions to assess children's nutritional status is especially disturbing. Where possible, information collected in these surveys should be complemented with longitudinal data.

I. INTRODUCTION

This report summarizes the findings, lessons learned and provides the recommendations of the Final Evaluation Team for the Child Survival IV project of Save the Children (USA) Bangladesh Field Office (BFO). The report includes both a summary of the responses to the questions concerning project sustainability required by USAID and also the detailed responses to those questions. The final evaluation was conducted as part of USAID's reporting requirements. In addition to the guidelines from USAID, the SCF, Bangladesh staff identified special areas of concern to be addressed by the Final Evaluation Team (FET)

A. Scope of Work:

* Conduct a project sustainability assessment using guidelines developed by USAID for the final evaluation
* Assess project achievements against project objectives including difficulty in achieving these objectives
* Review the field/impact area visit findings with special emphasis on project operations and management, supervision and monitoring, training, health information system, technical supports, linkages with GO's/NGO's
* Study KAP survey and other special studies being done so far by the project
* Identify and document lessons learned
* Provide recommendations for future direction of the project

B. Composition of the Team:

The final evaluation team (FET) was jointly selected by SCF Bangladesh field office staff and SCF headquarters in USA. The FET included:

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C. Evaluation methodology:

Methods used for the final evaluation included:

1. Study/review of related project documents/reports.

   * CS IV project proposal
   * Detailed Implementation Plan (DIP)
   * Annual Report
   * Mid-term evaluation report
   * Final K & P survey report of CS IV
   * Baseline K & P survey report of CS VIII
   * Justification for no cost extension of CS IV
   * PMIS reports and special analyses of PMIS data
   * Special study reports commissioned by SCF, BFO and carried out by University Research Corporation, Bangladesh and dealing with:
   * Participation in women's savings groups and health care behavior,
   * Health care services utilization in SCF catchment areas.
   * Study of the impact of the workshop on family planning.

* Review of recording and reporting tools.

2. Observation of on-going project activities and field visits.

3. Interview project staff at different levels. (SCF Bangladesh Field Office/HQ, Impact Area Office, village levels, etc.).

4. Informal group discussions with specific groups: WSGs, village level committees, field level workers, project & impact area staff, community leaders, etc.

5. Interviews with government and non-governmental organization representatives both at the Impact Area level and central level.

II. BACKGROUND AND PROJECT HISTORY

Bangladesh is one of the most densely populated countries in the world with roughly 116 million people living in an area about the size of the state of Wisconsin. 85 percent of Bangladeshis live in 68,000 disadvantaged rural villages. A high population growth rate (2.5 percent per year), widespread poverty (86 percent of families), low level of investment, high unemployment/ under employment, low literacy, severe resource constraints and recurrent natural disasters impede the nation's efforts towards development. The mortality rates of U5 children and mothers (130 per 1000 and 600 per 100,000 live births respectively), the nutritional status of the children U5 (66 percent of U5 children are moderately or severely malnourished) and the adult literacy rate (35 percent) are some of the stark statistics that reflect the situation in Bangladesh.[1]

Since independence in 1971, the Bangladesh government has been challenged with rebuilding a war torn nation, establishing development objectives and achieving them. To achieve these aims, the government of Bangladesh depends to a large extent on foreign aid, mainly bilateral assistance, but also including aid from a large number of NGOs.

Like most of the NGOs, Save the Children (USA) began its operations in Bangladesh by carrying out relief and rehabilitation activities after the devastating natural disaster that occurred in 1970 and then after the war of liberation in 1971. Soon after this (during 1972-73), the Bangladesh Field Office (BFO) began to focus its attention on integrated community development programs, following the agency's Community Based Integrated Rural Development (CBIRD) methodology. Development programs were designed in collaboration with community representatives, organized as Village Development Committees (VDCs). Their emphasis was mostly on infrastructure and agriculture.

During the mid-1970s, the community based program activities expanded and diversified to include health, nutrition, family planning, education and economic development, as well as the original efforts to develop infrastructure and improve agriculture. During that period the BFO also started working in four defined project areas: Rangunia, Nasirnagar, Ghior and Mirzapur, covering a population of about 40,000 in 17 villages by the year 1977. Vertical program activities in preventive health education, nutrition and family planning were implemented through unipurpose workers. In general, these program activities were not fully appreciated by the community as they did not address felt needs and were thus a low priority for most people, whose main desire in the health sector was for curative services.

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[1] NOTE: These statistics are from State of the World's Children, 1993, UNICEF

Since 1978 an integrated primary health care (PHC) program has been developed by the BFO field staff, with a balanced preventive and curative focus, using multipurpose community health workers, total family registration and target-based specified activities. This included ORT training, ANC, GM, Nutrition-education, EPI, Family Planning, TBA training, and the provision of safe water (tubewells) and latrines with a systematic program monitoring system. The approach was initially implemented in one of the project areas as a pilot program.

In 1982 this program was replicated in the other areas with special emphasis on child centered and women's development components. As the multipurpose workers became more active, a greater demand for primary health care emerged. The initial VDC felt needs expanded from agriculture and infrastructure to family health, education and economic development.

Save the Children started implementing the Child Survival I program in 1985, which enhanced the ongoing CBIRD program with a large health component. The priority health interventions were EPI, ORT, GMP, MCH, TBA training, and water and sanitation. Program efforts also concentrated on strengthening training, supervision and monitoring capacities. Male CHWs were introduced. Male and female workers from each neighborhood were assigned as a team to cover approximately 200-250 households. In close collaboration with the Medical Assistants and other Field Staff, they met with villagers on a regular basis to provide health education and basic PHC services.

In the final evaluation of the Child Survival I project, the success of the project was apparent in a decrease in under five mortality and some positive changes in the adoption of child protective behaviors. In order to promote further the successful interventions and to increase the population coverage, the BFO applied for and was awarded a second child survival grant (CS IV). By the time of its completion, the CS IV grant covered a population of more than 75,000.

The BFO maintained high levels of achievement of project objectives during the original four years of the CS IV grant. A no cost extension was requested for a fifth year, mainly for the implementation of sustainability activities. This required a major transformation in perspective, for both the BFO staff and also the staff at the community level, from an orientation toward direct service provision and the achievement of ambitious quantitative objectives to one of facilitating the establishment of linkages between communities and other service providers. It also required the development of new skills, techniques, processes and systems. These major changes required time and effort and did not come about automatically.

This focus on child survival program sustainability coincided with the initiation, by the BFO in 1992, of an overall phaseover process in the Ghior, Mirzapur and Rangunia impact areas, while initiating, simultaneously, a major expansion of coverage in the Nasirnagar impact area, by far the poorest of the four target areas in CS IV. This concentration of resources on the population of Nasirnagar reflects a recognition of the far greater level of need as well as the fewer existing services in Nasirnagar. It is also consistent with the increased emphasis within Save the Children generally on program sustainability and phaseover.

For the future, the BFO has proposed to Save the Children's headquarters to continue the expansion in Nasirnagar to Thana-wide coverage and to establish Nasirnagar as a longer term program base in the pursuit of several strategic interests as detailed below. (NOTE: This proposal must be approved by the headquarters before it can be officially adopted by the BFO. Based on initial discussions, approval appears likely.) Please see organogram (appendix 1) for current program organization.

A. Program Relevance and Replicability

Thana-wide coverage will provide several advantages that will enhance program relevance and replicability. First, it will provide the BFO with a stable base for testing community level interventions that can have wide, large scale impact. Secondly, by covering an entire GOB administrative unit, broad and effective collaboration with government will become much more feasible and of greater interest to government officials. This will enhance the potential both for short term partnership and also for longer term sustainability. Consequently, models developed will also be of wider relevance and replicability.

Sustainability will remain a major program objective, but phaseover will be addressed on an intervention-by-intervention basis, rather than on an overall level at one time. The BFO will continue to set and work to achieve time-bound objectives for the sustainability of various interventions to avoid creating attitudes of dependency. For example, field staff will continue to gauge the strength of women's savings groups according to the sustainability matrix recently developed. Phaseover activities will be pursued with individual groups as they approach the sustainable level. Once they have phased over from group strengthening interventions, these "mature" groups will continue to work with the BFO as program partners in the implementation of other activities. Field staff will continue to work with weaker groups to assist their movement toward that point.

By addressing sustainability on an intervention basis, the program can continue to introduce new and innovative program activities for testing and development without the concern that the program will soon need to leave the particular community and transfer to another. Such shifting affects a program's momentum by requiring time to reestablish the operating infrastructure prior to initiating organizational and then technical interventions.

B. Community Action Research

With a Thana-wide population of approximately 200,000, this expansion will provide a significant base for the ongoing enhancement of the research component of the BFO program. The BFO's "direct" implementation is expected to focus on a basic package of interventions in the areas of health, education and economic opportunities (with an emphasis on partnering and sustainability to the fullest degree possible). Building upon this, grants and other donations will be sought to support the conduct of operations and possibly other forms of research. This will likely focus mainly on testing and experimentation with specific interventions (e.g. MotherCare), but will also include retrospective and prospective research into the effectiveness of our ongoing activities.

The BFO's longitudinal data base will be maintained through sentinel surveillance. BFP management will seek grant funds and institutional linkages to promote the increased utilization and continued support for the PMIS and the BFO Management Information and Research Section. They are currently in dialogue regarding two different possibilities for such linkages (with the Center for International Health of Emory University in Atlanta and with the Department of Social Statistics and Demography of the University of Southhampton in the U.K.). It is anticipated that such linkages will strengthen both BFO's involvement and output in research as well as the networks for accessing ongoing funding.

C. Scale/Policy Impact

Based on the BFO operations research findings, major grants can be developed to replicate these activities on a much wider and, if successful, on a national scale. An example of this is

their current proposal to replicate district-wide the family planning workshops that they tested on the Thana-level one year ago. A study just completed by URC has documented the impact of the workshops and strongly supported their wider implementation.

The stability of a long term base is also expected to allow key staff to spend more time on task forces or committees of policy level institutions. This will not only provide greater input to policy dialogue but also will strengthen BFO networks and linkages for facilitating the development of partnerships that would be necessary for scaling up.

III. PRINCIPAL OBSERVATIONS AND RECOMMENDATIONS:

A. Overall Child Survival Program

The findings of the special survey carried out as a part of the Midterm Evaluation showed that the SC CS IV project had achieved almost all of its quantitative targets for the various interventions by the time the project was half completed. After two more years, at the originally scheduled time for the completion of the project, a no cost extension made possible the continuation of the project, but only after project managers made significant changes in program strategy. These changes (described below) resulted in a decrease in the intensity of service delivery and a consequent decrease in effectiveness. As a result of this, when the Rapid Knowledge Practice & Coverage (KPC) Survey was carried out in preparation for the Final Evaluation, six months after those strategic changes were initiated, it revealed, as should be expected, some decrease in numbers, although the achievement levels for several of the interventions held steady.

The computerized Project Management Information System (PMIS) which is used at the BFO is based on a manual health information system which consists of full population enrollment and on-going monitoring of targeted groups. The system was established by the (BFO) to provide detailed information on the SC project activities and facilitate analysis of longitudinal trends. During this evaluation, PMIS yielded data that not only supplemented and confirmed the KPC findings, but also went much further by providing measures of project outcome that were not otherwise available. Among many other things, the data revealed declines in mortality and fertility, which were irregular but non-trivial, as well as the effects of growth monitoring activities and food supplementation of high risk children on their nutrition status.

The various data sets show clearly that when resources are available, the SC project management staff in the BFO in Dhaka and the SC field staff in the project areas of the CS IV project are capable of carrying out the interventions required to meet the quantitative goals established in the DIP. In fact, however, the resources that were provided by AID/W and Save the Children (USA), are simply not available from indigenous sources in Bangladesh and this leads to the examination of the sustainability of the project.

1. Sustainability Issues

The question of project sustainability is a matter of serious concern to AID/W as well as to SC (USA) and the CS IV project managers in the BFO. What should be stressed is that the staff involved in SC CS IV, at every level in the system, have been concerned about sustainability and have carried out a wide variety of activities intended to improve sustainability of the CS activities. **What is clear is that it is not possible to sustain activities at their present level without substantial outside inputs. Based on their experience, the staff have come to the conclusion that the best that can be done at present is to search for ways, through community participation of many sorts, as well as various kinds of collaboration with the GOB health system, to continue as many of the interventions as possible, on a reduced**

scale or at reduced intensity where necessary. The rationale for this is described briefly in the summary below and in detail further on.

In order to explore the matter, AID/W had prepared a detailed questionnaire dealing with the many issues involved and had specified that they were to be addressed by the Final Evaluation Team. (The questionnaire is included as Appendix 2). In preparation for this, the senior BFO staff had prepared a detailed preliminary response to the questionnaire and made it available to the FET at the start of this evaluation.

The FET, in turn, devoted well over half the time available for the evaluation to reviewing the draft response, to the discussion of issues and questions raised in the draft with the BFO senior staff and with others, and finally to discussions within the FET and the preparation of a final revision. Thus, it can be seen that the sustainability review overwhelmed the evaluation process and left limited time to cover many other aspects of project operation and performance -- at least in this particular set of circumstances.

2. *Summary of the Sustainability Review*

Please refer to appendix 2. Briefly, the sustainability review showed first of all that the resources needed to carry on child survival activities as they have been in the CS IV project are simply not available. The absolutely constraining factors are the poverty, both of the vast majority of the families in the community and also of the government institutions of Bangladesh, which are hugely dependent on funds from donor agencies. The estimated recurrent cost of continuing the key child survival activities would not be excessive: it would amount to about one dollar per person, of the total project area population, per year, totaling around $70,000. On the other hand, estimates of projected revenues based on in-kind contributions, including labor, and the extremely limited possibilities for cost recovery for services and for drugs, totaled only around $30,000 over the next three years. It should be noted, as is clear in the responses to the review questionnaire, that SC has tried in a number of ways to help the communities find income generating activities that would support health service delivery, and that none of these have proved capable of producing sufficient income.

The SC team developed a variety of indicators of sustainability and monitored them. It is questionable whether the GOB will be able to sustain the quality and quantity of child protective service delivery. Furthermore, the team acted on the recommendations of the reviews of the initial proposal and the DIP, as well as those that resulted from the Midterm Evaluation. Most of these recommendations were followed carefully, and many were achieved. Child Survival projects alone, however, cannot solve the profound effects of poverty, which limit options for sustainability.

A host of efforts were made to elicit community participation that will enhance sustainability. Women's savings groups and village development committees were established and health education and training were provided to their members, as well as to community workers, family members, TBAs and village doctors. The BFO staff concluded that because of the interest in the community and the linkages and improved relationships with the health services of the GOB, that the GOB will provide the essential services to the extent possible within the existing constraints.

As indicated above, links have been established with a number of counterpart institutions, both governmental and private, including missionary hospitals. The problem lies in the fact that the GOB is dependent on donor countries and donor agencies for the major part of its development program and this includes a huge proportion of the health budget. The GOB health officials in the project area, however, have expressed their willingness to deliver services within the constraints of their budget. The CS IV staff carried out a variety of activities designed to improve program efficiency and also to enhance cost recovery. These activities were partially

successful in some respects, failed in others, but could not overcome the underlying problems of the economy and poverty, with all that that implies.

3. Review of Major Steps Taken Toward Sustainability and Phaseover to the Communities and the GOB.

Major steps taken on sustainability & phaseover issue	Purpose	Time Frame	Remarks
Meeting with VDC.	Form a phaseover committee.	Phaseover activities are a continuous process and is on going.	
Meetings with sectoral members.	Orientation on the phaseover process and issue of sustainability.		
Meeting with WSG leaders & members.	Invite the VDCs to submit project proposal on how they are going to sustain the CS activities after the agency leaves.		
Phaseover workshop with the VDCs, village elites, and GOB health representatives, Mirzapur: 13 Jun & 30 Jun '93 Ghior: 26 Mar & 14 Jul '93.	Inform the GOB representatives of the need to take over the responsibility as the agency leaves so that no vacuum is created in service delivery.		

Major steps taken on sustainability & phaseover issue	Purpose	Time Frame	Remarks
Mirzapur: Formal workshop held in Mirzapur (01-08-93) to hand over the primary health care centre to the GOB health authorities **Attendants:** The chairman of the thana health development committee who is also a member of parliament, VDC chairmen and WSG leaders, elites from the village.	The GOB health representative made a commitment to provide essential services like EPI, MCH, & FP, VAC and other primary health care services. The GOB health authority expressed their willingness to start operating from 1 Sep '93.	Handover of PHCC done on 01-08-93.	The GOB has started providing PHC service from 01-09-93.
Ghior: Workshop with the GOB health authorities on phaseover of the health activities. **Attendants:** Thana family planning officer, health inspector, FWV (GOB), FHA (GOB), representatives from the community & VDC chairman & village staff.	Authorities were informed that SC will cease to render health care services as of Sept '93. In this regard it is informed that the local GOB health department will continue the services with the same effort. The GOB representatives (THFPO) briefed on GOB service facilities and its constraints.	The phaseover activities are on going.	
	GOB is committed to provide the following services: * Family planning * Follow up of any post operative complication * Ensure supply of contraceptive materials & follow up of dropout cases * Follow up clients switching from one method to the other.	Phaseover activities are ongoing.	Better liasion and linkage to be maintained need to sustain these activities.
	One medical assistant has been providing curative service in the PHCC for 1 yr. He further assured us that he will arrange DDS kits for the centre.	Negotiation at higher level is needed to formalize the PH C activities.	The PHC strategy is being reviewed.

Major steps taken on sustainability & phaseover issue	Purpose	Time Frame	Remarks
IMPACT AREA: RANGUNIA			
Meetings and workshop held with the VDC and different sectoral committees and villages elites (Phaseover: workshop 23-25 April, 1993)	* Inform and orient them on the issue of sustainability & phaseover * Inform about the fact that no NGO can provide service to any area for indefinite period * What strategies will be taken regarding PHCCs. In each village a phaseover committee has been formed with WSG representatives from each village. Chandraghona Christian Mission Hospital provides support in terms of addressing the obstetric emergencies and also providing immunization & FP services. They were informed that they are expected to carry on CS activities as the agency leaves.		
WSG: Regular meetings are held with WSGs on the sustainability and phaseover issues. Linkage with Chandraghona Mission Hospital. Strengthening of WSG: The WSG members and leaders are being trained in child protective behavior.	They are being trained on linkages with local GOB service providers & other NGOs (Changrahone Christian Mission Hospital).		

Major steps taken on sustainability & phaseover issue	Purpose	Time Frame	Remarks
Nasirnagar: **Kunda & Gokarna** Meeting & workshop held with the VDC, WSG and village elites with participation of SC and village staff	They were appraised on the issues of sustainability and phaseover. Community orientation on phaseover was held on 29 Jun '93 (Moslendapur). They were invited to submit an action plan which will be reviewed at Dhaka level. **Activities in process and due to be completed:** Identification of properties and assets has been done and handover plan has been prepared. The VDC in Kunda intends to run two fish ponds which will bear the cost of 2 PHCCs. Several meetings have been conducted with groups concerning the issue.	Phaseover activities are ongoing.	The action plan and project proposal are being reviewed.
Linkages with GOB/Health officials at local level.	One GOB health person will attend the PHCC at Kunda to provide service temporarily. It is expected that this can be formalized officially at a higher level.		

4. *Recommendations on Sustainability*

Given the complicated situation described here, the serious needs for the basic child survival services, the fact that SC (USA) cannot be the continuing service provider in the project areas, and the profoundly limiting constraints that are operating, the team recommends that SC capitalize on the good relations that now exist with the GOB health system and establish:

<u>Baseline collaboration:</u>

* Henceforward the GOB will be responsible for service delivery in the project area.

* SC energy and resources will be devoted to working with the GOB staff in the area to find ways to deliver the essential child survival services, in ways which, as much as possible, will facilitate development of a comprehensive system of health care.

* The GOB and SC will work together to exploit and develop further the community resources that have evolved out of the current project activities.

Operating strategy:

* With appropriate community representatives and GOB health services staff, SC will carry out a careful joint review of the information gathered and the lessons learned from CS IV and agree on the interventions that are most needed and have been most successful and give them a priority ranking.

* Carry out jointly a careful assessment of all the resources available in the project areas that can be utilized for delivery of the child survival services.

* Agree jointly on which, and how many, of the priority interventions are feasible of delivery by the GOB health system with the resources available, as determined above, and then set about to deliver them. The governing mind-set should be based on this question: "What are the most important things we can do to increase child survival with the resources with which we have to work?"

* Identify the ways in which SC can use its resources to help the GOB staff develop and test ways of delivering the priority interventions effectively and efficiently.

The GOB is committed to provide primary health care, the health care infrastructure is gradually expanding, donors have not abandoned Bangladesh and funds do continue to be made available, so, however limited it may be, there is something that will go on. The role for Save the Children that is recommended here is to work with the GOB to make that something as appropriate and effective as possible within the existing constraints.

B. Nutrition Activities

There is a global consensus concerning the importance of nutrition in child survival programs. This is reflected, for example, in UNICEF's stress on GOBI-FFF, in which three of the elements, G, growth monitoring, B, breastfeeding and one of the Fs, food supplementation are meant to improve the nutrition of children. Thus, no one would challenge the emphasis on nutrition in the child survival program of AID/W in general, and in the SC CS IV project in Bangladesh in particular. On the other hand, there is little or no agreement about what, exactly, is the most effective way to deal with the problem.

The four most commonly promoted activities are growth monitoring, breastfeeding promotion, food supplementation and nutrition education, and these are the interventions that have been used in the SC CS IV project. All of them can be defended as reasonable approaches, but all of them have their critics or detractors.

* Growth monitoring, just the weighing and recording, too often becomes an end in itself and has no effect. Growth monitoring is therefore criticized because "it doesn't work", or "it's not worth the cost and effort." Supporters argue that it is the best approach we have -- if it is done properly, i.e., with adequate counselling and follow-up when growth falters. Properly carried out, growth monitoring can also identify children already malnourished for special attention.

* Almost no one opposes breastfeeding except the infant formula industry, which claims, in fact, to support it while it regularly manages to camouflage its opposition; and feminist extremists, with very few exceptions from affluent, highly industrialized countries, who see breastfeeding as a burden imposed and a plot to keep women at home and deprive them of career opportunities. Advocates, among other things, cite literally scores of studies, going back to 1868 that have shown that the mortality rate among bottle fed babies is many times higher than that among breastfed babies in conditions like those that prevail in countries like Bangladesh.

* Food supplementation is criticized for many reasons: It makes people dependent; it suppresses local food production; it's too costly; it's not a long term solution; the food is misused; etc., etc. Advocates argue that there are poverty-stricken families, jobless, landless, who simply can't obtain enough food and the food is there, provided by governments disposing of their surpluses. They believe that such food can and should be used creatively to meet the desperate needs of the poor.

* Nutrition education is criticized because often it's culturally inappropriate, or the advice is not feasible, among other reasons. It is defended by those who point out that in many situations there is enough food in the family or in the community; people, mothers, simply need to learn how to use it properly and there are things that can be done, again, providing the education is appropriate, comprehensible and feasible.

The stress on nutrition by the SC CS IV project is not at all unusual. What is unusual, if not quite unique about the nutrition interventions in the CS IV, was the fact that the records of the growth monitoring and food supplementation were fed into the PMIS in detail and are available for analysis. Equally important has been the willingness of SC headquarters to support the detailed analysis of those records, to produce the results which may be seen below.

1. Growth Monitoring

Growth monitoring activities in the CS IV project were carried out in a conventional manner, using Salters hanging spring scales and a standard growth chart. The response of parents and SC staff was generally cooperative. Levels of participation on a regular basis, as revealed in the Midterm and Final surveys were reasonable, with over 60 percent of the target population being weighed regularly when growth monitoring was a regular intervention of the project, i.e., at the time of the MTE.

The growth monitoring procedure was used as a vehicle for nutrition education of the mothers, to identify infants and young children already severely malnourished and to spot those whose growth was beginning to falter. As spelled out below, those who were severely malnourished (weights below 60 percent of expected weight for age) and those whose growth was faltering were eligible to receive food supplements until their nutritional status and growth improved. A comparison of the SC CS IV growth monitoring program with those described in the most recent extensive review of the subject[2] suggests that the program was executed with a level of coverage and competence that was well above average.

The growth monitoring activities of the SC CS IV project were well known to other agencies in Bangladesh, notably to UNICEF. Thus when the World Bank sent a team to explore a multi-million dollar nutrition project, of which 10 million were to be earmarked for growth

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[2] J. Cervinskas, N.M. Gerein and Sabu George, 1993. Growth Promotion and Child Development. Proceedings of a colloquium held in Nyeri, Kenya, 12-13 May 1992. Ottawa: International Development Research Centre.

monitoring, the SC project was identified by World Bank officials working on the Bangladesh nutrition project as a possible model for training and operation. Unfortunately, by then the changes in strategy mentioned above had been implemented and growth monitoring was no longer a project intervention.

Thanks to the PMIS, however, it is possible in this project to assess the effects of growth monitoring during the years that it was carried out. As a matter of fact the quality and quantity of the data in the records makes it possible to measure the changes in the nutritional status of the children, by age group and by exposure to varying interventions over specified time intervals. Figure 1, "Proportion of Children Under Gomez Categories," shows the results when weight-for-age and the "Gomez" system is used and depicts the proportion of children who were classified as normal, or suffering from first (mild), second (moderate), and third degree (severe) malnutrition each year for the duration of the project.

What is perhaps most important about the results is that they show clearly the extraordinarily high proportion of the children who were malnourished to one degree or another throughout the project areas. These findings are not surprising; the high rates are in fact quite consistent with the findings of the national Child Nutrition Survey carried out in 1988-89 by the Bangladesh Bureau of Statistics.[3]

What is also not surprising (because it unfortunately occurs so frequently in growth monitoring programs) but is disappointing nonetheless, is the evidence in that figure that prevalence of malnutrition did not decrease during the course of the project. Prevalence of malnutrition among infants from 6 to 11 months remained much the same. But in the 12 to 23 and the 24 to 36 month age groups prevalence increased from already devastatingly high to even higher levels of moderate and severe malnutrition during the last two years of the project. What must be borne in mind, as is stressed later in this document, is that those are the infants and children that are at risk of dying -- a risk shown in some studies to be ten times higher than that in children whose weights fall within the "normal" range. **Thus, more than any other evidence available, this shows that if we are serious about child survival, there is a desperate need in Bangladesh to continue efforts to cope with the problem of malnutrition in these children.**

2. *Food supplementation of high risk children*

If, as is so often the case, the evidence of an impact of growth monitoring per se on the nutritional status of children is discouraging in such a project, is the situation hopeless? We have reason to think that the situation can improve if there is adequate follow up of malnourished and growth faltering children--with follow up including food supplementation in cases of such extreme poverty where nutrition education alone is unlikely to be of much help.

Supplementary foods were provided to the mothers of infants and young children identified **through growth monitoring** to be at high risk. The children eligible for supplementation included those whose growth charts showed that they had failed to gain weight during a two month period, those whose weights had fallen during a one month period, and those whose weights at the time of weighing, whenever it occurred, showed them to be severely malnourished.

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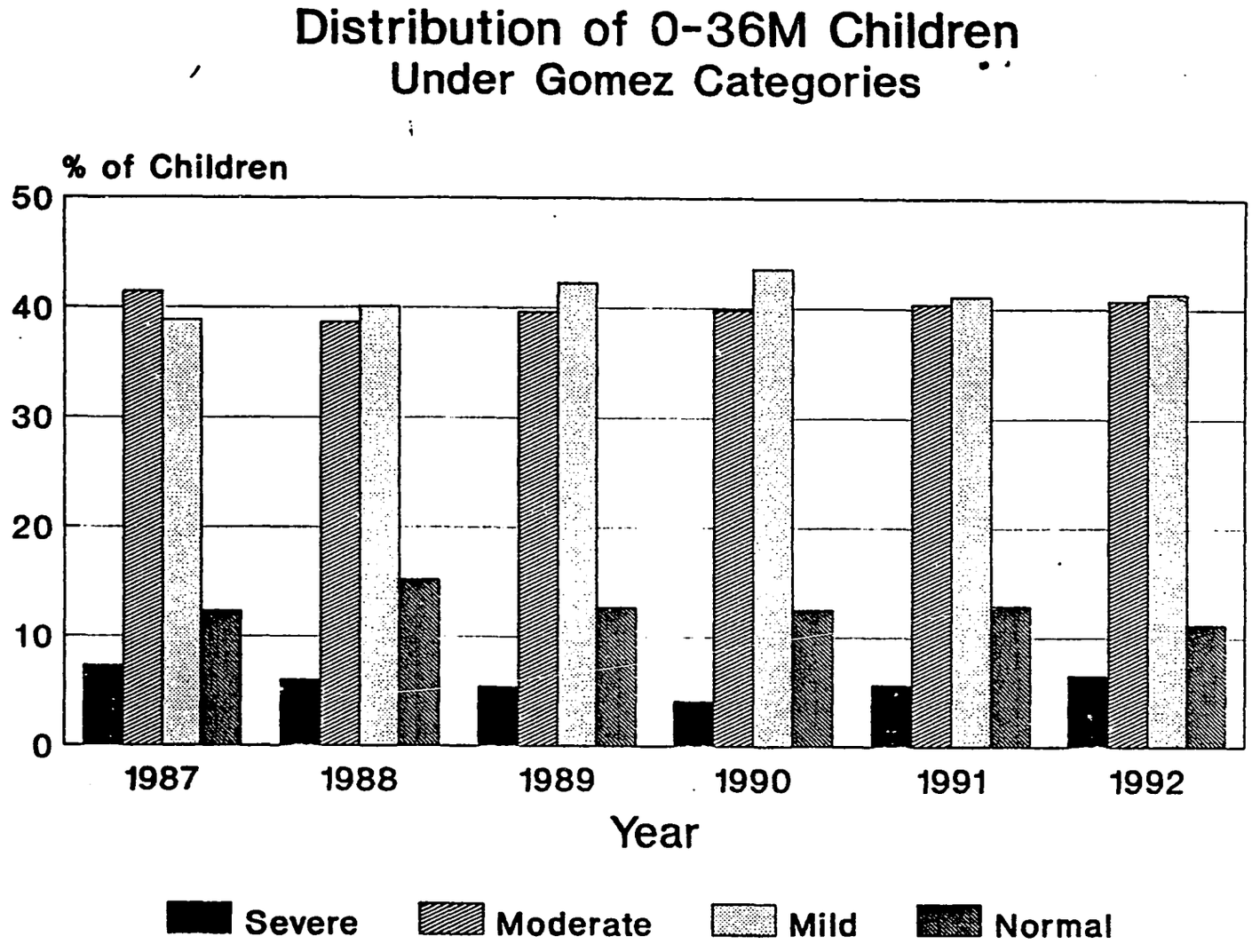
[3] Bangladesh Bureau of Statistics, 1991. Report of the Child Nutritional Status Survey 1989-90. Dhaka: Statistics Division, Ministry of Planning.

FIGURE 1



Children Weighed in March

Unfortunately, the weight graphs used did not include a line at the 60 percent of expected weight-for-age level, as is often and easily done. Instead, the field workers were compelled to use the cumbersome method of comparing the weight as recorded with that in a table of numbers, i.e., instead of being able to see, as soon as they plotted the weight on the chart, whether or not it fell below the critical line and the child should therefore be considered severely malnourished, it was necessary to carry out a more complicated and thus less reliable process to determine whether the child was eligible. It is not surprising, then, that most of the children who were enrolled in the supplementation program were those whose growth was faltering, not those who were already severely malnourished.

Whatever the route of admission to the supplementation program, what matters are the results, in terms of nutritional status and survival. PMIS could allow analysis of growth and mortality among supplemented and unsupplemented children: there is much interest both at the BFO and in SC's home office in proceeding with this type of analysis; results of such an analysis could inform the design of any nutrition projects which are undertaken as part of the World Bank project. Such analysis, however, is hampered by the fact that SC's CSIV project was not constructed as a research project: it is therefore difficult to identify with certainty a group of malnourished children who were eligible for the nutrition intervention but did not receive it. Nutrition interventions appear to have been among the activities which were curtailed in 1992: the BFO is exploring whether children who were first identified as being malnourished in 1992 can serve as "unsupplemented" controls.

Existing analyses and observation of program operation suggest that growth monitoring programs in deprived rural areas can be used effectively to IDENTIFY high risk children. Future analysis will reveal whether the types of interventions employed by SC effectively reduced mortality and malnutrition among these high risk children.

3. Micronutrient supplementation and deworming

There have been something on the order of ten studies from around the world that have shown that when vitamin A capsules are given at six monthly intervals, in countries like Bangladesh where children are known to be deficient in vitamin A, infant and young child mortality can be reduced. Thus when the chance arose to provide vitamin A capsules (VAC) every six months, as part of the CS IV nutrition program, it was done. There is also some evidence that in areas where helminthic infestation rates are high, deworming at intervals can eliminate competition for nutrients from the worms in the gut and thereby improve the nutritional situation of children.

VAC administration was begun in 1990 and by the time of the midterm evaluation 83 percent of the children between 6 and 72 months had received VAC. The final evaluation survey showed that 86 percent of the children over 6 months of age had ever received a VAC.

In this case, possibly because of a host of confounding variables, the PMIS data did not reveal any impact of these two interventions, either on growth or mortality.

4. Recommendations on Nutrition

The specific recommendations made below concerning follow-up and replication of the results obtained through growth monitoring and food supplementation that are reported above are based on several assumptions:

<u>Basic assumptions:</u>

* There is no likelihood whatsoever that the United States, various European countries, and Australia and New Zealand will stop making food surpluses available to

Third World countries in the foreseeable future. Some of this food will be available that could be used for supplementation purposes.

* In the interest of sustainability, and because it is clearly impossible for the existing programs to go on indefinitely, SC is committed to reduced involvement in the actual delivery of CS services.

* At the same time, the role of SC as the developer of a model for growth monitoring, for training field workers in growth monitoring and counselling, and for operating an MIS that is capable of providing good data for evaluating the results of growth monitoring and food supplementation for high risk children, is well known among key agencies in Bangladesh. SC's analytic and programmatic work in this area should continue.

* Growth promotion in Bangladesh is being promoted by UNICEF and the UNICEF staff responsible for those activities are well aware of what SC can offer. Moreover, there is at least the possibility that a World Bank loan will encourage the GOB to expand growth monitoring activities on a broad scale.

* Finally, with or without a World Bank loan, growth monitoring is being carried out by the GOB; the knowledge and expertise gained by SC in the nutrition implementations of CS IV can be of value to the GOB in improving and expanding such services.

Specific recommendations:

* The impact of SC's nutrition interventions on the growth and mortality of children should be rigorously studied.

* SC staff in the BFO and in the project areas should document carefully and immediately the details of the process for identifying high risk children and the operation of the food supplementation program, as well as the operation of the PMIS that made good documentation of the outcomes possible, in order to be able to demonstrate them and teach others to replicate them.

* Any significant findings on the impact of growth monitoring and food supplementation on nutritional status and survival, as well as the results of the review of the methodology, should be prepared for prompt dissemination and publication, both in Bangladesh and elsewhere, targeting child survival programs in particular.

* Where possible in its own projects SC should exert every effort to replicate successful growth monitoring and food supplementation interventions and monitor the results carefully.

* Whether or not it is possible to replicate interventions which are included in projects fully controlled by SC, SC should make the details of its successful programs available to other groups and provide technical assistance to those groups in carrying out such programs; if possible, SC should teach other groups how to use a Health Information System to longitudinally evaluate and monitor nutrition interventions. It is important for SC to help prove that other groups, even those without the resources or advantages enjoyed by SC, can carry out nutrition and CS activities and produce similar results.

* Finally, if indeed the World Bank loan is approved and it does include the growth monitoring component that has been discussed, SC should seek funds from the Bank to make possible the provision of technical assistance of all kinds for program implementation as well as monitoring the results. Such assistance will better enable the GOB to use such a loan effectively.

C. Women's Savings Groups

The establishment of Women's Savings Groups (WSGs) and the training of the leaders and their members antedates the CS IV project, since the Groups were a component of the Community Based Integrated Rural Development (CBIRD) program that SC launched long ago. They are discussed here because, like other elements of the CBIRD program, they do contribute to community development and well-being and they overlap with CS activities in a number of ways. There are now 381 of these groups with 6816 members and they provide a very important channel for communication and motivation of women in the project communities. Beyond that, they play a part in the sustainability plans for some of the CS activities -- i.e., attempts are being made to train some of them to carry on those activities after SC is no longer actively involved.

The FET had available the special study, Health Care Services Utilization in Save the Children (USA) Catchment Areas, carried out by URC,B. It is summarized below and the executive summary attached as Appendix 3. The entire monograph has been submitted as a separate document. It documents convincingly that WSG members participate more actively and effectively in almost all child survival activities. During the field visit to Nasirnagar the team met with a group of WSG leaders and had a very enlightening and impressive discussion with them, met some of them in their homes and saw some income generating projects in action. Finally team members had several conversations with BFO staff and others about the performance of these women.

The FET members were very impressed with these women. Their bearing, their confident way of speaking, their enthusiasm, and their knowledge of health matters, conveyed to the team that participation in the WSG activities does somehow truly result in empowerment of many of them and that this has a variety of consequences that impact positively on the CS IV program activities and on child survival. The team agreed that the existence of the WSGs and their impact on members may be important for much of the success of the CS IV project in achieving its goals.

Recommendations on Women's Savings Groups
Members of the FET were not alone in their subjective belief that participation in the WSGs has the effect of empowering some of the members. But the evidence that they have been empowered is largely anecdotal and the subjective opinions on the matter are just that: subjective. There is, at the same time, widespread agreement that empowerment of women is crucially necessary and terribly difficult to produce. On the other hand it is also widely assumed that to be poor, rural, Moslem, and a woman, in a country like Bangladesh, is to be powerless. But many of the women we met did not convey powerlessness at all. Because this is such an important issue and it appears that the WSG experience does somehow empower women, the FET recommends:

The URC study examined the behavior of WSG members, and that behavior may reflect the fact that they have been empowered, but the study did not attempt to determine or measure directly whether or not the women have been empowered. Empowerment is not a clear-cut matter, but the FET recommends that the BFO should seek out the best social science skills

available and recruit them to make a serious attempt to measure, in reasonably objective and quantitative terms, whether or not women who participate in the WSGs are significantly different from women who have not participated.

If those studies provide convincing evidence that empowerment does in fact occur in WSG participants, then the FET recommends that an even more serious effort should be made to understand what it is about the WSG participation that produces the empowerment. If it is truly happening, then it is needed all over Bangladesh, but if it is to be made to occur all over Bangladesh, it is essential to understand, to the fullest extent possible, how it happens -- or, what makes it happen. If that understanding is available, then it may be possible to empower women elsewhere in Bangladesh.

D. The Project Management Information System (PMIS)

Save the Children is not a research organization and was not created to compete for research grants. On the other hand the BFO managers recognized long ago that there is much that needs to be known about whether or not development and health projects actually produce the results that are intended, and often confidently, and naively, expected. They faced the fact that if we are really to understand what happens, how well or poorly projects succeed or fail, there is a need for in depth, quantitative documentation of what goes on, at the field level. With those needs in mind, and the support of SC managers and planners at headquarters in Westport, the BFO started the Project Management Information System in Dhaka -- providing the computers, the programs and the data processors that made it possible to take the data that flowed in from the field, process it, and make it available for tabulation and analysis.

There is no question whatsoever, that a computerized PMIS like the one in Dhaka is difficult to establish and maintain, complicated, costly, cumbersome and generally a bother. If the personnel running the PMIS do not understand clearly what it is the interventions consist of and what they are supposed to accomplish, the result may be that useless data are produced. What is worse, such a system can easily become an end in itself, rather than an effective means to find out exactly what is happening.

What the data managed by the PMIS, and processed in the BFO, shows about how the SC CS IV project is doing, and which of the program elements are new or surprisingly effective is abundantly clear in this report. Outcome measures produced by the PMIS, are far more complete, and convincing, than can possibly be obtained in the usual short term, small sample, cross sectional survey. What the PMIS makes possible, costly and cumbersome though it may be, is crucial if SC and other such agencies are to learn from their experience and improve program efficiency and effectiveness.

Recommendations on PMIS
The FET believes that the PMIS in the BFO is an essential tool as SC moves from simple service delivery and development activities toward studying and evaluating those activities to improve them. We recommend that the PMIS be continued and that the effort required to utilize its output be expanded.

BFO should review the existing FWA register and should incorporate aspects of it in BFO programs for consistency and sustainability. The usefulness of PMIS could be enhanced if it were expanded to include data related to maternal mortality.

E. Special Studies

In a vein similar to that regarding the PMIS, the SC CS IV project has benefitted from the willingness of the BFO managers to invest in the support of special studies of aspects of the development and health activities that cannot be adequately understood through the usual survey methods of evaluation.

Recommendations:
The FET commends the BFO on its willingness to support these studies as part of the final evaluation and recommends that other such studies that may be expected to contribute information that will be useful to program development or improvement should be funded. The further in depth studies of the effects of participation in WSGs, or of how such participation produces empowerment, if it is shown to do so, are examples of the studies that are promising.

IV. CHILD SURVIVAL IV PROJECT ACHIEVEMENTS AND ASSESSMENT METHODS

The Save the Children Child Survival IV (SC CS IV) project in Bangladesh is committed to measure the results achieved, as is the case with all AID/W-supported child survival projects. Like other CS projects the SC CS IV project carried out the standardized Rapid Knowledge, Practice and Coverage (KPC) Survey, developed by the Child Survival Support Program (CSSP) at Johns Hopkins, which is intended to provide quantitative data sufficient to assess the achievements of the project. Although the survey was designed to be useful in many settings and sounds like a simple process, in practice there may be problems. In the case of the SC CS IV project in Bangladesh, there were a number of factors that limited its usefulness; some of these will be discussed below.

Fortunately, the SC CS IV project had other sources of data and did not have to rely exclusively on the Rapid KPC Survey findings. From the beginning the staff of the SC Bangladesh Field Office (BFO) had invested heavily in the creation of a Program Management Information System (PMIS) and have maintained it carefully ever since. A key characteristic of this, and other SC CS projects is the fact that all families in the project catchment areas are registered at the start of the project and the family information becomes the baseline entry in the computerized database at project headquarters in Dhaka. Subsequently all vital data pertaining to every individual in the project area, as well as information concerning all project activities, including child survival interventions is recorded and sent to Dhaka for entry in the PMIS. Thus, in addition to the KPC survey data, there is a relative abundance of other reliable data to use for quantitative evaluation of the achievements of this project.

In this report the achievements of the SC CS IV project are documented and presented in several different ways:

A. Key Indicators of Child Survival Project Performance

The PVO Child Survival Technical Report, for April, 1993, from the CSSP at Johns Hopkins, presented a discussion of the Rapid KPC Survey and included (on page 8) a proposal for the use of seventeen key indicators of project performance. The list made sense to the FET and since it was "hot off the press" we decided to try it. It is presented below. One of the things we learned is that the CSSP Rapid KPC survey did not provide all of the data needed to measure the 17 "key indicators." This is one of the limitations discussed later.

KEY INDICATORS OF CS PROJECT PERFORMANCES

(As per Final K&P survey)

Distribution of Children by Age:

0-3m	=	94
4-5m	=	32
9-11m	=	67
12-23m	=	107

Appropriate Infant Feeding Practices:

1. Initiation of breast feeding:

	No.	%
* within 8 hrs. after birth	227	75.66
within 8hrs - 3 days	42	14.00
after 3 days of birth	25	8.33
can't remember	6	2.00
Total:	300	99.99

2. Exclusive breast feeding:

	No.	%
* 0-3m	52	55.3
4-5m	6	18.8
6-11m	3	4.5
12-23m	1	0.9

3. Introduction of semisolid/sloid foods:

Age	semisolid/solid	
	No.	%
0-4m	15	13.4
*5-9m	35	68.6
10-11m	26	86.7
12-23m	101	94.4

(# includes any or all responded 'Yes' to Q 11-c,e,f,g,h &i)

4. Persistence of breast feeding now:
(and being given solid/semi solid food)

	No.	%
0-11m	75	39.5
12-19m	78	94.0
*20-23m	19	100%

Management of Diarrhoeal Diseases:

5. Continued breast feeding during diarrhoea:

	No.	%
*More or same	48	65.75
Less than usual	20	27.39
Stopped completely	2	2.73
Not breast feed	3	4.10
	73	

6. Continued fluids during diarrhoea:

	No.	%
*Gave more or same	32	72.7
Gave less than usual	10	22.7
Stopped completely	2	4.5
Child exclusively breast feed	29	
	73	

(# of children exclusively breast feed were not included in the denominator)

7. Continued food during diarrhoea:

	No.	%
*Gave more or same	27	69.2
Gave less than usual	10	25.6
Stopped completely	2	5.1
Child exclusively breast feed	34	
	73	

(# of children exclusively breast feed were not included in the denominator)

8. Used ORT during diarrhoea:

	No.	%
*Used ORT	47	64.4
Used IV	1	1.4
Used anti-diarrhoeal medicine	42	57.5
	73	

(# used ORT includes any or all who answered 'yes' to Q22 - b,c&d).

Pneumonia Control:

9. Did seek medical treatment
(those who had rapid and difficult breathing)

	No.	%
*Sought treatment	64	82.1
did not seek treatment	14	17.9
	78	

Vaccination Coverage:
(Not true picture -as based on Card only)

10-12. EPI access and coverage by card (only 41.5% had a card)

*Children 12-23 had DPT1	48	44.9
*Children 12-23 had OPV3	42	39.3
*Children 12-23 had Measles	39	36.4
Children 12-23 had DPT3	42	39.3

13. Dropout rate [(DPT_1-DPT_3) / DPT1]x100 for 12-23m

$$= [(48-42)/ 48] \times 100 = 12.5\%$$

Maternal Care:

14. Maternal Card:
N/A (survey did not ask the question about maternal card for the birth)

15. Tetanus toxoid coverage: (33.3% had a card)

	No.	%
*Mothers who had 2 or more TT	72	72
Mothers who had 1TT record	26	26
none recorded	2	2

16. Mothers who had one or more antenatal visits:

	No.	%
Had ANC visits	226	75.3
Did not go for ANC visits	74	24.7

17. Modern contraceptive coverage:
(those who do not want more children within next 2yrs. = 287)

	No.	%
*Mothers contracepting	54	18.81%
Not contracepting	233	81.18%

B. A comparison of the findings from the Rapid KPC surveys in the CS IV project areas of Nasirnagar with the findings from the same survey carried out in new villages in Nasirnagar to provide baseline data for CS VIII.

At the start of CS IV, it was felt that a baseline survey was not necessary; at the time of the Midterm Evaluation of CS IV, the CSSP Rapid KPC Survey had not been completed. Thus, when the CSSP Rapid KPC Survey was used for the Final Evaluation, no exactly comparable data were available to use for comparison and to estimate change -- improvements -- over the life of the project. A Rapid KPC Survey was, however, carried out simultaneously in a number of new communities in Nasirnagar that have been selected for the CS VIII project. The SC CS IV staff in Dhaka suggested that the findings of this Survey could serve to meet the need for a baseline, or control population for CS IV. The two data sets were obtained, respectively, from "old" families living in the CS IV project areas of Nasirnagar and benefiting from the child survival interventions throughout, and from "new" families that live in similar circumstances in other parts of Nasirnagar, and will be included in CS VIII, but did not receive the benefits of CS IV. The SC staff proposed that the "new " Nasirnagar families, covered in the CS VIII KPC survey, could serve as a control population for the CS IV families; the FET concurred.

Both the SC staff and the FET recognize that there are several constraints on the statistical and epidemiologic validity of the comparison outlined above: confidence intervals calculated from the samples used in the K&P surveys are likely to be too wide to allow strict comparison of samples; moreover, the "new" Nasirnagar villages are not a true control -- there was almost certainly some "contamination" from the "old" villages in the "new" villages. Nevertheless, these samples at least let us observe whether there are trends in data which suggest that CS interventions may have had some impact.

See tables on the following pages.

COMPARISON OF THE K & P FINDINGS IN THE CS-4 AREAS OF NASIRNAGAR AND NEW BASELINE, THE CS VIII AREAS OF NASIRNAGAR THAT WERE USED TO PROVIDE BASELINE DATA.

N = 180 old NN (CS-4) N = 300 NNN (CS-8)

Mother's Characteristics:

		CS-4	CS-8
Data:	Mean Age	25.7 yr	25.9 yr
	WSG membership	48.6%	10.0%
	Child's mean age	8.8 m	9.0m
	Work away	2.8%	5.0%
	Involved in IG activities	14.4%	7.3%
	Types of IG. Livestock/poultry	7.8%	3.3%
	& small trade/shop	3.3%	0.3%
	Education: None	83.3%	81.6%
	Can't Read	85.0%	83.9%

Respondents in both the Cohorts under comparison seems to be comparable in terms of their age. education, and age of their last child.

There are differences in their WSG membership. working away. involvement in IGA and types of IG activities among the old and new areas which could be assumed as a result of the SC program. The WSG membership difference is clearly a result of SC's effort to organize WSGs. Self-employment opportunities developed or promoted by the SC program can explain higher involvement of the women in IGA activities and lower proportion of mothers moving away for IG activities in the CS-4 areas. It is also visible from the data that. in SC program areas - more women are involved with livestock poultry and shops or small trades than in the new area. This could be the result of the loan for IGA and IG extension activities of the SC program.

Health Awareness:

		CS-4	CS-8
Data:	Reported health		
	Problems: Reap	52.2%	50.3%
	Febrile	38.9%	36.7%
	D/D	36.7%	31.0%
	OB/GYN	5.0%	3.0%
	Arthralgia	22.2%	21.0%
	Others	23.3%	22.3%

* Average expenditure on health last month Tk.160.89 112.62

From the above data on reported health problems and expenditure made it could be assumed that people in the old areas are a bit more aware about health problems and care than in the new areas.

Note: Since the two cohorts are from the same geographic area. the disease prevalences are same. The slight differences in recognition of health problem in CS4 are may be due to some increased awareness.

# of Child

		CS-4(NN)	CS-8(NNN)
0-4m	=	59	88
4-6m	=	19	30
6m-1yr	=	33	63
1-2 yr	=	69	119
Total	:	180	300

Breastfeeding & Child Nutrition:

Data:	CS-4	CS-8
Breastfed first time after delivery:		
within 8 hrs	82.2%	67.3%
within 8 hrs - 3 days	8.3%	17.6%
after 3 days	8.3%	13.6%
couldn't remember	1.1%	1.3%
Exclusive breast feeding:		
0m-4m	56.0%	43.0%
4m-6m	21.0%	7.1%
6m-1yr	3.0%	9.5%
1yr-2yr	0.0%	5.8%
Feeding semisolid food:		
4m-6m	42.0%	20.0%
Giving Protein (egg, fish, lentils):		
6m-1yr	69.7%	53.9%
1yr-2yr	97.1%	73.9%
6m-2yr	88.2%	67.0%
Giving green leafy vegetable:		
4m-6m	15.7%	0.0%
6m-1yr	48.4%	26.9%
1yr-2yr	85.5%	63.8%

Mother's practices in terms of breast feeding practice and supplementation is better in the project areas than in the non project areas.

Initiation of breast feeding, exclusive breast feeding up to 4 month starting semisolid supple-mentation between 4-6m, supplementing with protein foods specially fish, egg lentils and giving green leafy vegetables are higher in project area than in non-project area.

Diarrhoea Management:

Data:	CS-4	CS-8
Last 2 wks. incidence	25.0%	29.3%
Breast feed - same or more	64.4%	57.9%
Fluid given more or same	82.1%	45.6%
Solid or semi solid given more or same	40.0%	17.0%
ORS sachet used	22.2%	20.5%
SSS used	35.6%	9.1%
I.V. fluid used	4.4%	10.2%
Anti diarrhoeal medicine use	55.6%	61.4%
No treatment given	6.7%	13.6%
ORT given (ORS, SSS, CBORS)	55.5%	29.5%
Signs to Cause seek Treatment:		
Signs of Dehydration (Sunken eye/dry mouth)	30.0%	16.7%
Prolonged Diarrhoea	43.3%	36.7%
Vomiting	51.7%	39.7%
Weak/Tired	50.6%	40.0%
Fever	17.2%	21.3%
Blood in Stool	1.7%	3.0%
Action would take if diarrhoea occurs:		
Administer ORS	75.0%	41.3%
Initiate fluid therapy	4.4%	2.7%
give the child more to drink	1.7%	3.3%
give the child smaller & more frequent feeds	10.0%	5.3%
take child to hospital	63.9%	58.7%
withhold food	1.1%	5.3%
Action would be taken during recovery:		
does not know	4.4%	13.7%
more food than usual	22.2%	13.0%
give food higher caloric content	52.8%	41.0%
give smaller more frequent feed	19.4%	22.0%

Diarrhoeal prevalence among the children was a bit less in the program area than in the non program area. It would be difficult to say whether this difference has been a result of CS intervention or not. Proportionately more mothers in the project area managed the diarrhoeal cases appropriately than the mothers in the non project area mainly interms of continuation and or increased breast feeding, oral rehydration; giving more or same food and fluid during diarrhoea of the child. Proportionately lower number of mothers using I.V. fluid, anti-diarrhoeal medicines and treatment may be due to the increased competence of the project area mothers than the non project area mothers.

The Data about the knowledge about signs and symptoms during diarrhoea that would cause them to seek treatment shows that the mothers in the project areas were partially better than the non project area mothers, but their knowledge in this regard was found to be incomplete also.

It seems from the data that knowledge about rehydration by ORT in the project area is more, but interms, the signs and symptoms that would cause them to seek treatment seems to be partially incomplete as seen from the two vital signs like fever and blood in the stools.

ADD KPC COMPARISON RESULTS HERE

Regarding the knowledge about action to be taken if diarrhoea occurs or during recovery from the answers it seems that the question were not clear to the respondents and mixed up or inconsistent answers were given by most of the participants.

Acute Resp. Illness:

Data:	CS-4	CS-8
Prevalence	22.5%	35.3%
Rapid/difficult breathing	97.4%	93.3%
Sought treatment	84.2%	59.2%
S/S that would cause seek treatment:		
Fast/difficult breathing	79.4%	69.0%
chest in-drawing	50.0%	40.0%
fever	18.3%	19.7%
cough	44.4%	35.0%
DK	3.9%	5.3%

Though ARI was not a component of CS-4 data shows the project area mothers were more aware about the danger signs of ARI and sought treatment more than the non project area mothers.

Immunization:

Data:	CS-4	CS-8
ever received immunization	58.9%	47.8%
over had a immunication card	55.3%	45.9%
knowledge correct age of measles	17.8%	8.1%
drop out rates: BCG -> measles	53.0%	57.9%
DPT1 -> DPT3	50.0%	46.6%

Maternal Care:

Data:	CS-4	CS-8
Correct knowledge why TT is given to P-mothers	70.6%	37.5%
ever had a TT card	57.7%	43.1%
pregnant now	1.1%	3.0%
intends to have the next child after 2 to more years	45.7%	39.6%
Uses modern method of contraception	13.0%	9.7%
Method mix (variety)	more (P+C)	less (S+)
Knowledge of food rich in iron	65.0%	36.5%
ANC practice	68.9%	21.3%
more food intake during last pregnancy	26.7%	10.4%
cord care by TBA	72.2%	50.8%
cord care by self/family member	25.0%	46.8%

Level of awareness and knowledge about different maternal care abd needs are more in the project area as indicated by knowledge about TT, birth spacing, nutritional needs during pregnancy etc. Important maternal care practices are also more in project area as indicated by birth spacing practice, ANC, food intake during pregnancy, dependency on TBAs who are more trained in project area.

Vitamin 'A'

Data:	CS-4	CS-8
Children (6m-2yr).ever received Vit 'A'	66.3%	35.2%
Mother knows Vit-A prevent night blindness	39.0%	52.9%

Vitamin 'A' distribution coverage among the target children are more in the project area than in the non-project area but the knowledge of preventing night blindness by Vitamin 'A' is more in the non-project area than in the project area which is covered by GOB program. One interesting thing here is in the non-project area the knowledge level is more than the coverage level, whereas in the project area the situation is reverse services were better but education or retention of knowledge was poor in the project area.

Growth Monitoring:

Data:	CS-4	CS-8
everweighed	24.6%	0.7%
have a growth card	18.4%	0.7%

Growth monitoring is not a priority area for GOB services, CS-8 area figures reflects the non-availability of the GM services. Since GM was one of the component of CS-4 and dropped the component afterwards the figure shows the ramnent of the old program of CS-4 roject. The two respondent in the non-project area who responded weighed and having a growth card might got it from other areas or may be from the project area.

C. Project achievements, as reflected in some of the PMIS data, including changes in the mortality rates

This is a sample of the data available from the PMIS that showed in quantitative terms, the achievements, year by year, in the target population of the SC CS IV project. The FET found an astonishing wealth of data, documenting project activities, participation and coverage rates, and outcomes. Surely the most revealing, in a child survival program, are the changes in infant and under 5 mortality that occurred during the life of this project. Thanks to the PMIS it was even possible to prepare estimates of infant mortality by cause, which revealed, among other things, that deaths from immunizable diseases declined substantially. No less interesting are the estimates of the decline in the total fertility rate that have occurred in the project area.

See tables on the following pages.

YEAR BY YEAR PROJECT ACHIEVEMENTS AS SHOWN BY PMIS DATA.

Major Objectives/Activities: (as per PMIS)

1. Area expansion:

a. Area expansion — CS-IV

	1988	1989	1990	1991	1992	1993
Population	49406	55511	59661	74289	75072	75706

2. Community Organization (WSGs)

Impact Area	# C+D Household	# of HH in WSG	%	# of WSG	# of members
Rangunia	1374	730	59.2	61	976
Nasirnagar	5652	3362	70.1	202	3789
Ghior	1364	800	58.6	76	1301
Mirzapur	696	488	59.5	42	750
BFO	9086	5380	53.1	381	6816

(% of total Household = 41.4%)

3. EPI

	1987	1988	1989	1990	1991	1992	1993
Completed by 11 month (%)	9.1	28.3	43.6	72.5	72.1	7.3	55.1
complete coverage 9-23 months (%)	43.0	73.0	84.0	87.0	83.0	83.0	
TT2 coverage (15-45 yrs) (%)	36.8	68.8	87.7	90.5	90.6	90.1	87.7

4. Diarrhoea Management

	As per MTE	As per FK&P
Competent	96%	78.7%
Used	100%	64.4%

5. Nutrition:

	1987	1988	1989	1990	1991	1992	1993
% 6-36m weighed	76.0	88.0	93.2	90.7	88.6	82.2	0.0
5 <36m regularly weighed	15.1	49.2	62.2	60.1	59.1	0.0	
% VAC			87.6	87.0.	3.0	93.0	

6. MCH:

	1988	1989	1990	1991	1992	1993
% of Preg. mothers brought under PMP	44.9	67.4	70.1	79.2	79.4	78.2

7. TBA training status as of January, 1993

Area	# TBA	# Training. 21 days	%	# Training <21 days	%	# Total any trg..	%
Rangunia	32	32	100	00	00	32	100
Ghior	13	13	100	00	00	13	100
Mirzapur	36	36	100	00	00	36	100
Nasirnagar	268	268	36	90	33	188	70
Total	349	349	51.3	90	25.3	269	77

8. Birth Spacing

	1988	1989	1990	1991	1992	1993
CPR	36.0	36.4	43.4	44.2	44.1	44.7

9. Sanitation Status of old area as of 30 June'93

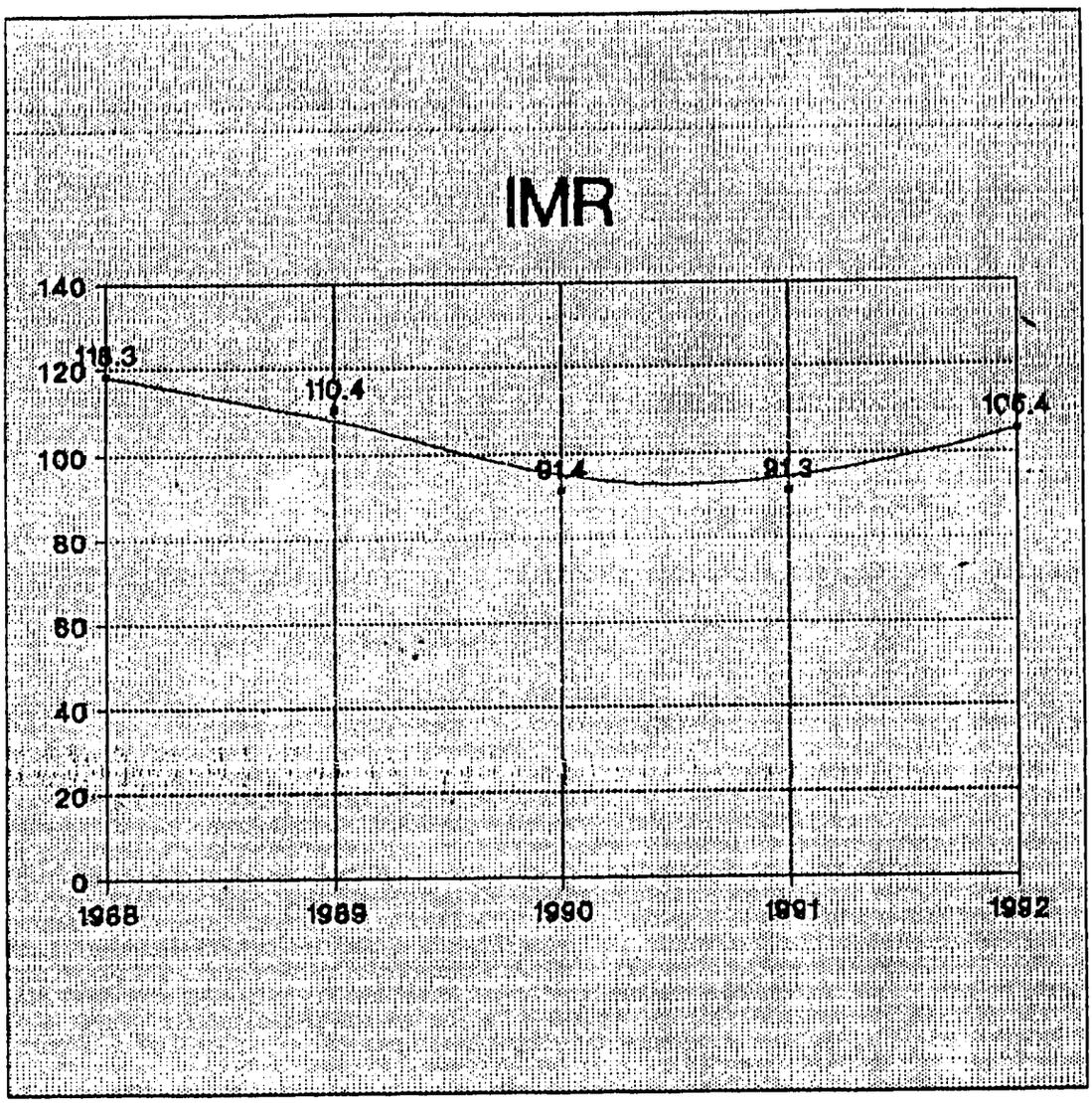
		#	%
Tubewells:	Functional	1788	96.4
	Non-Functional	67	3.6

HH/TW = 5.2/TW

Safe Latrine	# HH Have	%	# HH don't have	%
	2388	25.8	6887	74.2

10. Cause specific death for children under one year (% of deaths)

	1988	1989	1990	1991	1992
# of death 0-1 year	202	181	153	146	161
Diarrhoeal Disease	11.4	4.9	9.1	6.8	11.8
ARI	29.2	29.8	28.7	32.2	24.8
Malnutrition	9.4	6.1	4.5	10.0	7.4
Febrile	2.5	6.1	2.6	3.4	3.1
Birth Related	23.7	37.6	30.1	30.8	35.4
Immuniz. disease	11.4	4.4	2.6	2.7	1.8
Skin Infection/septicaenia	2.0	4.9	5.2	6.1	3.1
Accident/Trauma	2.9	2.2	0.6	0.7	0.6
Oral Thrush	-	-	-	-	2.5
Others	7.9	3.8	16.3	6.1	4.3
# LB	1708	1639	1674	1598	1528
IMR	118.3	110.4	91.4	91.3	105.4


IMR
140
120
100
80
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118.3
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1988
1989
1990
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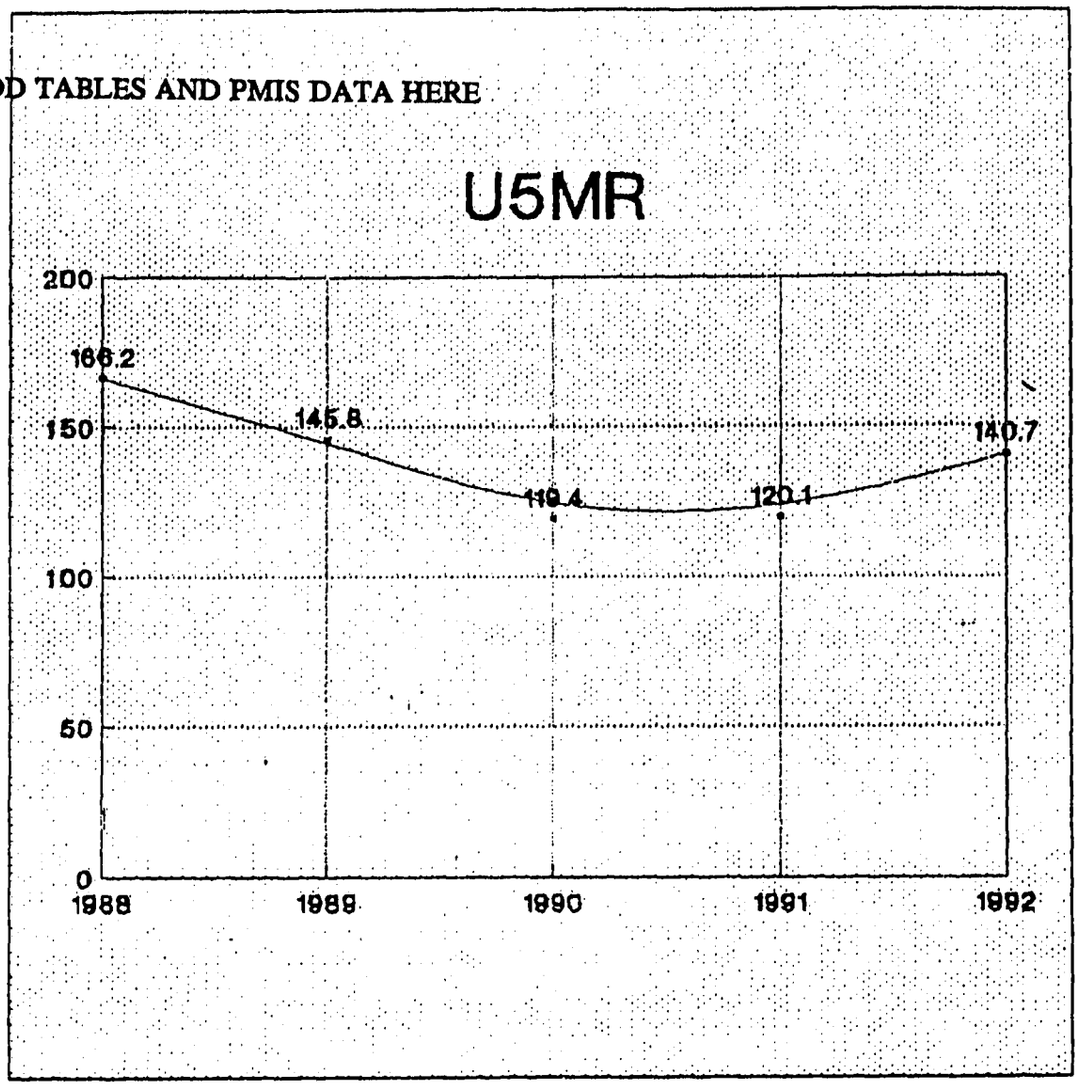
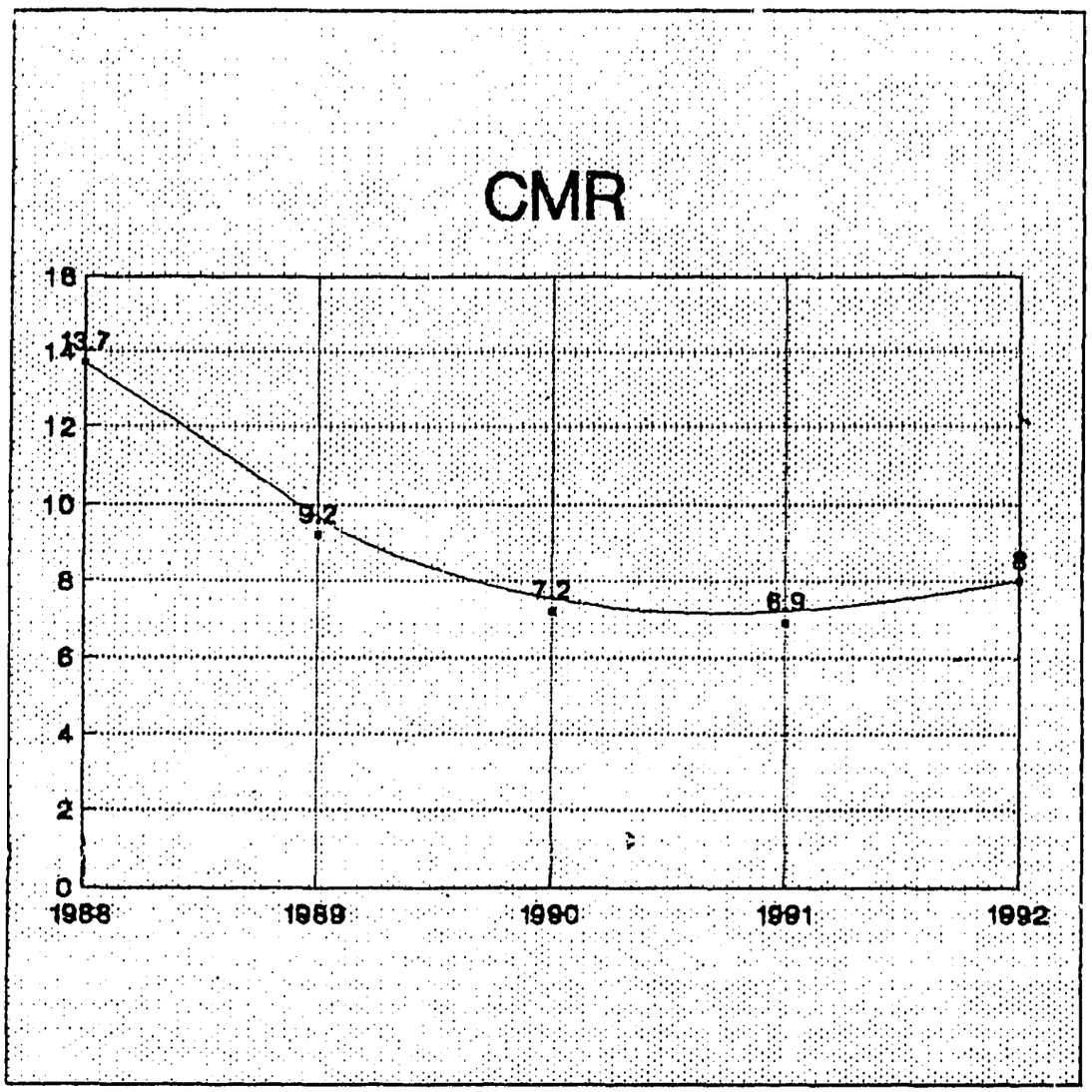
1992

ADD TABLES AND PMIS DATA HERE




CMR
16
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13.7
9.2
7.2
6.9
8
1988
1989
1990
1991
1992

D. The nutritional impact of growth monitoring and a comparison of the nutritional status of children who were enrolled in the food supplementation program of the CS IV project with that of those who did not receive supplementation.

There is very little -- the temptation is to say there is nothing -- that is better documented regarding child survival in countries like Bangladesh, than the association between severe malnutrition and mortality in young children. In fact, one of the earliest and best studies of this association was carried out at the IDDR,B in Bangladesh (Chen, et al, Am J Clin Nutr 33: 1836-1845, 1980). Chen and his colleagues showed that Bangladeshi infants and young children who were severely malnourished are many times more likely to die than those that are adequately nourished. Their findings have been confirmed in Bangladesh and in many other countries. Given the critical importance of nutrition, the results of the SC CS IV activities in growth monitoring, vitamin A supplementation and the provision of food supplements to high risk infants and young children are of special interest. For that reason SC staff, both in Dhaka and also in Westport, are committed to producing a careful and detailed analysis, made possible only by the PMIS. Please refer to Figure 1 in section IIIB.

E. The complete findings of the Rapid KPC Survey, published as the Child Survival 4 Final Survey Report and included here as appendix 4.

This is the presentation of the complete findings from the Rapid KPC Survey carried out in February of 1993. As noted above the value of the information obtained in this Survey was seriously limited by several factors and they bear discussing at this time. One of these had to do with the timing of the Survey; others had to do with the KPC Survey methodology and the questionnaire.

F. Project Achievements vs. Project Objectives

(A comparison of project achievements and objectives is Appendix 9.)

V. PROBLEMS WITH THE RAPID KPC SURVEY:

A. The timing of project termination and survey execution

In the summer of 1992, in anticipation of the completion of the CS IV project, and the need for self-sufficiency and development of a sustainability strategy, major changes in program were carried out. Among other things the field staff were notified that they could not be carried over to the CS VIII project and that their employment would necessarily be terminated at the end of the CS IV project. Understandably this news had a significant impact on the morale and performance of the field staff. This took place in August and September of 1992 and the Rapid KPC survey was not carried out until February of 1993. Thus there was a period of about six months when field staff performance had fallen off. The University Research Corporation, (Bangladesh) study, Health Care Services Utilization and Behavioral Pattern in Save the Children (USA) Catchment Areas (See Appendix 5 for executive summary; the entire monograph has been submitted as a separate document), that utilization of services in this project was significantly provider driven; when the providers quit driving, service utilization fell off and this is apparent in the findings of the survey.

B. Sample Selection

In the training for the Rapid KPC survey, SC staff in Dhaka were instructed to select their sample for interviews from households in which there were babies under 2 years of age. In households where there were two such children, they were instructed to ask the survey questions with regard to the younger of the two. This had the effect of biasing the sample toward younger infants, and eliminating older siblings that were still under two. This is apparent in the age of the infants covered in the survey:

Age in months	Number	%
0- 5	126	42
6 - 11	67	22
12 - 17	77	26
18 - 23	30	10

This skewed sample had two important effects on the information that was obtained in the survey. First, because project effort had diminished very considerably in the six months prior to the survey, as noted above, it meant that many of the babies under 6 months of age had not been included in any of the project activities, thus having the effect of making performance look worse than it had been when the project was in full operation. Second, on the other hand, since the very young are breastfed and relatively healthy, it meant that the sample surveyed did not include a proportionate share of the older infants, more likely to have had infections or to be malnourished although that would not necessarily show up in the survey findings.

C. Survey Content and Methodology

Some of the problems encountered had to do with the survey questionnaire itself. The SC project staff in Dhaka and the entire FET agreed strongly that the problems made it difficult to use the data generated by the survey and also limited its value in measuring the effectiveness of the projects. Among the specific items, aside from the methodologic problems in sample selection that are mentioned above, that the FET believe require review and revision are the following:

* The "standard" Rapid KPC Survey that was used in the project areas had been translated into Bangladeshi before it was sent to Dhaka. According to Bangladeshi staff members of the SC team in Dhaka, the translations were not always appropriate or clear and they felt that the questions sometimes confused the mothers being interviewed, and the interviewers as well at times. At the time the survey was carried out the staff were told that the survey was standardized and should not be altered.

* In other cases, the questions asked do not cover the specific information that is needed, and it is necessary to try to calculate the data. One example of this is the matter of whether or not the baby is still breastfed exclusively. That question as such is not asked. Moreover, in Bangladesh, essentially without exceptions, mothers give the newborn baby water or something else in the first few days after birth. Thus, even though the baby is breastfed exclusively for some months after that, it cannot, in a literal sense, be said to be exclusively breastfed from birth. This was a source of confusion.

* To cite another example, although the PVO Child Survival Technical Report for April 1993, as mentioned above, recommends that the percent of mothers with a maternal card for the birth of the youngest child less than 24 months of age be used as a "key indicator", and in spite of the fact that the SC CS IV project had prepared a

maternal card and used it faithfully, there was no question in the Rapid KPC Survey that elicits this information.

* The fact that good nutrition is of crucial importance to infants and young children, and is a focus of concern in child survival projects, is reflected by the number of questions in the Rapid KPC survey that are devoted to breastfeeding, the consumption of various foods and to growth monitoring. In spite of this, the survey yields no useful information whatsoever concerning the actual nutrition status of the children covered. Moreover, the food consumption questions are notoriously useless. Nutritionists have long since learned that qualitative data of that sort prove nothing about the actual nutrient intake, but may in fact be misleading by giving the impression that children are being given the food they need when quantities are totally inadequate.

* Hundreds, if not thousands of field surveys, carried out under all kinds of adverse conditions, have shown that it is possible to weigh and measure infants and young children and make useful estimates of their nutrition status. If those who are concerned about child survival are serious, and are aware of the importance of nutrition, it seems essential to determine whether or not the USAID/PVO child survival projects are or are not having any useful impact on malnutrition. Only when that kind of information is available is it possible for project managers -- and project back-up teams in the various PVO headquarters, as well as the CSSP team in Baltimore and concerned USAID staff in Washington -- to take the necessary corrective measures if the project is not effective and if, again, we are serious about nutrition in child survival projects. (It must be added that, thanks to the PMIS in Dhaka, it is possible to measure the impact of growth monitoring and food supplementation in the CS IV project.)

The selection of the sample from among mothers of children younger than two years means that the prevalence of contraception may be underestimated.

VI. FINDINGS FROM FIELD VISITS

The CS IV project carried out activities in four areas: Mirzapur and Ghior, to the northwest of Dhaka, in Nasirnagar to the northeast, and in Rangunia, southeast. As noted elsewhere, the SC team in Bangladesh has decided to phase out the CS activities in Ghior and in Mirzapur now, in Rangunia over the next year, and not only to continue but also to expand CS activities in Nasirnagar in the SC CS VIII project. The reason for this is that Nasirnagar is recognized as the poorest of the four project areas and far and away the most needy.

Because the FET had very limited time to carry out the final evaluation, the decision was made to limit field visits to the project areas in Nasirnagar. Accordingly, Drs. Yasmin Ali Haque, Nilufer Kamroze Jaha, and Joe Wray, accompanied by Dr. Najma Khatun of the SC staff in Dhaka, visited the field sites. Dr. Abul Barket, who had spent many weeks in Nasirnagar, directing and carrying out the special studies that SC/BANGLADESH commissioned the URC,B to do, did not participate in the field visit, nor did Dr. Kabir Ahmed.

Most the time in the field was devoted to discussions in Kunda, where the field headquarters was located, and in the town of Nasirnagar, where we met the Thana Medical Officer and his staff and visited the Thana hospital. Please see appendix 8 for the focus group questions used.

Again because of limited time, rather than attempting to carry out detailed interviews with individuals, focus group discussions (FGDs) were arranged with groups representing the relevant members of the community. FGDs were held with Village Development Committee

(VDC) members, members and leaders of Women's Savings Groups (WSGs), with CS IV project field workers, and with a number of GOB health officials.

A. Village Development Committees (VDCs)

The members of the Kunda VDC were invited to meet the FET. The group comprised an elected chairman, elected sectoral (women's, youth and landless) representatives and nominated members (agriculture, education). The group included one of the larger landowners in the community, who had donated the land on which the secondary school was built. The group were jubilant over the fact that a boy in their school had place second nationally in the science placement test.

The VDC perceived itself as the link between SC and the community. They are consulted before any intervention is to be designed or implemented. Individual or group loans are also sanctioned with the concurrence of the VDCs. The loan programmes have helped in the betterment of the socio-economic condition of those who have invested wisely. The VDC were able to give specific examples:

* One man from a 'D' category family had invested his loan money in setting up a kerosene and mustard oil business and his household is now rated category 'B'.

* A woman from a 'C' category family had used her loan to make containers for fodder, salt, etc. out of cement. Her success enabled her to open a 'sales centre' in the Thana headquarters where sent her husband to run the business and she even purchased land. However, she is now in a disadvantaged position. Her husband left her for another woman, remarried and she had to sell her land to meet the fees for legal support for her son. But, she has not given up -- her husband is back in her "control", she has set him up as a roadside vendor (accountable to her) and she is now applying for a fresh loan.

Involvement in the VDC has reportedly brought about a change in the health behavior of the members. Limits to such change were reported, however: one of them has had six daughters in hope of a son.

VDC members who participated in the FGD.

1. Haji Ahad Ali, Chairman
2. Mr. Akkas Ali Mollah
3. Mr. Ayub Ali Mollah (landless sector member)
4. Ms. Falumia
5. Mr. Shahnewaz, Headmaster, Private School
6. Mr. Hakim, Youth sector member
7. Ms. Tahera, Women's sector member
8. Ms. Sufia, Women's sector member
9. Shirajul Hoque Munshi, Vice Chairman (Agri. sector member)

B. Discussions with Women's Savings Group (WSG) Leaders.

On the day of the FET's field visit, Group Leaders of five WSGs came to the SC office together with their area WSG sectoral leader with an application for SC assistance in rebuilding houses washed away and damaged by recent floods. This provided and opportunity for talking to a group of highly motivated women, who were in no way intimidated by the presence of "outsiders" (including a foreigner.)

The women interviewed represented groups that had been functional for three to seven years. They perceived "empowerment" as the main advantage of group formation and activities. In the beginning they had faced opposition from husbands and in-laws. In the early days people (men) made fun of them as they went to meetings; now they make way for them. Their views and opinions have an impact on household decision making and not only do they have more self-esteem, but also they feel that their status is enhanced.

The economic benefit from being involved in the WSGs has varied. The savings are perceived as an asset as it makes them eligible for group as well as individual loans. Sale of vegetables (from home gardens), eggs, poultry and rice (put aside from daily rations) are the main sources of money for the women to contribute to the savings funds. The money is collected during the monthly meetings of the WSGs and deposited in the groups account in a commercial bank

The WSG members typically are from the poorer to poorest families of the community and are mostly illiterate. Through participation in the adult literacy programme of SCF they are now able to sign their names, but remain dependent on the SC staff as in most groups even the secretary/treasurer is uneducated.

There is no question that WSG members perceive the need for educating their children, and especially their daughters. However, in practice this is not always possible. There is no charge for primary education and the necessary books are free and for girls this is extended to class VIII, but most families are unable to afford the requisite "decent clothes" and recurrent costs for notebooks, pencils, etc.

Protective health behavior is a matter with which the WSG members are quite conversant. They confidently describe the health practices promoted by CS IV field staff and claim to have changed their practices accordingly. According to one group leader, "... even our dumbest member will be able to answer your every query confidently ..." The WSG members believe that their "changed" practices have resulted in improved health and nutritional status of their children, given the economic constraints that they face. The group members see themselves as "health focal points" for their communities because people tend to consult them for advice.

One of the most impressive things reported by these women is the fact that in some communities members of the WSGs have banded together to form committees against the physical abuse of women by their husbands, which is common in many of the villages. When women stand alone, they are essentially powerless; working together they are not afraid to speak out and in one case the group united, reported a serious abuser to the authorities, and were successful in having him convicted and jailed. This might be considered the most convincing measure of the "empowerment" achieved by this group of poor literate women.

WSG members who participated in the FGD

1 Ms. Anwara Begum, Chairman & WSG leader
2 Ms. Halima Begum, Paira group member
3 Mr. Toa Chan, Vice Chairman of Paira group
4 Mr. Safar Chan, Champa group member
5 Mr. Par Chan, Dalim group member
6 Ms. Kamala Rani, Fulmala group member
7 Ms. Arak Chan, Tia group member

C. Discussions with GOB Health Officials Concerning SCF's CS IV Project Activities at Thana Level:

It was revealed from the discussions with the thana level health officials revealed that they seem to be very positive about SCF's CS project activities and their impact. Dr. Shahidul Hoque, Nasirnagar Thana Health Administrator, cited one example: because of the lack of electricity for the last four month (i.e., May to August) they could not provide EPI services in all unions, but with the help of the SCF project team, they have been able to continue EPI services in the SCF CS project area. In the remaining unions, when electricity is available again, they will be able to devote all their efforts to overcoming the backlog.

Even though the SCF CS project has shown some positive outcomes, the GOB officials feel that there should be more collaboration to strengthen SCF CS staff knowledge and effort to improve MCH-FP services, i.e., to clarify each other's roles in order to best be able to work efficiently "hand-in-hand" to achieve the best results.

Dr. Abdus Samad, In-charge Thana family planning officer, suggested that during GOB's FWA monthly orientation meeting CS staff could be invited to share their knowledge and skill, so that uniform messages can be provided to run improved MCH-FP programme at the field level.

1. Supervision & Monitoring of SCF's CS staff:
GOB officials expressed their satisfaction with SC staff because both field and supervisory staff are always found by GOB to be present at their working place and also available to share ideas about project outcomes and improvement.

2. Sustainability:
In this respect GOB officials did not make any positive comment. However, they mentioned some factors that result in non utilization of health facilities, such as:

* long distance of health facilities from client residence
* inconvenience of transport as well as cost
* non availability of adequate medicine
* inadequate logistical support
* vacant posts

They feel that an increase of community health awareness will result in increased utilization of the available govt. facilities by the community.

3. Commitment about Collaboration:
In this regard they said they have already organized one joint workshop with SCF for the improvement of MCH-FP performances at the thana level.

Mr. Zatindra Chandra (ATFPO) mentioned that they have also some future plan for area demarcation among GOB and SCF and assign specific responsibility to the worker for specific task. This activities are in process.

Beside this GOB officials also mentioned that considering the low literacy rate , low per capita income and poor road communication system in Nasirnagar there is need for special programmes to overcome these problems. Due to a lack of electricity, mass media programs have had little outreach and affect.

Moreover, the strong commitment of the SCF staff also encouraged them to be more committed to further collaborative effort towards improvement of health system of the people in this thana.

GOB Staff interviewed

1. Dr. Shahidul Hoque, THA, Nasirnagar
2. Dr. Abdus Samad (MOMCH-FP and In-charge TFPO)
3. Mr. Zatindra Chandra (ATFPO)
4. A FWV, whose name was not recorded (MCWC)
5. Manowara Begum, FWV (rented FWC)
6. Maya Rani, FWA

D. Discussions with CS IV field workers (VDW & PDT)

Discussions were held with community level workers who were presently reemployed as the SC MotherCare project staff. These workers had received basic training/orientation upon recruitment and special training from time to time depending upon the needs of the program. These field workers realize that training is a continuous process, however, they felt that the training they received was sufficient to enable them perform their prescribed jobs/responsibilities.

The field workers feel that their job was difficult to execute at the beginning of the project and it had become easier with time. The community as a whole is now more supportive of their efforts and they now serve as health care advisors/focal points.

The field workers regularly met with their supervisors and local area office staff and there was a well established system for monitoring and feedback on performance.

As part of the SC phasing out process some of these workers had been provided with loans intended to allow them to generate some income which would serve as an incentive to remain within the area and continue to promote protective health behavior.

SCF Staff interviewed

1. Mr. Kolimullah Koli, Impact Area Manager
2. Mr. Nurul Amin, Medical Assistant (Community Health Organizer-CHO-PHC)
3. Mrs. Gita Pal, Community Development Organizer
4. Mr. Salam, Community Development Coordinator
5. Mrs. Rowshan Ara Begum, Medical Assistant (CHO-MCH)

Family Health Promoters

1. Mr. Morshed Kamal
2. Mr. Pantash Core
3. Ms. Amena Begum
4. Ms. Sarna Rani Sarkar

VII. LESSONS LEARNED FROM SPECIALLY COMMISSIONED STUDIES.

A. URC Study Findings from Health Care Utilization and Behavioral Pattern in SCF's Catchment Area

(Please see appendix 5 for executive summary; entire monograph has been submitted as a separate document.)

Shows:

1. Percentage distribution of the sources of preventive health services utilized by MWRAs in the community.

1.A. Persons with whom they discuss health related problems.

	Nasirnagar %	Total SCF Area (Pg-22) %
a) Neighbors	44.8	48.7
b) NGO workers	43.1	39.1
c) Village doctors	20.7	18.2
d) Don't discuss with anybody	22.0	24.5

1.B. Health Service Centre/Providers contacted.

NGO workers	28.0	30.7
Clinic	47.0	42.7
Village doctor	37.9	27.6
GOB workers	3.9	5.5
THC/FWC	8.6	10.4
Registered Physicians	10.8	9.9

2. Percentage distribution of sources of health care which MWRAs contact most often for treatment of diseases at preliminary or primary and at later critical stages.

2.A. Health Centre/Personnel Contacted:

2.A.1. Preliminary stages:	Nasirnagar %	Total SCF Area %
Thana health center	6.9	5.5
Family welfare center	3.9	2.9
Govt. dispensary	0.4	3.9
NGO clinics	49.6	53.9
Village doctors	57.8	52.6
Spiritual healers	1.7	2.9
Registered physicians	3	2.9
District hospital	--	1.3

2.A.2. Critical Stages:

Thana health center	55.6	43.2
Family welfare center	1.3	0.8
GOB dispensary	4.3	8.4
NGO clinics	29.3	28.4
Village doctors	9.1	12.5
Spiritual healers	12.9	12.2
Registered physicians	0.4	0.5
District hospital	--	6.3

All these above findings also support the feeling of GOB officials regarding the need to improve facilities utilization and consultation for services.

B. URC: Study of the Impact of the Workshop on Family Planning, conducted with the traditional and religious leaders in Nasirnagar thana by SCF (USA)

(Please refer to appendix 6 for an executive summary of this monograph. The entire monograph has been submitted as a separate document.)

Lessons Learned:

* The overall contribution of the workshop in terms of net-effect was 28.4% CAR.

* Out of 12.7% points increase in CAR, 3.61% points was due to net-effect of the workshop.

Recommendation:

If the SC replicates this type of workshops in the future, there should be ample scope for more in-depth studies, incorporating all possible variables and indicators so that the relative contributions of all possible factors can be identified. Such workshops should deal with the issues identified as problems faced by the participants in motivating the target groups. To increase the effectiveness of the information dissemination points, satisfied clients, among others, should be included in the selection of workshop participants.

C. URC study: Participation in Women's Savings Groups and implications for Health Care Behavior in Save the Children (USA) Catchment Areas (Please see appendix 3 for an executive summary of this monograph. The entire monograph has been submitted as a separate document.)

Highlights of the findings:

* WSG members had a mean of 1.5 years of schooling (p. 11).

* 80.5 percent of husbands had a "highly positive" attitude to wife's participation in the WSGs (p. 19).

* 41 percent of current WSG members were currently using contraceptives, compared with a usage rate of 37 percent of women who had dropped out of their WSG,34 percent of women who had never belonged and 15 percent who had adopted permanent contraceptive measures (p. 22).

* 87 percent of the WSG members chose to consult a qualified practitioner when there was severe illness in their family (p. 22).

* 79 percent of WSG members who had been pregnant had received the TT immunization (p. 23).

* 89.5 percent reported that they always gave ORS to their children in case of diarrhoea (p.24)

* The WSG members enjoyed higher mobility (p. 25).

* WSG women considered themselves less dominated their husbands and felt that they have an enhanced role in household decision making (pp. 26,27).

* WSG members disseminate messages concerning health care and health promotive behavior that they have learned to others (p.36).

* There is a higher degree of health consciousness among WSG members (p. 36).

Lessons Learned:

* There are positive indications that health related behavioral change among WSG members is sustainable, if there are:

* Repeated training and reinforcement of messages.

* Frequent contacts with service providers.

* Assistance to others in establishing contract with service providers.

* Dissemination of knowledge.

* Internalization of protective health behavior.

The potential for financial and managerial sustainability of the WSGs as an institution is low because:

* WSG members come from poverty stricken families and communities

* WSG members have limited education.

* Managerial skills are lacking.

D. BASELINE SURVEY CS-8

1. Literacy

a)	No schooling	18.0%
b)	Can read one sentence	16.4%
c)	1 to 5 years schooling	82.0%
d)	6 to 8 years	12.0%
e)	9 or more years	2.0%

2. Main Health Problem

a)	Respiratory	31%
b)	Fever	22.3%
c)	Diarrhoea	19.1%
d)	Ob/Gyn	1.8%
e)	Rheumatoid joint problem	13.2%
f)	Other	12.6%

3. Money spent last month for health services

a)	Mean	115.19 taka
b)	Range	0 - 1600 taka

4. How soon should a women see a health professional when she becomes aware that she is pregnant?

a)	Does not know	32.7%
b)	No need to see health worker	14.3%
c)	Last trimester (7-9 months)	7.3%
d)	Middle of pregnancy (4-6 months)	22.9%
e)	First trimester (1-3)	22.9%

5. During last pregnancy amount of food ate?

a)	Less than usual	60.0%
b)	Same as usual	27.7%
c)	More than usual	10.3%

6. At the time of delivery who tied the cord?

a)	Themselves	40.0%
b)	Family member	11.0%
c)	TBA	45%
d)	Health Professional (Midwifes Physician)	2.8%

Considering all these factors and for sustainability reasons the team recommends that strong collaborative efforts be taken for maximum utilization of GOB's health and family planning facilities and also the development manpower for improvement of MCH-FP program at the local level.

E. LESSONS LEARNED FROM SUSTAINABILITY CONSULTANCY

Please refer to appendix 7 for an executive summary of Dr. Bert Hirschhorn's consultancy report. As per Dr. Hirschhorn's recommendations on programs and policies on sustainability, the team recommends:

* Utilize WSGs as an indigenous network with intermittent technical assistance from SCF.

* Put all SC effort in Nasirnagar into expanding the MCH-FP program as much as possible, since there are practically no other NGOs working in this area with health and family planning, little government service, the need is great and SCF experience is solid.

* Put emphasis on locating the records of high risk pregnancies detected and referred and determine their outcomes.

* Document the evidence of complicated pregnancies that were not detected though a visit was made.

* Document the evidence of inadequate referral services.

* The Government's FWA register should be followed for record keeping so that it could serve the purpose of both GOB and SCF's interest of valid documentation and also for sustainability reason.

Dr. Hirschhorn states that:

* "Anything that increases the people's capacity for self-sufficiency, including the capacity to demand their rights, is a step toward sustainability.

* Anything that improves and endows the capacity of government is a step towards sustainability.

* Anything that contributes to the knowledge of development is another step.

* The tools for moving progressively toward sustainable development include:

  - conscientization;
  - increasing leverage of power by coalitions of those with little power;
  - redress of operation;
  - cross-subsidies;
  - endowment trusts;
  - increasing total wealth and ensure enough income to get beyond day to day subsistence and health;
  - repair and maintenance of environment."

In the past SCF's work was limited to a small area. Now the time has come to expand SCF's working area with an intensive program.

More capacity is needed in writing up ideas and results for the scientific and development communities.

VIII. SUMMARY: LESSONS LEARNED AND RECOMMENDATIONS

A. Management and Project Operation:

1. The fact that SC had well established and well supported community development activities going on in the project areas, well before the CS activities began to be implemented is important to the success of the latter. The integrated approach of SC programme activities, combining community development and CS has served to strengthen both and has facilitated the achievement of the CS objectives, e.g.:

* The attainment of targets on safe water and sanitation has been possible through the SC water and sanitation programme activities.

* The formation and function of WSGs and provision of income generation activities.

2. When time-bound quantitative goals are driving the project, then baseline figures are essential for evaluating the output. However, when the project has a relatively short life span with time-bound target oriented objectives, then long-term vision of PVO planners and managers is distracted and their ability to address the issues of sustainability are severely limited. Thus, project objectives should stress more than just target numbers and need instead to include sustainability goals. Where sustainability is major concern, activity plans for the

phase out should be part of DIP and goals which should be stated in quantitative terms, covering, for example, such issues as:

* Certain phaseover activities.

* Cost recovery targets.

* Community contributions.

3. There is clearly a need for some standardization of the planning and evaluation tools that are required by USAID and promoted by the CSSP at Johns Hopkins. There is also a need, however, for sufficient flexibility to allow adequate adaptation to local conditions and requirements. This, as noted above, was especially true with regard to the Rapid KPC questionnaire, which both the SC BFO staff and the FET considered to be poorly adapted to some conditions in Bangladesh and did not easily yield the specific quantitative data needed to measure project achievement.

4. This evaluation would have been much less satisfactory if the special studies commissioned by the SC BFO and carried out by the University Research Corporation (Bangladesh) had not been available. They provided a wealth of information, both qualitative and quantitative, that has been especially useful to the SC program management and was also immensely helpful to the FET. This report cannot possibly include more than a fraction of the information nor give adequate space to the implications of some of the findings. As noted elsewhere, the FET warmly commends the SC BFO for carrying out these studies, and SC headquarters in Westport for supporting them. We believe that such studies provide a model of the kind of in depth information that is essential to understand what is really happening in the field and strongly recommend the continued support of such studies by SC.

5. Detailed and quantitative information produced by the Project Management Information System (PMIS) was also of tremendous help to the FET in carrying out this evaluation. There is no doubt that such a system is expensive and at times burdensome to the staff. It is also true that there is such an abundance of data that it may seem overwhelming and difficult to assimilate, and the information is by no means always well used. As can be seen in this report, however, there are things that can be demonstrated with such data that are simply impossible otherwise. It can be argued that if PVOs are going to be involved in countries like Bangladesh, they should go beyond simple minded delivery of services and use their resources and skills to carry out operations research for which a system capable of producing just such solid and comprehensive data is essential..

6. Valuable as a sophisticated PMIS may be for purposes of careful evaluation or to support operations research in improving health care delivery, it was clear from the CS IV project that at the field level the manually kept and processed records were more useful on a day-to-day basis and proved to be a more effective management tool. Similarly, although a consolidated record system might seem to be more economical and convenient. In practice that was not the case. Field staff kept more reliable records when separate simple registers were maintained for each intervention activity.

7. Major changes in the CS IV project strategy as it moved into the "no cost extension", strongly affected project impact or achievement. Strategic decisions, made by the project management in order to make the overall project more sustainable, included attempts to make service delivery less staff intensive, and the cessation of the delivery of curative PHC services (except for those included as part of the MotherCare Project). Unfortunately, these changes, among others, resulted in an immediate decline in measurable outcomes related to quantitative DIP objectives. This shows more clearly than any other aspect of the project the contradiction

between the need for sustainability of such projects and the quantitative goals that have been called for in the DIP guidelines. Clearly when there are significant changes in program strategy, then program targets need to be reconsidered and redefined.

8. Influence at the national level depends in part on PVO size and political clout, but it also depends on reputation, which is based mainly on performance. The BFO of SC has a formal agreement and relationship with the Ministry of Local Government and Rural Development, but not with the Ministry of Health and Family Welfare. This impairs project effectiveness in health and family planning activities and should be corrected, primarily because Thana level health officials are not sure of the status.

9. On the other hand the SC CS IV project has an excellent reputation with GOB health officials at local levels where collaboration depends more on personal relations. Local GOB health officials clearly recognize the contribution of SC CS IV to their EPI performance, for example. Similarly, at the national level, or rather in the PHC community in Dhaka, the SC CS IV project has an excellent reputation for performance in growth monitoring and food supplementation and is acknowledged by UNICEF officials and others as the best model in Bangladesh for the proposed World Bank loan-supported nutrition program. It is ironic and truly unfortunate that it was considered necessary to eliminate those activities as a result of the strategy changes mentioned above.

10. As noted, SC had been involved in carrying out community development projects in the CS IV project areas for years before the CS interventions actually began. One of the lessons that seemed apparent to the FET was that the pre-existence of these activities had given the community and its leaders a level of confidence in SC that facilitated the introduction of the CS activities. It appeared that any development project, as long as it won the trust of community members, can serve as a vehicle for introducing CS interventions at the community level. Similarly, project Management involvement with community committees made the project stronger.

B. Implementation and Interventions

1. Joint NGO, GOB approach to increasing community awareness and motivation through workshops, etc., is more effective (See URC study of workshop for more lessons.)

2. Formation of WSGs has empowered women and this has increased receptivity to service and behavioral change

3. Effective coordination with GOB has resulted in increased EPI coverage with a downward trend in deaths from immunizable diseases.

4. SC PVO activities in conjunction with CS activities (IEC) appropriate logistic support have served to strengthen the GOB FP activities with a resulting increase in CPR and decline in the TFR.

5. Population registration and socioeconomic classification of the households followed by appropriate targeting activities has improved program.

6. BFO staff should carefully evaluate the impact of their nutrition and growth monitoring interventions to assess their impact on the growth and survival of malnourished children: findings from such evaluations can inform the development of nutrition interventions undertaken as part of the World Bank's nutrition project.

7. BFO staff need to follow the trained TBAs to ensure change in "harmful" practices.

C. Linkages

1. Phaseover plans should include GOB personnel as part of sustainability strategy developed at the beginning of the project.

2. Project achievements should be reported to MOH at the national level.

D. Community Participation.

1. The community participation effects of CS IV cannot be separated from those of other SC development activities.

2. An integrated approach enhances community support and participation.

3. SC/CS responsiveness to national calamities and disasters had increased community response.

4. Communities participate in activities that are responsive to their felt needs.

5. Build on WSGs capability and capacity as the basic unit of "empowerment" for poor rural women.

6. Women's Savings Groups appeal to the economic interest of poor families, thereby making it easier, more possible for "C" and "D" category women in these villages to participate in group activities (including SC CS activities) outside their homes.

7. Actual increase in income through WSG increases participation of women in family decision making and increasing credibility of the program.

8. A more rigorous anthropological investigation is needed of the current women's savings groups strategy to determine those aspects of the approach creating empowerment and financial security.

E. Susustainability

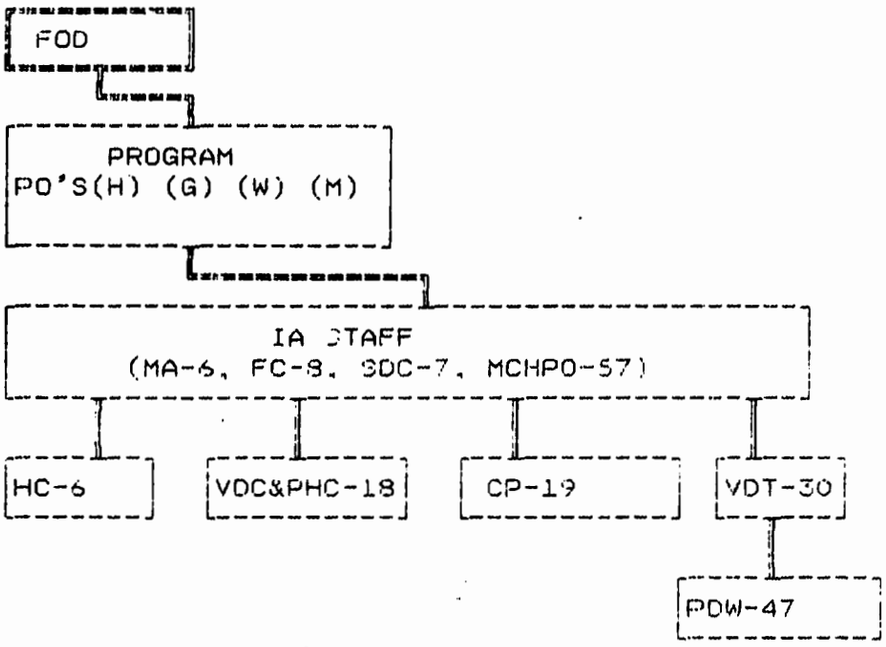
1. Absolute poverty at both the community and government levels imposes the greatest constraint to sustaining project activities as they have occurred previously.

2. Save the Children should systematically explore the availability of resources (both government and non-government) to sustain CS interventions within its impact area after the end of the CS project. Ideally, this type of exploration should begin at the start of the project: negotiation of a formal or informal agreement with government at the start of a project that a basic level of services will be provided will facilitate sustainability as well as transfer of skills between Save the Children and government staff.

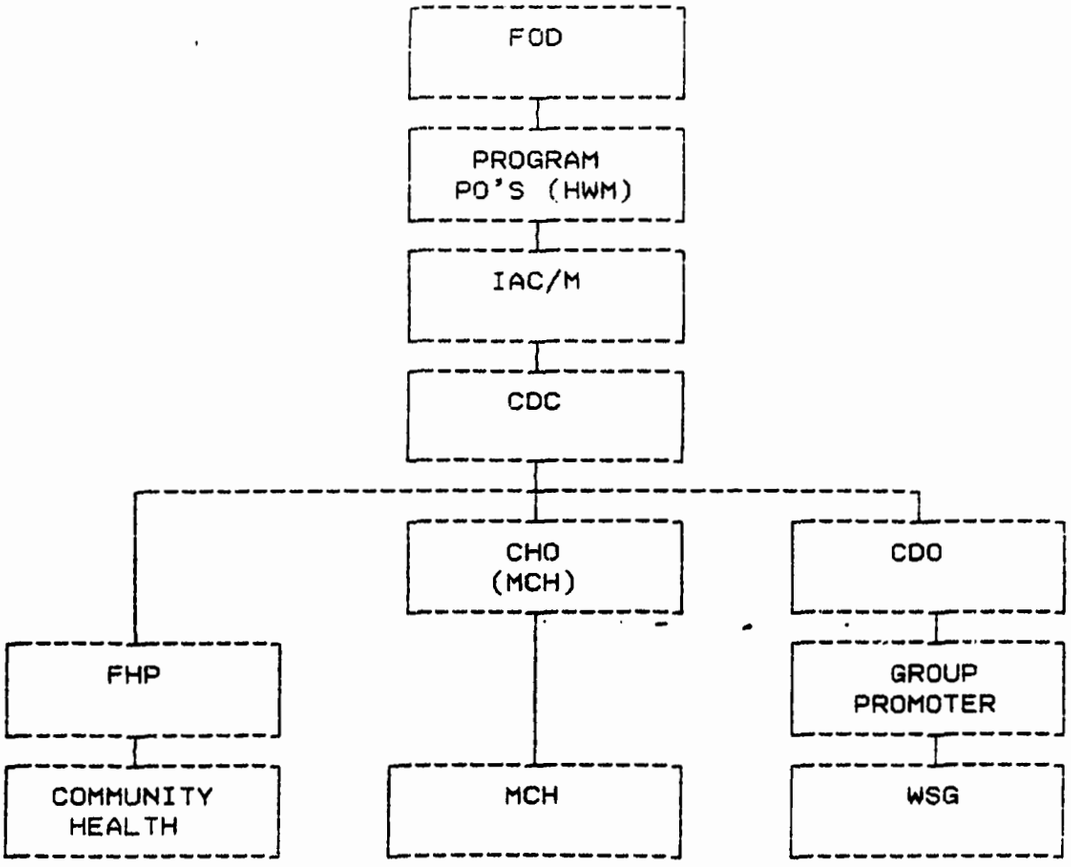
3. Linkages should be established with service providers (government and non-government) from the outset of a project.

BANGLADESH FIELD OFFICE
ORGANOGRAM

Organogram : Old Area



Organogram: new area



APPENDIX 2

SUSTAINABILITY QUESTION AND ISSUES TO BE ADDRESSED BY THE PVO CHILD SURVIVAL PROJECT FINAL EVALUATION TEAM

A. Sustainability Status:

A.1. At what point does A.I.D. funding for child survival project activities end?

According to the original CS IV proposal submitted to USAID, it was expected that all project activities would be completed by August 31, 1992. Because of unavoidable circumstances -- delays in project start up, political upheavals, both internal & external, cyclones and flooding, etc. -- as well as changes in focus and strategies, SC/B requested in April 1992 a one year no-cost extension in order to continue CS activities until August 1993. In the meantime, however, SC/B was awarded a CS VIII grant to continue its CS activities in certain impact areas, while phasing down activities in other areas.

As the CS IV funding comes to an end, the project has achieved "remarkable success in reaching its stated objectives," as reported in the MTE, as well as in the view of the SC/B staff who have managed and carried out the activities. In addition, the following features of a new SC/B/CS approach are worthy of note:

- SC/B has already developed and is well under way in the process of implementing a new strategy for its program operation directed towards more sustainable development rather than concentrating on meeting short term output oriented objectives. The salient features of the new strategy include:

  - women's empowerment, depending on involvement of members of the Women's Savings Groups,

  - shifting from paid community worker-based implementation to volunteer-based implementation,

  - emphasizing broad-based wider coverage interventions, rather than intensive small scale interventions,

  - adopting a two-tiered approach in implementation rather than one tiered direct implementation.

- The organization has shifted its basis for community institutional development from community village health committees (VHCs) to women's savings groups (WSGs).

- The organization is currently phasing out of two of its four impact areas (Ghior and Mirzapur), maintaining operations in another (Rangunia) and expanding activities in the poorest and most disadvantaged area (Nasirnagar). Expansion in this area will continue to the Thana level for greater potential for collaboration with government and for replicability.

- The community level workers who worked hard to achieve the original CS IV output objectives are demoralized and are maintaining less discipline as they see the program and their positions coming to an end.

A.2 At what point does the organization plan to cease child survival activities?

SC/B, according to its new strategic plan, expects to cease CS project activities once it has established and managed to sustain a minimum package of CS activities through the following strategies:

- Women Savings Group (WSG) leaders are to be extensively trained so that they are competent and able to promote and reinforce child protective behaviors among the members and their neighbors.

- Women's savings groups and village health volunteers are to be linked with the existing and available service facilities (GOB/NGO) for services like EPI, MCH, Vitamin A Capsule distribution, and primary health care.

- The village level health workers are linked with the GOB by being selected as volunteers in the new Health Volunteer Program initiative of the GOB.

- The trained village health volunteers will be provided with income generating activities to encourage them to remain in the community. This way they will continue to influence the community to adopt child protective behaviors.

- Through these GOB and NGO activities, key child survival interventions will be adequately addressed in the remaining SC/B project area.

A.3 How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

The main local institutions targeted for phasing over activities include WSGs, Village Development Committees (VDCs), NGO and GOB health and family planning infrastructure.

- The VDC and WSG approach is aimed at involving the community in order to address effective interventions and sustainability. SC/B has implemented various income generating activities through these community groups.

- Frequent discussions, formal meetings and workshops have been held with group members, community leaders, and other members of the community. During these processes, the population has been oriented regarding phaseover issues.

- Workshops have been conducted involving the local GOB & NGO service provider together with the community in order to establish a linkage between these two groups. It has been possible, for example, to hand over the health centre established by SC/B in Mirzapur to GOB staff to continue PHC activities.

B. Estimated Recurrent Costs and Projected Revenues.

B.1 Identify the key Child Survival Activities that project management perceives as most effective and would like to see sustained.

- The CS activities undertaken in CS IV are: EPI, ORT, Nutrition, GM, VAC, Deworming, FP, MCH (PNC, ANC, Breast feeding, mother's training family counselling), social mobilization and community participation.

- All the CS activities undertaken so far were relevant for the community. The key child survival activities the project management perceives as most effective and would like to see sustained are: EPI, ORT, Nutrition, FP, MCH, and Social Mobilization and Community Participation.

- However, based on SC levels of achievement and past experience, as well as increased availability of GOB services/supplies in the project areas, the project management thinks that the future emphasis on various CS components should vary. Expected emphasis by CS components and reasons thereby are shown in Table B.1.1.

Table B.1.1 Expected Emphasis by CS Components

CS Component	1. EPI	2. ORT	3. Nutrition/GM/ VAC/Dew-orming	4. FP	5. MCH (Breast feeding, PNC/ANC TBA & mother traing, family counselling)	
Expected Results	Relatively lower emphasis than before	Relatively lower emphasis than before	Equal emphasis as before	Same emphasis as before, but with changed strategy	Same emphasis as before	Same emphasis as before
Reasons for expected emphasis	1. Achieved more or less the national target. 2. GOB infrastructure facilities are already available in the CS-IV intervention areas. 3. Emphasis will be needed in order to maintain and sustain coverage.	1. Although competency of the target population has increased, the gap between ORT knowledge and practice is still pronounced. This gap should be reduced.	1. GM and growth promotional activities are relatively high cost components. Rehabilitation of the growth faltering child is costly. Thus reduced emphasis will be given. Emphasized areas would be: nutrition and VAC. 2. Introduction of less staff intensive strategy.	1. Demographic impact of this component activity is well recognized by the GOB in its five year plan documents. 2. For sustainability, strategy will change to emphasize linkage with government for distribution of contraceptives to the clients.	1. Child survival impact of this component is significant.	1. Past experience shows that social mobilization and community participation should be enhanced in order to ensure sustainability of CS.

B.2 What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least there years after child survival funding ends?

As already mentioned in B.1, of the six major CS components in CS IV, the program managers believe that equal emphasis should continue to be given to three, namely social mobilization and community participation, MCH, and FP. For the reasons given in Table B.1.1 reduced emphasis should be given to the EPI, ORT, and the growth monitoring part of nutrition (VAC and deworming would remain about the same). Thus, as shown in Table

B.2.1, in order to continue the key child survival activities BFO needs 67.05 percent of the previous budgeted amount.

Table B.2.2 sets forth the amount of recurrent costs required for the next three years based on the following assumptions: (a) that there would be no need for consultants and evaluation during the period, eliminating those costs and reducing travel accordingly, and (b) that the cost apportionment exercise done in Table B.2.1 is valid and the line items of recurrent costs will follow the previous pattern except for consultants/evaluation. The total projected requirement for the recurrent costs for the next three years is US $198,495. This amount broken down by key CS components would be: US $ 79,162 for MCH, US $ 47,935 for nutrition/VAC, US $29,636 for social mobilization and community participation, US $ 28,436 for EPI, US $ 8,950 for FP and US $ 4,376 for ORT.

Table: B.2. Cost apportionment by CS activities

Component of CS	Share of total cost (%)	Share after desegregating for item 6	In relation to the previous load for the component (%)	Share of the previous total cost	Share of the total future cost
1. EPI	25	24.3	40	9.72	14.5
2. ORT	5	3.7	40	1.48	2.2
3. Nutrition/GM/VAC/Deworming	35	32.3	50	16.15	24.1
4. FP	5	3.0	100	3.00	4.5
5. MCH (PNC, ANC, Breast feeding, TBA training, mother's training family counselling)	30	26.7	100	26.70	39.8
6. Social mobilization and community participation[1]	–	10	100	10.00	14.9
	100	100	–	67.05	100

1 Based on the discussion of the FET with the knowledgeable persons in BFO, it was estimates that about 10 percent of the total cost of the program is directed towards item 6.

Items 1 through 5 involves expenses on account of item 6. Thus, a scoring exercise was done, with 5 as the highest score and 1 the lowest. According to the best judgements the results of scoring was: highest (5) for MCH, followed by Nutrition (4), FP(3), ORT(2), and EPI(1). Based on these score values components share after desegregating for item 6 was estimated. Cost loads by CS components have been estimated based on the best judgement on the expected relative emphasis on account of the each individual CS activities.

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Table B.2.2 Projected recurrent expenditure needed to continue the Child Survival activities during the next three years (1994-1996) by key activities. (US$)

Key CS Activities	Line Item: Staff Salary	Travel	ODC	Supplies	Total
EPI	19,393.35	1,892.12	3,575.12	3,575.12	28,435.71
ORT	2,942.44	287.08	542.43	603.84	4,375.79
Nutr/VAC	32,233.08	3,144.83	5,942.10	6,614.79	47,934.80
MCH	53,231.40	5,193.53	9,813.09	10,924.01	79,162.03
FP	6,018.62	587.21	1,109.52	1,235.13	8,950.48
Social Mobil./ Comm. Part.	19,928.33	1,944.32	3,673.74	4,089.64	29,636.03
Total	133,747.22	13,049.08	24,656.00	27,042.53	198,494.83

B.3 What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

As already mentioned, the amount needed to cover the recurrent expenses during the three years after the CS funding ends, would be US$ 232,603. This assumes that project activities including monitoring and evaluation systems remain at current levels. However the annual amount needed would vary between US $70,224 for each of first two years, and US $92,147 for the third year. The need for a larger amount in the third year is due to two factors, namely: (a) the necessary severance payments for field staff at the end of the third year, and (b) the need to cover costs of consultancy and evaluations in the third year. The yearly breakdown of projected costs by line items is shown in Table B.3.1.

Table B.3.1: Projected recurrent expenditure by year and line items (US$)

Line Items	Year 1	Year 2	Year 3	Total
Salary/staff	41,461.64	41,461.64	50,823.94	133,747.22
Travel	4,349.25	4,349.25	4,350.10	13,049.07
ODC	8,217.85	8,217.85	8,217.85	24,656.01
Supplies	9,014.18	9,014.18	9,014.18	27,042.54
Total	63,042.92	63,042.92	72,406.07	198,494.84

B.4 Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary).

The target area of CS project is rural and disadvantaged in terms of social, economic, and environmental considerations. More than 50 percent of the households are absolutely landless, 70 percent of the women illiterate, 90 percent of children are malnourished. Moreover, natural calamities (e.g. flood, crop failure) are frequent, and people are fatalistic. The economic situation of the landless, and marginal farmers means that their ability to pay for preventive health care services is extremely limited. Moreover, preventive health care services are still not a perceived need for most of them. Thus, in this context, the presence of GOB health care services is a necessary precondition if the minimum needs of the community for preventive health services are to be met.

However, the GOB funds available for health care and for family planning, are dependent on donor funding sources. Annual per capita health expenditure from GOB sources is only US $8. Studies show that the benefits of GOB health expenses accrue more to the large land holding households than to the landless and near landless families[1].

Thus, given the very limited capacity of the great majority of the rural population to pay for services, as well as the inequitable distribution of the benefits of the GOB's expenditures, the annual projected cost of approximately US $70,000 would amount to less than US $1 per capita, assuming a population coverage of 75,000, which should be considered as reasonable.

B.5 What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after AID CS funding ends?

Community's capacity to pay for child survival activities, as discussed in B.4, is extremely limited. However, with the increased awareness and internalization of the benefits of the CS activities, the beneficiaries would most likely be willing to pay some fees for services, low-cost essential medicines, as well as undertake the cost of travel to the service delivery points. The indications of these may be found in the special studies that were commissioned as part of the final evaluation -- the study of health care utilization, and the

1 World Bank (1990): Bangladesh - poverty and public expenditures. An evaluation of the impact of selected government programs.

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study of the impact of workshops -- which show that about 60 percent of the mothers do not depend on the provider's initiative to treat diarrhoea and use oral solutions, and more than a fourth do not depend on the provider's initiatives for immunization and pregnancy check-ups. Thus it appears that significant proportions of mothers use their own initiative to get the services. Thus, the transition from provider-driven to self-driven initiatives in the utilization of preventive health care services is taking place in the community. This reflects the behavioral changes required for sustainability which of course are the result of a long-term process. However, as noted in B.4, the amount that might actually be paid for these services is extremely limited.

At the present rate of cost recovery (which might improve as the degree of felt need in the population increases or if there are improvements in the economic conditions of the majority of the population) the projected revenue for the next 3 years would be US $31,514, i.e., 13.5 percent of the total recurrent cost projected for the next three years[2]. This projected revenue is based on estimates of the value of labor contributed by the community (85 percent of the total) and sums actually paid for the purchase of medicines and services (15 percent of the total). One of the major findings from the past experience of community contributions in the CS project areas is that the community is relatively much more willing to contribute their time/labor than they are able to pay cash for services. Thus, in order to enhance the degree of community participation and attain a higher degree of financial sustainability the CS program managers should pay more attention to encouraging the community to provide as much labor as possible.

B.6 Identify costs which are not likely to be sustainable.

Costs which are not likely to be sustainable include the following items: salaries and benefits of the staff, consultants, evaluation, travel and per diem, other direct costs, and equipments. At lease a part of the costs related to the supplies and services may be recovered.

B.7 Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to AID's support of those project?

The lesson learned pertaining to the projection of costs and revenues that might be applicable and useful to other child survival projects are as follows:

- Similar projects should have all relevant documents in place before attempting projection exercises. For example, well defined per unit cost of various CS activities as well as by budget line-items. Where costs are different from place to place, estimates should also be prepared for different project locations.

- Information on revenues should be documented by time, sources, types and locations.

- Protection exercises should begin well ahead of the start of the FET.

- With regard to the possibilities of revenue generation and cost recovery, the all-pervasive poverty in Bangladesh means that there is little likelihood of self-sufficiency in the reasonably near future, but the fact that Bangladeshis are better able and more willing to contribute their labor than cash probably has implications for programs in other parts of Bangladesh, as well as other countries.

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2 Calculated based on estimates provided in Table B.2.2 and E.7.1.

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C. Sustainability Plan:

C.1 Please identify number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.

SC Staff

1 Mr. Kolimullah Koli, IA Manager
2 Mr. Nurul Amin, Medical Assistant (CHO-PHC)
3 Mrs. Gita Pal, CDO
4 Mr. Salam, CDC
5 Mrs. Rowshan Ara Begum, Medical Assistant (CHO-MCH)

C.2 Briefly describe the project's plan for sustainability as laid out in the DIP, or other relevant A.I.D. reports.

The elements of the sustainability plan described in the DIP including the following:

- Foster community ownership and support by involving community committees in all stages and aspects of project implementation.

- Building institutions through which demand for services can be expressed and initiatives undertaken to respond to those demands.

- Identify and utilize the resources that are available in the area to complement SC's program.

- Assist communities themselves to develop economic resources to pay for the services. SC together with the community will explore the following income generating (IG) schemes for covering recurrent project costs:

  - Community owned IG projects, projects from which are designated to help finance the PHC program, agriculture project, grain storage projects.
  - Fee for services at PHC centres
  - Assumption of portion of PHC program cost from the community development fund (VDF)
  - Tube well project for landless committees to enable them to pay for health services.
  - Small loan for poor families to booster individual pay ability for health.
  - WSG's IG projects etc.

- Cost reduction through:

  - Extensive training of families to adopt child protective behavior at their own initiative & not depending on paid workers.
  - Linkage with existing resources/service providers
  - Experimenting with using volunteers in the extended areas.
  - Strengthening program managers skills.

At the time of the no cost extension proposal, several other elements that are intended to contribute to sustainability were added:

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- WSG leaders will be extensively trained as trainers of child protective behaviors and will be linked with the existing GOB/NGO services facilities.

- Phasing over of implementation responsibilities to GOB system.

- IG grant to CHWs to retain them in the community with their expertise to be available in the community.

- Study to document lessons for development of effective interventions.

C.3 Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

Sustainability promoting activities carried out over the lifetime are as follows:

- 18 community committees and 381 WSGs were involved in all the stages and aspects of the project implementation from planning to evaluation of the project activities.

- Linkages were established with the following institutions:

  - **GOB**: for EPI, FP, & health care services in all areas.

  - **Kumudini Hospital**: for TBA training, MCH Care in Mirzapur area.

  - **Chandraghona Mission Hospital**: for Clinical FP, referral and assistance in EPI services in Rangunia.

  - **TBA training institute/Directorate GOB**: for TOT of CHO(MCH).

  - **UNICEF**: for material assistance in water and sanitation program.

  - **Other NGOs like NIPORT,GTZ,IPHN,VHSS,BRAC,ICDDR(B), BPHC,WIF,JHU**: and others for technical assistance, material support and sharing of ideas, experiences etc.

- The following IG activities were explored to develop cost sharing mechanisms:

  - community aquaculture project

  - community grain storage projects

  - developing community development fund (VDF)

  - group & individual IG projects and activities like, irrigation schemes, small trades, food processing, poultry and livestock, share cropping and land mortgage etc.

  - development of credit program through WSGs.

  - changing fees for curative services, MCH services and contraceptives etc.

- The cost reducing endeavors included:

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- extensive family and group level training on child protective behavior to create demands and competence.

- tapping available resources and utilizing existing service facilities as mentioned earlier.

- experimenting with volunteers.

- training WSG leaders on TOT for child survival behaviors and building the linkage with the existing service facilities.

- phasing over to GOB system certain CS activities.

- Training of village practitioners on protective health care and improvement of the quality of their curative services. Members of this group are the most utilized health care providers in the community.

- Advocating for the inclusion of CHWs as CHVs (Community Health Volunteers) under the GOB new CHV initiative.

- Special studies were commissioned to gain insight for future (development) of a sustainable program strategy development.

C.4 Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

- Developing awareness among the community and WSGs (Ref: URC studies)

- Tapping available resources and establishing linkages with the local GOB & NGO service providers.

- Some individual and group income generating activities.

- Fee for service for curative care

- Developing local staff and strengthening program implementors skills of implementation.

Still to be Implemented:

IG grant/loan to CHWs to retain them in the community.

Unplanned activities undertaken:

- Commissioning special studies to assess the sustainability effort.

- Training of village practitioners on protective health care and improving the quality of their services.

- Advocating the inclusion of CHWs as CHVs under the GOB's CHV initiative.

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C.5 Did any counterpart institutions (MOH, development agencies, local NGOs, etc .), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

- The relevant GOB and NGO institutions committed to provide:

- Materials for training and social mobilization, referral services,

- Limited logistic support and technical assistance. This did not involve any form of cash flow.

C.6 What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

The reasons for success include:

- SCs activities complement GOB and NGO program activities

- Linkage was established between SC and counterparts

- Commitment and motivation of SC staff

Reasons for failure included:

- Lack of GOB infrastructure in certain project impact areas

- Interruption in timely and appropriate logistic support

- Impact area population represents only 0.07% of the population of Bangladesh and is too small to attract substantial GOB interest.

D. Monitoring and evaluation of sustainability:

D.1 List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes.

The projected has used the following indicators to track any achievement towards sustainability:

i) **Fostering of community ownership and support:**
- No. of community committees
- community contribution/donation

ii) **Building institutions:**
- No. of WSGs
- No. of WSG leaders trained as trainers
- % of households covered in WSGs
- No. of health centres handed over to GOB and NGOs
- No. of TBAs and village doctors trained

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iii) **Utilization of existing services:**
- % of children and women aged 15-45 yrs immunized.
- % of pregnancies had ANC & PNC.
- % of FCs using contraception.
- % of children aged 6m-6 yrs. receiving VAC regularly.

iv) **Protective and promotive health behaviors:**
- % of Diarrhoeal Diseases treated appropriately with ORT
- % of children under 5 mos. who were exclusively breast fed.
- % of children (4-6 Months) receiving appropriate supplementation.
- % of children under 2 yrs who are breast fed.
- % of pregnant and lactating mothers who are taking more food then usual.

v) **Cost recovery and reduction:**
- % of costs recovered (Fees, IG)
- # of active IG loans/projects.

D.2 Do these indicators show any accomplishments in sustaiability?

In general, where project input has been withdrawn or significantly decreased, the indicators show that both the quality and quantity of child protective service delivery and utilization and the coverage level of various activities have not been well sustained. The level of knowledge and positive attitudes have increased, however, and remain reasonably high, but the practice level is not consistently maintained. Cost recovery and sharing by the community through endowment fund does not seem to work. Broad-based community institutions are not effectively sustained when project input is withdrawn. WSGs are more interested in economic development. Communities seem not to give a high priority to acting on their own initiative in the health care area. Individual IGs targeted for poor seem to be used more for food and other priority sectors than protective health care.

D.3 What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

The special studies commissioned by SC and conducted by URC(B) as well as the final K&P survey give qualitative data on the potential of the project's sustainability status.

D.4 Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

People affliated with the following in-country agencies were involved in the MTE & FE:

Midterm Evaluation

1. National Nutrition Council
2. Radda Barnen (Swedish Save the Children)
3. ICDDR(B)
4. University of Dhaka (INFS)

Final Evaluation

1. John Snow Inc. (JSI)
2. GTZ/NIPPORT
3. UNICEF

4. URC(B).

D.5 Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

Recommendation by technical reviewers	Action by the PVO
Proposal: * WSG & Community participation encouraged	* emphasis was given at every stage of project implementation
DIP * Ideas good but activities phased, H4-H6 should be in target formulation and work plan (Format F).	* Most of the activities (H4-H6) were ongoing in nature, format doesn't contain the line items relevant to the work.
* Sustained intervention reinforcement is needed for continuation of behavior.	* The project emphasized continuation of the reinforcement mechanism by providing IGA or including them as GOBs CHV initiative program
* Strong HIS of BFO to investigate the question of sustainability of health behavioral changes.	* Not only HIS but also special studies have been commissioned to investigate the health behavioral changes.

D.6 Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

Recommendations on Sustainability by MTET 1990

Recommended	Achieved
Develop a plan and strategy for persuading MOH and donors to visit the old impact areas to observe the implementation of CS activities: other NGOs should also be encouraged to seek opportunities.	Discussion, meetings and formal workshop have been organized with the GOB authorities. In this context the higher GOB authorities visited the old area (Mirzapur) & took much interest in making the SCs primary health care centre into a GOB subcentre.

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Develop a systematic program for increasing linkage with counterparts at all levels where possible.	Through the above meetings workshops and through regular meetings with the Union level, Thana level & District level linkages were maintained to enhance the transition of activities from the project to counter part institutions.
Develop a proposal for USAID & other donors for a "set-a-side" fund which will be used for staff development, e.g. training, loan project, capital investment or grants.	Proposal for loan project included under no-cost extension of the CS4 project:
In order to support health education messages for WSGs a series of contest among village WSGs could be promoted. the "Theme" of the contest could be the best health education message on different health behaviors. The WSG could be challenged to develop role play, dance, skit, song or dance which are the desired behavior KAP.	Through the participatory training & workshops with the WSGs the health education message in local terms and effective ways of dissemination were used.
Need to focus on phaseover by the village staff & field staff: Facilitation of their progress could be done by strong linkage with GOB and NGOs at local level and thereby identifying the local counterparts. The skill of local counterparts can be strengthened by providing training.	Series of formal & non-formal meetings and discussion were carried out on the phaseover process.
Village doctors may provide sustainable service delivery.	Training provided to village doctors to increase their skill in the related field.
Facilitating the VDCs to gain NGO status and this will be an important component of phaseover. SC should play a supervisor role during implementation through the last stage of phaseover.	Depending on the capacity of the different committees the phaseover is under consideration.
Expand training for WSG in record keeping, investment and income generating activities.	Training sessions organized.
Review the present objectives & appropriate targets for each intervention. Review and develop HIS as part of new village strategy. Careful attention should be given on overall health of children for all socio-economic groups.	This has been considered and included in the new program strategy that the PVO is following.

E. Community Participation:

E.1 Please identify community leaders interviewed and indicate which groups the represent.

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VDC (FGD)

1 Hoagie Ahad Ali, Chairman
2 Mr. Akkas Ali Mollah
3 Mr. Ayub Ali Mollah (landless sector member)
4 Ms. Falumia
5 Mr. Shahnewaz, Headmaster, Private School
6 Mr. Hakim, Youth sector member
7 Ms. Tahera, Women's sector member
8 Ms. Sufia, Women's sector member
9 Shirajul Hoque Munshi, Vice Chairman (Agricultuaral sector member)

FW(FHV)
1 Mr. Morshed Kamal
2 Mr. Pantash Core
3 Ms. Amena Begum
4 Ms. Sarna Rani Sarkar

WSGs (FGD).
1 Ms. Anwara Begum, Chairman & WSG leader
2 Ms. Halima Begum, Paira group member
3 Mr. Toa Chan, Vice Chairman of Paira group
4 Mr. Safar Chan, Champa group member
5 Mr. Par Chan, Dalim group member
6 Ms. Kamala Rani, Fulmala group member
7 Ms. Arak Chan, Tia group member

E.2 Which child survival activities do community leaders perceive as being effective at meeting current health needs?

Primary curative services, MCH services & EPI services.

E.3 What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

The project provided training and knowledge to the community to better understand the need for child protective behavior. They were linked with existing health care providers. In this way there is creation of demand in the community which motivates them to seek services. This was accomplished through the following:

WSGs : The women savings group leaders and members are trained in preventive and promotive health behavior. The purpose is to develop them as a substitute for the community health worker. The women savings group were strengthened as an institution so that they can undertake and help in continuing the CS activities within the community as the agency leaves.

VDC Approach: In order to foster community support and to work with the community SC(US) organized village development committees. These committees participate in setting priorities, in planning and in the implementation of the activities.

Community Workers: The community workers are provided with training on child protective behaviors. They are also trained on linkage building with the GOB and other existing service

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providers or NGOs within the area. The community workers will know where to go for services and they will utilize the services at times of need.

Family Training: Training in child protective behaviors is provided at the family level. This included training in the administration of ORT, immunization, MCH and family planning, nutrition and vitamin A, use of potable water and sanitation; it is assumed that once families are trained, they will retain the knowledge.

Training of the TBAs and village doctor: The TBAs and the village doctors are trained and this will help to secure sustainable service delivery. The TBAs with their improved knowledge and skill will practice safer delivery methods. Moreover they will be able to motivate the mother to seek antenatal care when needed and will motivate them to accept referral in case of difficulty.

They are also trained to use the linkages with GOB and other health care resources within the area. Moreover good linkage and rapport with all local health institutions will help sustain activities in the area.

The project established and maintained linkage and rapport with the GOB institutions. During the life of the project meetings and workshops were organized to elicit the participation of GOB health authorities and community leaders. The GOB health authorities were requested by the community to operate and continue the child survival activities within the area as the project ends. The GOB consented to this. The GOB officials visited the operational sites (PHC) and expressed their interest and willingness to take over some of the essential services.

E.4 How did communities participate in the design, implementation and/or evaluation of child survival activities?

The Village Development Committees participated in prioritizing and planning, selecting project beneficiaries, identifying and mobilizing resources, budgeting, planning and project implementation. Moreover a regular feedback on the impact of the program is provided.

The village development committee members and other committee members were the signatories for approving project proposal and fund utilization. In this way the community and community committees were involved in all stages and aspect of the project implementation and management.

E.5 What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

There are 18 community committees that are involved with health program within the project areas. They used to meet once a month or more often if needed. However, recently SC has changed its approach from a community focussed strategy to a strategy focussed on women and children. SC has organized 381 WSGs in its project areas and these groups are taking over many of the community health support activities. As a result, the community committee meetings are now scheduled as and when needed. On an average each of these committees met four times during the past six months. The committee members were representative of their communities except with regard to gender.

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E.6 What are the most significant issues currently being addressed by these health committees?

Currently the problems relating to phaseover are the most significant issues being addressed by the health committees. Through meetings and discussions the committees were appraised of the importance of phaseover and of their roles. They were informed that no voluntary organization can render services in any community for an indefinite period.

During the life of the project SC along with the community has developed good linkages and rapport with the GOB and NGOs. Thus, as the SC activities are phased out, it is expected that because of these linkages and the improved relationships with GOB, as well as the interest the community, the GOB will provide the essential health services to the extent possible within the existing constraints.

E.7 What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

The resources contributed by the communities are mostly their time, land and facilities for offices, PHC centres, staff housing, etc., as well as some fees for curative services. Estimates of the dollar value of these contributions were obtained in the URC,B study of health services utilization and are summarized in the table below.

Table E.7.1 Community contributions by types of contribution during CS IV period.

	Labor			
Year	Time (hours)	Value (US$)	Cash (US$)	Total
1989-90	8999	2251	277	2528
1990-91	24591	6148	2032	8180
1991-92	42111	10528	1420	11948
1992-93	30758	7690	1168	8858
Total:	**106459**	**26617**	**4897**	**31514**

* 1988-89 estimates are not available

Source: Prepared by FET based on information provided by Finance Chief, BFO, Dhaka

E.8 What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

Reasons for Success:

- All sectors of the community are represented on the committees
- Cohesiveness among the committee members
- Committee initiative in approaching local elite/influentials for mobilizing contributions such as land, etc.

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- SC strategy of planning interventions that respond to needs perceived by the community.

Reasons for Failure:

- Committee members are of lower socioeconomic group 87 percent are from families below the poverty level,

- Overall commitment to preventive and promotive health care is still below the level needed to motivate them to community action.

F. Ability and willingness of counterpart institutions to sustain activities.

F.1 Please identify persons interviewed and indicate their organization and relationship to the child survival project.

GOB Staff

1 Dr. Shahidul Hoque, THA, Nasirnagar
2 Dr. Abdus Samad (MOMCH-FP and In-charge TFPO)
3 Mr. Zatindra Chandra (ATFPO)
4 A FWV, whose name was not recorded
5 Manowara Begum, FWV
6 Maya Rani, FWA

F.2 What linkages exist between thge child survival project and the activities of key health development agencies (local/ municipal/ district/ provincial/ state level)? Do these linkages involve any financial exchange?

The project activities are linked and coordinated with the available and existing key health development agencies to supplement and/or complement the activities of existing services. The project activities are implemented through tapping all the available resources and are linked with the following agencies:

- GOB district and thana EPI Dept: GOB provides the vaccines and vaccinator, while the project motivates and mobilizes the target group including awareness raising and supplementing transportation, syringes and needles etc as per need.

- Thana level GOB population control and family planning program: GOB provides contraceptives; SC: motivates and mobilizes clients.

- The following GOB and NGO organizations provide training, technical assistance and/or material support:

  - GOB TBA Training Directorate,

  - GOB Institute of Public Health and Nutrition,

  - UNICEF,

  - VHSS,

- ICDDR(B),

- Kumudini Hospital,

- Chandraghona Mission Hospital etc.

The project has maintained linkages with the above institutions mainly for resource tapping, with minimum financial exchange.

F.3 What are the key local institutions the PVO expects to take part in sustaining project activities?

Beyond the community groups established by the project, the WSGs and VDCs, the EPI and FP program of the GOB in all the areas and other NGOs like Kumudini Hospital in Mirzapur, Christian Mission Hospital at Chandraghona, Rangunia, are expected to take part in sustaining some of the project activities.

F.4 Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

According to interviews, as well as reports by staff, the EPI and MCH based FP (Birth Spacing) activities are perceived as the most effective.

F.5 What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once A.I.D. funding terminates?

The PVO organized workshops and training sessions for the GOB personnel. The PVO also participate in monthly meeting at District level and shares experiences and lessons.

Moreover the PVO organized training of trainers (TOT) and workshops family planning training for different levels of workers involved in FP, community leaders and religious leaders.

F.6 What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

The GOB is dependent on donor countries and donor agencies for the major part of its development program. There is always a budget constraint and it is clear that the necessary costs cannot be covered under such.

GOB authorities, however, have committed and expressed their willingness to render the services within the area once the agency leaves.

The GOB structure may not be able to maintain the same level of coverage. Moreover, the impact area represents only negligible percentage (0.07) of the country population.

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F.7 Are there any project activities that counterpart organizations perceive as effective?

Massive consciousness raising through family level and group training process. EPI, FP, MCH program activities and the monitoring system, specially the ability of mobilizing the hard to reach group are perceived to be effective activities. The monitoring system developed is also appreciated by the counterpart and other institution.

G. Project Expenditures:

G.1 Attach a pipeline analysis of project expenditures

A current pipeline analysis of yearly expenses can be found on the last page.

G.2 Compare budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

No variations were found between the total amount budgeted for CS IV and the amount expended. However, for all the line items representing the recurrent costs there was some over or underspending during the project period.

G.3 Did the project handle finances in a competent manner?

Based on our discussions with the finance chief, and Finance officers, as well as analysis of the books of accounts it can be concluded that the project has handled financial matters in a competent manner. Project staff used the flexibility allowed in the grant document in order to respond to emerging needs and project learnings.

G.4 Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to AID's support strategy?

The lessons learned regarding project expenditures which might be helpful to other PVO project are:

- Budgeting exercises should be done more carefully. In doing that, two things should be considered: calculations of line items in a more detailed and logical fashion, and applying the historical experiences pertaining to the under/over spending line items.

H. Attempts to increase Efficiency:

H.1 What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

The PVO implemented the following strategies in attempts to reduce the costs, increase productivity, or make the project more efficient:

- Decreased the number of paid community health workers and introduced the new strategy to train and use women's savings group leaders as trainers of mothers in child protective behaviors.

- Used a target group based approach rather than depending on house-to-house visits to reach the target populations.

- Utilized fewer but more highly skilled development workers from outside the community to increase the efficiency in developing and transferring skills to the community groups.

- Adopted a role that was complementary to the existing GOB program activities rather than a supplementary role.

- Recovered some cost for certain health services.

- Developed and used PMIS for effective planning, implementation and management of the program.

- Continued formative supervision training to upgrade skills and efficiency of the staff members.

- Maximized utilization of resources of existing agencies for program services and developed long-term linkages with these agencies and institutions.

H.2 What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

Reasons for the success achieved include:

- National policies and priorities are addressed.

- Recognition by the community of the project's importance and contribution.

- Integrated approach of the PVO.

- Interpersonal relationship and communication at community and institutional level.

- Motivated/committed project staff.

These factors for success have been reflected as positive behavioral changes in the community and local institutions.

Reasons for failure:

- Generalized low awareness about health

- Low socio-economic condition of the target people.

- Protective and preventive health care is not a cash priority for the community people.

- Implementor's emphasis was on achieving time bound objectives set at the higher side of the scale as well as ensuring quality of the services.

- Prioritizing hard to reach group by available services.

- Inadequate govt. infrastructure/services etc.

H.3 Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to AID's support of these projects?

Sustainability and efficiency might be contradict ones in a short term project with time bound objectives of providing essential service coverage in an under developed situation.

I. Cost Recovery Attempts:

I.1 What specific cost recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

The project experimented with charging a nominal fee for certain curative services and also charged for some items such as contraceptives, medicines, antenatal care, etc. The total amount recovered was simply too negligible to offset project expenditures. In addition the PVO also tried to introduce some community level income generating projects that were intended to produce enough income to cover the cost of the heal care activities. The supervisory staff at the field level managed the implementation.

I.2 Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did the revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

The cost recovered, as noted, was very negligible and the total amount recovered from the health activities during the four years of the project was approximately $18,630. That sum barely covers 3 percent of the total project costs. The attempted cost recovery through charging a fee for services or the cost of materials was carried out during the service delivery encounters and did not require much extra effort to implement the mechanism.

I.3 What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

Charging for services that are not perceived as felt needs or as priority health care activities (i.e., protective and preventive health care) for the 70 percent of the population living below subsistence level has a negative effect on service utilization. Community residents from higher socio-economic group can buy the services (from anywhere), thus resulting in inequities in service utilization.

I.4 What are the reasons for the success or failure of the household income generating activities of this project?

No household income-generation activities were implemented under CS4 project.

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I.5 Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to AID's support strategy?

The lessons learned regarding cost recovery that might be applicable to other PVO child survival projects or to AID's support strategy are as follows:

- Cost recovery in CS Projects should not be carried out when they have the effect of denial of access to services by the poor.
- Before introduction of any cost recovery scheme the pricing exercises should be carefully done, carefully taking into account the ability of the predominant part of the target groups to pay for services.
- 'Safety net' should continue in order to provide services to those who can not pay for the services due to poverty.
- Cost recovery should not be treated as an immediate goal of the program.
- Sustainability at the initial stage should not be equated with the degree of cost recovery.
- In order to attain a relatively high degree of cost recovery, activities enhancing the income generation potentials at the household levels should be promoted.

J. Household Income Generation:

Please Note: This is not a part of CS IV project. However, the PVO has initiated a variety of income generating activities as part of its regular development program.

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COOPERATIVE AGREEMENT PDC-0502-A-00-5095

CHILD SURVIVAL IV: BANGLADESH

21-Oct-93

BUDGET VS. ACTUALS FOR YEAR 5 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT AWARD

					YEAR 5: EXPENSES VS. PLANNED BUDGET				LIFE OF GRANT: CUM EXPENSES VS. TOTAL GRANT			
	EXPENSES YEAR 1	EXPENSES YEAR 2	EXPENSES YEAR 3	EXPENSES YEAR 4	EXPENSES 07/31/93	PLANNED BUDGET **	BALANCE	% SPENT	CUMULATIVE ACTUALS	TOTAL PLANNED BUDGET	BALANCE	% SPENT
Staff	62,467.92	71,271.66	52,525.69	84,154.42	46,754.52	36,845.58	(9,908.94)	126.9%	317,174.21	307,265.27	(9,908.94)	103.2%
Consultants	11,536.25	3,322.78	467.46	15,737.65	20,146.41	29,262.35	9,115.94	68.8%	51,210.55	60,326.49	9,115.94	84.9%
Travel	2,174.28	4,964.59	5,669.82	5,602.66	4,323.96	15,397.34	11,073.38	28.1%	22,755.31	33,828.69	11,073.38	67.3%
Equipment	25,310.88	0.00	0.00	0.00	0.00	0.00	0.00		25,310.88	25,310.88	0.00	100.0%
Other Direct Costs	3,419.50	16,277.69	13,266.05	16,371.95	5,317.85	49,925.50	44,607.65	10.7%	54,653.04	99,260.69	44,607.65	55.1%
Supplies	16,041.23	14,178.41	15,288.34	15,161.60	3,622.47	16,838.40	13,215.93	21.5%	64,292.05	77,507.98	13,215.93	82.9%
TOTAL	120,950.06	110,035.13	87,217.36	137,028.28	80,165.21	148,269.17	68,103.96	54.1%	535,396.04	603,500.00	68,103.96	88.7%

* Final Year 4 expenses; Year 5 expenses through: 07/31/93
** Revised budget from DIPs. Year 3 & Year 4 Planned Budget from F.O.'s Annual Report Year 5 includes balances from year 4
*** LOG Budget and no-cost extension approved through 8/31/93 with Amendment #7 dated 6/23/92

Year 1 = Sept. 1, 1988 – Aug. 31, 1989
Year 2 = Sept. 1, 1989 – Aug. 31, 1990
Year 3 = Sept. 1, 1990 – Aug. 31, 1991
Year 4 = Sept. 1, 1991 – Aug. 31, 1992
Year 5 = Sept. 1, 1992 – Aug. 31, 1993

No-cost extension approved thru 3/31/94 per Amendment #9; includes Bangladesh no-cost extension thru 11/30/93.

LINE ITEM FLEXIBILITY: Changes to the LOG Budget for each line-item needs to be documented and justified if budget is increased or decreased by 20% (or more) from the line-item LOG Total Planned Budget
In all cases FIELD OFFICE TOTAL PLANNED BUDGET may not change

SAVE THE CHILDREN/US
BANGLADESH FIELD OFFICE

UNIVERSITY RESEARCH CORPORATION/BANGLADESH

Participation in Women's Savings Groups and Implications for Health Care Behavior in Save the Children/US Catchment Areas

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EXECUTIVE SUMMARY

INTRODUCTION

In rural Bangladesh, women are traditionally subordinated and disadvantaged. However, it is argued that the involvement of rural women in income-generating activities alongside functional literacy and the use of primary health care facilities would enthuse certain degree of economic and social independence among them, that would help raise their consciousness, enhance their ability to think, and thereby ensure them a greater role in the household decision-making process. Recognizing this fact, Save The Children (USA) is implementing an integrated community based development program which is focussed on Women's Savings Groups as the key forum for development interventions. The major sectoral activities are in primary health care, economic development/sustainable agriculture and education. Through Women's Savings Groups (WSGs), Save The Children (USA) targets poor women, providing training, technical assistance and some service delivery to increase their family income, improve health and nutrition, and enhance awareness.

According to recent statistics, SC is currently operating in 10 (ten) unions under four thanas (Nasirnagar, Rangunia, Mirzapur, and Ghior) of Bangladesh, covering a total population of 76,041.

OBJECTIVES OF THE STUDY

The overall objective of the study was to investigate into the motives and factors that influence women's participantion/non-participation in WSGs in the four project areas, as well as their (motives' and factors') implications/influences/relationship with health care behavior in terms of sustainability. The specific objectives of the study were to: (i) identify the characteristics of the respondents (WSG participants, dropouts, and never participants) and their husbands, e.g., age, number of children, education, occupation, religion, land ownership, adequacy of family income, husband's attitude toward wife's involvement in WSGs/income-generating activities, family health status, etc; (ii) determine the knowledge of, and attitudes toward, e.g., ideal family size, female age at marriage, familial harmony, desire for more children, sex preference for children, felt health needs, food needs for pregnant and lactating mothers, ages at which babies should be given weaning food/solid food/green leafy vegetables, etc.; (iii) understand the behavior and practices of the respondents, e.g., contraceptive behavior, pregnancy status, parental vs. husband's status, female education, religiosity, treatment in case of diseases, female mobility, role in family decision-making, practice regarding TT vaccine and immunization of children, use of ORS, schooling of children, etc.; (iv) determine the incentives/disincentives (direct or indirect), which motivate women to participate or not to participate in WSGs; (v) assess whether the motives and characteristics of WSG participants have any influence (direct/indirect) on health care behavior/service utilization, as well as their participation in health care system; and (vi) ascertain the feasibility of attaining sustainable health care goals (behavioral and institutional) through WSG as an institution, considering the motives and characteristics of the WSG members.

METHODOLOGY

Keeping in view the objectives of the study, it was decided that there would be three groups of respondents: WSG participants, dropouts, and never participants, to be selected from the four project areas.

Regarding the selection of sample, two different strategies were followed: one for WSG participants, and another for dropouts and never participants.

First, it was decided that the WSG participants would be selected, using proportionate stratified random sampling procedure to ensure adequate representation to the four project areas. In 1990, SC was covering a total population of 52,000 of which 44.2 percent, 25.0 percent, 11.5 percent, and 19.2 percent respectively were from Nasirnagar, Rangunia, Mirzapur, and Ghior (Khuda et al., 1990a). Using the formula proposed by Fisher et al.,(1991), the optimum sample size for a population of about 10,000 households becomes 278. Proportionate distribution of this optimum sample size (278) yielded 123, 70, 32, and 53 participants respectively for Nasirnagar, Rangunia, Mirzapur, and Ghior Thanas. Using the SC PMIS as the sample frame, the required sample of participants was randomly selected from among the WSG participants of the four project areas.

Second, assuming that the dropouts and the never participants each are homogeneous populations, a randomly drawn sample of 30 from each of the project areas for each of the two categories of respondents would be representative of their universe. Thus, the sample size for the dropouts and the never participants each was 120 (30 randomly selected respondents x 4 project areas). While the SC PMIS was used as the sample frame for the dropouts, the register maintained at the field SC office was used as the sample frame for the never participants. However, it may be pointed out that the PMIS sample frame for the dropouts yielded a total of 25 dropout cases from Ghior impact area, instead of the desired minimum of 30 for that area. Thus, the total sample size for the dropout category was 115 instead of 120.

Taking the three categories together, the total number of respondents covered by the study was 513.

FINDINGS AND IMPLICATIONS

An important methodological point to note is that viewed from socioeconomic indicators such as landownership, level of adequacy of income, occupational structure, education, and materials used for dwelling units the participants are certainly less well of than the other two groups. This implies that while comparing the health-related attitude and behavior of these groups, proper cautions shall have to be considered. Also, considering the relatively disadvantaged socioeconomic background of the WSG participants, almost equal degree of the relative value of this group in terms of health-related attitude or behavior with the other groups, especially with the never participants, should be treated as a sign of behavioral progress among the WSG participants.

The WSG participants and the dropouts are about the same age, and they are older than the never participants. The probability of participating in WSGs is higher among the currently married women and women having higher number of children. Socioeconomically disadvantaged group of women, i.e., the relatively less well-off women are more likely to benefit from participating in WSG.

The proportion of respondents knowledgeable about the special food requirement of the pregnant and the lactating mothers is highest among the participants, while it is lowest among the never participants. Compared to the never participants, higher proportion of the WSG participants intend to educate their children and hold the view that the level of education received by the daughters should be higher than that of the sons. Son preference is less pronounced among the participants than the never participants. Furthermore, compared to the other two categories of respondents lowest proportion of the participants expressed desire for more children.

Contraceptive prevalence is highest among the participants and lowest among the never participants. Again, among the respondents with 4+ living children, contraceptive use is highest among the participants and lowest among the never participants. Also, the participants uses 'clinical methods' to a greater extent than the others. The proportions of respondents taking TT vaccine themselves as well as having their children immunized are higher among the participants than the never participants. The proportions of respondents giving ORS to their children during diarrheal episodes as well as seeking medical doctors' advice in case of sickness are higher among the participants than either of the dropouts or the never participants. The participants have greater role in household decision-making and greater mobility than the never participants.

Taking the knowledge, attitude, and behavior of the respondents into consideration, it appears that women who have higher number of living children, who intend to educate their children, who have lesser desire for additional children, who are using contraceptives, who are utilizing health care facilities, who have relatively higher degree of mobility, etc., are more likely to benefit from WSG participation.

The primary consideration for joining the WSGs is economic: accumulation of savings, meeting various household expenses, etc. This implies that most women join the WSG with the expectation that they would be able to attain some "economic power", thereby improving their status both within the family and the community.

The major factor encouraging dropping out/discontinuation of membership is financial mismanagement of WSGs. This implies that financial management of group funds must be sound; otherwise, group members would dropout. Thus, there is a need to ensure sound financial management of group funds to be not only able to minimize dropout but also attract the never participants to join the group.

The major factor discouraging participation in WSGs is the dislike from husbands/in-laws. So, as part of its program, the SC needs to motivate and educate the husbands and in-laws of the potential benefits of participating in the WSGs. If this is undertaken with all seriousness, it would be possible to overcome their dislike and resistance.

The evidence found in this study indicates that in case the SC decides to phase out, it would be difficult on the part of the residents of its catchment areas to be able to sustain their health behavior. However, there are also some positive indications. Most of the participants, having received training in health and family planning, might be able to sustain some of the health care services currently provided by the SC. Also, a higher proportion of the participants compared to the other two groups have contacts with the health and family planning service providers. The proportion helping others in establishing contacts with the health service providers is higher among the participants than the others. Health-related topics are widely discussed in the WSG meetings, thereby helping raise health-related consciousness among the members. A very high proportion of the members also disseminate knowledge acquired in the group meetings with the non-members, thereby indicating that they help raise health-related consciousness in the community in general.

The community members, in general, seek medical advice in times of sickness. The proportions seeking such advice as well as using ORS and deworming medicines were higher among the WSG participants, suggesting that in the event of the SC withdrawing from the area the WSG participants would be more able than the community members to take care at least some of the essential health-related needs. However, the degree to which the WSG participants would be able to take care of some of their essential health-related needs in the event of the SC withdrawing of the area varies by characteristics of the participants. For example, the proportion seeking medical advice was highest among those aged 30-39 years, those with no schooling, and those with no household land ownership. Thus, in case the SC decides to withdraw from the area, it should ensure that the other participant groups as well as the community in general are able to take care of their essential health-related needs; otherwise, at least some of the SC's past efforts and resources would be considered not to have yielded the desired result.

Appendix 4.

Save the Children

Bangladesh Field Office

Child Survival 4

Final Survey Report

Agency for International Development

Grant # PDC 0502-A-00-5095-00

February 1993

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Appendix 1: English Questionnaire

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Appendix 3: Training Schedule

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EXECUTIVE SUMMARY

A Knowledge and Practice (K & P) Survey was carried out in 28 villages of 4 impact areas: Nasirnagar Thana of Brahmanbaria District, Ghior Upazila, Mirzapur Upazila and Rangunia Thana of Chittagong District of Bangladesh from February 1st to February 18, 1993. The survey was achieved through cooperation between Save the Children Bangladesh Field Office, SCF/Headquarters and Johns Hopkins University Child Survival Support Program (PVO CSSP). The objective of the survey was to provide a final assessment on the health knowledge and practices of mothers with children under two years of age.

A Child Survival (CS) IV project is being implemented by SCF/Bangladesh, a PVO with Headquarters in Westport/USA. The project is receiving US $875,347 in A.I.D. funding from the Bureau for Food and Humanitarian Assistance/Office of Private and Voluntary Cooperation (FHA/PVC) to implement CS activities from July, 1988 to September, 1993.

The standardized survey questionnaire designed by the Johns Hopkins University PVO CSSP was refined by SCF/Bangladesh and SCF/Headquarters - it was based on a standardized format which A.I.D. is requiring of all PVO Child Survival projects. The field team received training in 30 cluster sample surveys facilitated by the PVO CSSP Survey Trainer David Newberry and SCF/Headquarters representative Loren Galvao. The training was conducted so that the SCF/Bangladesh staff further can carry out this type of survey to measure project progress. The survey was accomplished in eighteen days (the Child Survival VIII K & P baseline survey was conducted simultaneously).

Major findings included: 75.7% of mothers started breastfeeding during the first eight hours after delivery; exclusive breastfeeding below 4 months of age was 55.3%; 63.2% of the mothers started weaning when child was between 4 and 6 months; 46.8% of mothers reported that their child had received Vitamin A capsules; 26% of the mothers were treating diarrhea with ORS and 46.6% with SSS; 82% of the mothers whose child had ALRI in the last 2 weeks sought treatment; the Immunization Overall Drop-Out rate [(BCG -Measles)/BCG x 100] was 53.38%; the contraceptive prevalence rate was 19.3%; 75.3% of the mothers visited a health facility while pregnant with child; in 78.7% of deliveries in this sample a TBA cut and tied the cord; the membership in Women's Saving's groups was 48.8% and 27.3% of mothers were able to read.

I. INTRODUCTION

A. Background information

Bangladesh is located in Southern Asia and has a total area of 57,295 sq miles with a population of 116.6 million. The per capita GNP is $200, with birth rate 3[illegible] per 1,000 population, population annual growth rate of 2.5% and a total fertility rate of 4.8 per woman. The infant mortality rate is 101 and the contraceptive prevalence is 31% (Source: UNICEF 1993).

Save The Children Federation Bangladesh Field Office (SCF/BFO) started to implement Child Survival activities in the middle 1980's: CSI from 1985 through 1988 and CS IV from July, 1988 through June, 1992. A no-cost extension for CS IV was approved by A.I.D. until September, 1993. The CS IV implementation plan includes Nutrition (30%), Immunization (25%), Maternal Health (20%), Child Spacing (10%) and ORT (15%).

BFO data indicates that for the "old villages" in Nasirnagar, the 1990 under-5 mortality rate exceeded 150 and the Infant Mortality Rate 120. The MotherCare Study in Nasirnagar documented low birth weight, prematurity, neonatal infections and obstetric complications to be major causes of death among very young infants. Nationally, 95% of deliveries are carried out at home, in the absence of trained personnel (source: NIPORT, 1989). Exclusive breastfeeding and weaning at the correct age are almost nonexistent (unpublished study; Bangladesh National Breastfeeding campaign). Nationally, 95% of the population is aware of ORS but only 30% use it. Child and maternal malnutrition are widespread. BFO data shows that in CS IV villages of Nasirnargar, proportions of malnourished children aged 0-11 months, 12-23 months and 24-35 months are 52%, 88% and 91% respectively. Night blindness was reported for 1.56% of the children aged 6 months to 6 years old in the Chittagong division (source: IPHN/UNICEF, 1989). Women's status in these traditional rural societies is very low and the female literacy rate is about 10% in Nasirnagar (Source: Bangladesh Government data, 1991).

B. Intervention area

The intervention area for CS IV is within four defined impact areas. The original population covered was 47,000 persons in 17 villages. In 1989 there was an extension into new 10 villages in Nasirnagar. Thus, the survey covered a total population of 76,100 in 27 villages. This expansion was in response to the need to coordinate with the government health plan and preexisting services.

The area of Nasirnagar differs from the other three impact areas. Nasirnagar has a poorer, more isolated, less educated population; the population density (2701 persons/sq mile) is the highest next to Dhaka in Bangladesh. The communications are limited especially during the four months when the annual flooding takes place. The economy is predominantly based on agriculture. The other impact areas, Mirzapur, Ghior and Rangunia have an approximate population density of 1800-1900

persons per square mile, produce 2-3 crops per year, have a more reliable communication system and other productive opportunities to agriculture. The Public Health system and health infrastructure in place are also more developed in those impact areas than in Nasirnagar.

The final K & P survey was conducted simultaneously with the CS VIII K & P baseline survey and it covered a population of 76,100 persons. There is an overlapping area in Nasirnagar for CS IV and CS VIII (population of 58,977).

The CSIV project is in the process of phase-over until September, 1993. Although the K & P final survey was conducted now, a formal Final Evaluation will be conducted in July, 1993 to assess the program Sustainability Strategy and to conduct any other studies that the SCF/BFO perceives as relevant for a Child Survival Final Evaluation.

C. Objectives of the survey

A standardized survey was carried out following an agreement between SCF and the PVO Child Survival Support Program (CSSP) at John Hopkins University. Subsequent arrangements were made by the project staff in collaboration with SCF to bring David Newberry, a survey trainer from PVO CSSP and Dr. Loren Galvao SCF/Westport to Bangladesh and train the project staff in carrying out the survey. The SCF/BFO core staff would be adequately trained to conduct future Rapid K & P surveys with a minimum of external assistance.

The objective of the survey was to provide SCF/BFO with knowledge and practice final evaluation information in the project impact areas about the following issues:

* Mothers' knowledge (mothers of children under two) regarding: maternal care, child spacing, appropriate weaning practices and nutrition, diarrheal disease control, immunizations.

* Mothers' practices related to the intervention areas mentioned above. The survey also attempts to assess women's empowerment by evaluating women's literacy levels, membership in Women's Saving's groups and participation in Income Generation Activities.

* Immunization card coverage rate of children (12-23 months) with BCG, DPT, OPV, and measles vaccine.

* Card coverage rate with Tetanus Toxoid (TT) of mothers of children under two

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D. **Schedule of activities**

Dec/92-Jan/93	Communication and coordination with survey trainers prior to their arrival at project site.
January 31/93	Dr. Loren Galvao's arrival
February 1/93	David Newberry's arrival
February 1-3	Orientation to project and preliminary training of project coordinators - Core Team formation Finalizing the questionnaire - 48 questions Translation of the questionnaire into Bengali Logistic preparation and preparation of materials Training Preparation and assignments
February 4-6	Training of supervisors (4th) Training of interviewers and supervisors (5th) Field (Pilot) test of the teams & questionnaire including a debriefing and hand tabulations (6th) final adjustments and reproduced questionnaire
February 7-8	Data collection (two days) 300 interviews of 48 questions for CSVIII K & P baseline.
February 9	Team of supervisors and interviewers travel to Rangunia, Ghior and Mirzapur impact areas.
February 10 11	Data collection for CS IV in Nasirnagar, Rangunia, and Ghior and Mirzapur.
February 11	Hand tabulation of CS IV data
February 14	Data entry of CS IV data on SPSS computer software.
February 15	Finalized CS VIII Report
February 16	Finalizing data entry and analysis. Started CSIV report writing.
February 17	Report Writing
February 18	Feedback of the data to SCF/BFO and finalized CS IV survey draft report
February/93	Feedback by SCF/BFO CS IV program manager to communities surveyed

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II. METHODOLOGY

A. The questionnaire

The standardized survey questionnaire was designed by CSSP Johns Hopkins with assistance of US and international experts for the various intervention areas. Frequent discussions were held with SCF/Headquarters, SCF/BFO and CSSP survey trainer to further customize and finalize the standard questionnaire according to the actual CSIV and CS VIII project interventions and the project area. The questionnaire was administered to mothers aged 14 to 45 with a child of under 24 months of age.

The questionnaire was composed of 48 questions.

Q# 1-2 deal with demographic data (age) and Women's Savings Group Membership.

Q# 3-5 collect data regarding mother's occupation and caretakers

Q# 6-7 collect data on main health problem in the household and health care cost for last month in that household.

Q# 8-13 deal with breastfeeding and other nutrition practices

Q# 14-17 deal with growth monitoring and Vitamin A

Q# 18-25 deal with diarrheal disease control (practice and knowledge).

Q# 26-29 deal with ARI

Q# 30-37 child and mother immunization

Q# 38-46 child spacing and maternal care

Q# 47-48 mother's literacy

To assess "Women's Empowerment" an attempt was made by asking the questions on Women's Savings Groups membership, participation in Income Generation Activities and literacy levels.

The questionnaire was first written in English and then translated into Bengali, the official language in Bangladesh. A translated version was presented to interviewers and supervisors during training. This was further refined for clarity of the intent of the questions.

B. Determination of sample size

The sampling methodology followed the 30 cluster sampling according the WHO/EPI model.

For the determination of the sample sizes, the following formula was used

$n = z^2 pq/d^2$

where n = the sample size, z = statistical certainty chosen p = coverage rate; level of knowledge, and q = 1-p, d = degree of precision.

The sample size was set up in the following way: the degree of precision (d) was set up at 0.1 and the p was set up at 0.5. Thus, the resulting minimum sample size was 210, which was increased at 300.

The number of clusters was 30 with a sample size equal to 300. Thus, for each cluster ten mothers with children under two years of age were interviewed.

C. Selection of sample

The following methodology was used: the sampling interval was calculated by dividing the total population by 30; and using a random number as a starting point 30 clusters were chosen.

The starting point for each cluster was determined in the following manner: the center of the village was located and a random direction was selected. The households were counted towards that direction and the first household was randomly selected among them as a starting point household. The second and subsequent households were the ones which were nearest to the previous one, following always the same direction previously set by the team.

For each cluster, 10 mothers were interviewed in both intervention areas. Due to time constraints, in cases that the mother was not available at the time of the interview another household was chosen (the household nearest to the last household).

D. Method of Data Analysis

The data analysis was performed in two different ways: by hand and by computer. The tabulation by hand was performed to allow field staff to understand completely all the steps of the survey process. The use of computer was performed for a more refined data analysis.

The data entry and analysis was done by computer using SPSS program. For the data analysis frequencies were generated and some cross tabulations. BFO project staff will further develop other cross tabulations.

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III. THE SURVEY

A. Training

There were 10 supervisors (project officers) and 15 female interviewers (community health workers and students), whose training lasted three days (including the pilot test). The training was carried out in Bengali by the Project Manager, the Senior Program Officer and the Computer System Manager.

The training included the purpose of the survey, sample size, sampling methodology, starting point, understanding of the meaning of each question and how to ask each question. Role plays were used to familiarize the interviewers with the technique to be used. Each interviewer was expected to role play the entire questionnaire 3 times and conducted three household interviews each during the field exercise.

The tasks of the supervisors and interviewers were also outlined. The three main tasks of the supervisors were to:

1. Select the starting point
2. Observe one interview each day
3. Check the questionnaires for accuracy and completeness and sign each when finished as their approval assurance

Finally, the interviewers and supervisors went out into a project area (that had not been selected as one of the 30 clusters) to interview 3 mothers for the pilot test. A debriefing session was held to deal with any questions that had arisen during the afternoon and to re-emphasize important points in preparation for data gathering the following day. Staff were available for input throughout the entire training process. The debriefing session after the pilot test was conducted by the Project Manager, the Senior Program Officer and Computer System Manager.

B. The interviews

The supervisors assured, during the data collection, an observation of an interview for each interviewer per day. They verified the questionnaire in order to check out its quality.

There were concerns for sensitive questions contained in the questionnaire, namely the maternal care questions on birth spacing, prenatal care and delivery. For this reason, the surveyors decided only to select female interviewers in order to make sure that the mothers interviewed were comfortable answering the questions thus assuring the reliability of the data. The male supervisors were asked to withdraw from all interviews just before the interviewer began the sensitive questions on maternal care. The three female supervisors were expected to remain throughout the entire interview.

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IV. SURVEY RESULTS

Q1a. Distribution of Mothers by Age in Years

	Number	Percent
Age in years		
Upto 19	63	21.1%
20 to 24	82	27.4%
25 to 29	83	27.8%
30 to 34	40	13.4%
35 to 39	25	8.4%
40 to 44	6	2.0%
Total	299	100.0%

Mean 25.047 Median 25.000 Mode 22.000

Q1b. Distribution of Mothers by Membership in Women Savings Group

	Number	Percent
Membership		
Yes	142	48.0%
No	154	52.0%
Total	296	100.0%

Q2. Distribution of Children by Age in Months

	Number	Percent
Age in months		
Upto 5	126	42.0%
6 to 11	67	22.3%
12 to 17	77	25.7%
18 to 23	30	10.0%
Total	300	100.0%

Mean 8.979 Median 9.000 Mode 3.000

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Q5. Distribution of Mothers by Care Taker
While the Mother is Away From Home
(Multiple Answers Possible)

	Number	Percent
Mother takes child with her		
No	271	90.3%
Yes	29	9.7%
Husband/partner		
No	250	83.3%
Yes	50	16.7%
Older children		
No	172	57.3%
Yes	128	42.7%
Other relatives		
No	140	46.7%
Yes	160	53.3%
Neighbors/friends		
No	207	69.0%
Yes	93	31.0%
Maid		
No	296	98.7%
Yes	4	1.3%
Nursery school		
No	297	99.0%
Yes	3	1.0%
Never away from home		
No	300	100.0%
Total YES	467	

Q2

Q6. Distribution of Households Main Health Problem
(Multiple Answers Possible)

	Number	Percent
Respiratory		
No	129	43.0%
Yes	171	57.0%
Fever, convulsion		
No	201	67.0%
Yes	99	33.0%
Vomiting, diarrhea		
No	183	61.0%
Yes	117	39.0%
OB/GYN		
No	288	96.0%
Yes	12	4.0%
Rheumatoid & joint problems		
No	236	78.7%
Yes	64	21.3%
Other		
No	228	76.0%
Yes	72	24.0%
Total YES	535	

Q7. Distribution of Households by Amount Money Spent
to Treat Illness in Last Month

	Number	Percent
Amount in Taka		
None	60	20.0%
Upto 50	56	18.7%
51 to 100	40	13.3%
101 to 150	10	3.3%
151 to 200	25	8.3%
201 to 300	22	7.3%
301 to 500	26	8.7%
501 & above	17	5.7%
No response	44	14.7%
Total	300	100.0%

Mean	210.043	Median	72.500	Mode	.000
Sum	53771.008				

93

Q8. Distribution of Mothers by Breastfeeding Now

	Number	Percent
Breastfeeding now		
Yes	292	98.0%
No	6	2.0%
Total	298	100.0%

Q9. Distribution of Mothers by Ever Breastfed

	Number	Percent
Ever breastfed		
Yes	5	83.3%
No Response	1	16.7
Total	6	100.0%

Q10. Distribution of Mothers by When Breastfed First Time After Delivery

	Number	Percent
First time breastfed		
Within 1 hour after delivery	129	43.0%
Within 1 to 8 hours after delivery	98	32.7%
Within 8 hours to 3 days after delivery	42	14.0%
3 days after delivery	25	8.3%
Can not remember	6	2.0%
Total	300	100.0%

94

Q11. Distribution of Mothers by Giving the Child

	Number	Percent
Water or sweetened water		
Yes	143	47.7%
No	157	52.3%
Cow milk, goat milk or formula		
Yes	112	37.5%
No	187	62.5%
Semisolid foods		
Yes	142	47.7%
No	156	52.3%
Fruits or juices		
Yes	136	45.3%
No	164	54.7%
Carrot, squash, mango or papaya		
Yes	117	39.4%
No	180	60.6%
Leafy green vegetables		
Yes	126	42.1%
No	173	57.9%
Meat or fish		
Yes	104	34.8%
No	195	65.2%
Lentils		
Yes	116	38.7%
No	184	61.3%
Eggs		
Yes	110	36.7%
No	189	63.0%

Q12. Distribution of Mothers by When Should Start Adding Foods to Breastfeeding

	Number	Percent
When		
Between 4 and 6 months	139	46.3%
Earlier than 4 months	39	13.0%
6 months or later	94	31.3%
Do not know	28	9.3%
Total	300	100.0%

Q13. Distribution of Mothers by What Should the Additional Foods to Breastfeeding be (Multiple Answers Possible)

	Number	Percent
Does not know		
No	279	93.0%
Yes	21	7.0%
Gruels/porridge/chatu/rice		
No	78	26.0%
Yes	222	74.0%
Lentils/egg/meat/fish		
No	154	51.3%
Yes	146	48.7%
Fruits/vegetables		
No	120	40.0%
Yes	180	60.0%
Other		
No	259	86.3%
Yes	41	13.7%

Q14. Distribution of Children by Ever Weighed

	Number	Percent
Ever weighed		
Yes	131	43.8%
No	167	55.9%
Does not know	1	.3%
Total	299	100.0%

Q15. Distribution of Children by Growth Monitoring Card

	Number	Percent
Have growth card		
Yes	115	38.7%
Lost card	11	3.7%
No	171	57.6%
Total	297	100.0%

96

Q22. Distribution of Children by Treatment During Diarrhea
(Multiple Answers Possible)

	Number	Percent
Nothing		
No	68	93.2%
Yes	5	6.8%
ORS		
No	54	74.0%
Yes	19	26.0%
Sugar-salt solution		
No	39	53.4%
Yes	34	46.6%
Cereal based ORT/barley water		
No	72	98.6%
Yes	1	1.4%
Infusion or other fluids		
No	70	95.9%
Yes	3	4.1%
Anti-diarrhea medicine		
No	31	42.5%
Yes	42	57.5%
Other		
No	58	79.5%
Yes	15	20.5%

97

Q23. Distribution of Mothers by Signs/Symptoms would Cause to Seek Advice or Treatment for Diarrhea of the Child (Multiple Answers Possible)

	Number	Percent
Does not know		
No	291	97.0%
Yes	9	3.0%
Vomiting		
No	152	50.7%
Yes	148	49.3%
Fever		
No	242	80.7%
Yes	58	19.3%
Dry mouth, sunken eyes		
No	215	71.7%
Yes	85	28.3%
Diarrhea of prolonged duration		
No	167	55.7%
Yes	133	44.3%
Blood in stool		
No	273	91.0%
Yes	27	9.0%
Loss of appetite		
No	287	95.7%
Yes	13	4.3%
Weakness or tiredness		
No	146	48.7%
Yes	154	51.3%
Other		
No	223	74.3%
Yes	77	25.7%

Q22. Distribution of Children by Treatment During Diarrhea
(Multiple Answers Possible)

	Number	Percent
Nothing		
No	68	93.2%
Yes	5	6.8%
ORS		
No	54	74.0%
Yes	19	26.0%
Sugar-salt solution		
No	39	53.4%
Yes	34	46.6%
Cereal based ORT/barley water		
No	72	98.6%
Yes	1	1.4%
Infusion or other fluids		
No	70	95.9%
Yes	3	4.1%
Anti-diarrhea medicine		
No	31	42.5%
Yes	42	57.5%
Other		
No	58	79.5%
Yes	15	20.5%

99

Q23. Distribution of Mothers by Signs/Symptoms would Cause to Seek Advice or Treatment for Diarrhea of the Child (Multiple Answers Possible)

	Number	Percent
Does not know		
No	291	97.0%
Yes	9	3.0%
Vomiting		
No	152	50.7%
Yes	148	49.3%
Fever		
No	242	80.7%
Yes	58	19.3%
Dry mouth, sunken eyes		
No	215	71.7%
Yes	85	28.3%
Diarrhea of prolonged duration		
No	167	55.7%
Yes	133	44.3%
Blood in stool		
No	273	91.0%
Yes	27	9.0%
Loss of appetite		
No	287	95.7%
Yes	13	4.3%
Weakness or tiredness		
No	146	48.7%
Yes	154	51.3%
Other		
No	223	74.3%
Yes	77	25.7%

Q25. Distribution of Mothers by Important Actions Should be Taken If the Child is Recovering Diarrhea (Multiple Answers Possible)

	Number	Percent
Does not know		
No	284	94.7%
Yes	16	5.3%
Give the child smaller more frequent feeds		
No	224	74.7%
Yes	76	25.3%
More foods than usual		
No	229	76.3%
Yes	71	23.7%
Give food with higher caloric content		
No	126	42.0%
Yes	174	58.0%
Other		
No	245	81.7%
Yes	55	18.3%

Q26. Distribution of Children by Cough or Difficult Breathing in the Last Two Weeks

	Number	Percent
Cough or difficult breathing		
Yes	86	28.9%
No	211	70.8%
Total	297	100.0%

Q27. Distribution of Children by Rapid Difficult Breathing When Ill

	Number	Percent
Rapid difficult breathing		
Yes	78	91.8%
No	7	8.2%
Total	85	100.0%

101

Q31. Distribution of Mothers by Age to Receive Measles Vaccine

	Number	Percent
Age in months		
Correct	83	27.7%
Incorrect	62	20.7%
Does not know	155	51.7%
Total	300	100.0%

Q32. Distribution of Mothers by Reasons Why Pregnant Women Need to be Vaccinated with TT

	Number	Percent
Reasons		
To protect both mother/newborn	186	62.0%
To protect only women	51	17.0%
To protect only newborn	10	3.3%
Does not know	53	17.7%
Total	300	100.0%

Q33. Distribution of Mothers by How Many TT to Receive to Protect the Newborn Against Tetanus

	Number	Percent
How many		
One	37	12.3%
Two	105	35.0%
More than two	130	43.3%
None	1	.3%
Does not know	27	9.0%
Total	300	100.0%

Q34. Distribution of Children by Immunization Card

	Number	Percent
Immunization Card		
Yes	124	41.5%
Lost it	65	21.7%
Never had one	110	36.8%
Total	299	100.0%

Q35. Distribution of Children Immunized by Card

Age in month	No		Yes	
	Number	Percent	Number	Percent
BCG				
Upto 11	123	63.7%	70	36.3%
12 to 23	59	55.1%	48	44.9%
OPV1				
Upto 11	121	62.7%	72	37.3%
12 to 23	59	55.1%	48	44.9%
OPV2				
Upto 11	143	74.1%	50	25.9%
12 to 23	59	55.1%	48	44.9%
OPV3				
Upto 11	156	80.8%	37	19.2%
12 to 23	65	60.7%	42	39.3%
DPT1				
Upto 11	122	63.2%	71	36.8%
12 to 23	59	55.1%	48	44.9%
DPT2				
Upto 11	143	74.1%	50	25.9%
12 to 23	60	56.1%	47	43.9%
DPT3				
Upto 11	156	80.8%	37	19.2%
12 to 23	65	60.7%	42	39.3%
Measles				
Upto 11	177	91.7%	16	8.3%
12 to 23	68	63.6%	39	36.4%

Overall Drop Out Rate:
(BCG - Measles)/ BCG x 100= (118-55)/118 x 100= 53.38%

DPT Drop Out Rate:
(DPT1 -DPT3)/ DPT1 x 100= (119 - 79)/119 x 100= 33.61%

OPV Drop Out Rate:
(OPV1 -OPV3)/OPV1 x 100= (120- 79)/ 120 x 100= 34.16%

Q36. Distribution of Mothers by TT Card

	Number	Percent
TT card		
Yes	100	33.3%
Lost it	98	32.7%
No	102	34.0%
Total	300	100.0%

Q37. Distribution of Mothers TT Immunization by Card

	Number	Percent
TT record		
One	26	25.5%
Two	36	35.3%
Three	39	38.2%
None	1	1.0%
Total	100	100.0%

Q38. Distribution of Mothers by Pregnant Now

	Number	Percent
Pregnant now		
Yes	4	1.3%
No	296	98.7%
Total	300	100.0%

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Q39. Distribution of Mothers by When to Have Next Child

	Number	Percent
Next child		
Less than 2 years	8	2.7%
2 to 3 years	29	9.8%
3 or more years	105	35.5%
Does not know	55	18.6%
No more child	99	33.4%
Total	296	100.0%

Q40. Distribution of Mothers by Contraception

	Number	Percent
Contracepting		
Yes	57	19.3%
No	239	80.7%
Total	296	100.0%

Q41. Distribution of Mothers by Methods of Contraception

	Number	Percent
Methods		
Tubal ligation	7	13.0%
Injections	4	7.4%
Pill	33	61.1%
IUD	1	1.9%
Condom	9	16.7%
Total	54	100.0%

Q42. Distribution of Mothers by When After Pregnancy Should See a Health Professional

	Number	Percent
When		
1 to 3 months	99	33.0%
4 to 6 months	124	41.3%
7 to 9 months	18	6.0%
No need to see health worker	10	3.3%
Does not know	49	16.3%
Total	300	100.0%

Q46. Distribution of Mothers by Who Tied and Cut the Cord

	Number	Percent
Who		
Yourself	33	11.0%
Family member	13	4.3%
TBA	236	78.7%
Health professional	15	5.0%
Other	1	.3%
Does not know	2	.7%
Total	300	100.0%

Q47. Distribution of Mothers by Highest Educational Level

	Number	Percent
Highest education		
None	212	70.7%
1 to 5 years	47	15.7%
6 to 8 years	25	8.3%
9 or more years	16	5.3%
Total	300	100.0%

Q48. Distribution of Mothers by Can Read

	Number	Percent
Can read		
Yes	82	27.3%
No	218	72.7%
Total	300	100.0%

Distribution of Children by Exclusive Breastfeeding

	Exclusive breastfeeding			
	No		Yes	
	Number	Percent	Number	Percent
Age in month				
Upto 3	42	44.7%	52	55.3%
4 to 23	196	95.1%	10	4.9%

Distribution of Children by Weaning Practice

	Weaning practice			
	No		Yes	
	Number	Percent	Number	Percent
Age in month				
Upto 3	72	76.6%	22	23.4%
4 to 6	14	36.8%	24	63.2%
7 to 23	12	7.1%	156	92.9%

B. **Summary of results**

Age Distribution

In Bangladesh age determination for mothers may be a problem. The interviewers were carefully trained to establish the correct age of mothers using a historical calendar. For under two children age determination is not a problem; mothers could remember the Bangla dates and from that the supervisors could translate those in European style dates using diaries which contained Bangla and English dates.

The mean age of children in this sample was 8.9 months. 193 (64.3%) of children are between 0-11 months. The mean age of mothers in the survey was 25.04 years. The range in mother's age was 15 to 44 years.

Socio-Economic Characteristics

Women's Savings group rate of membership was 48.0%. This positive result reflects the strong focus that SCF/BFO has placed in the development of Women's Savings Groups throughout this project. Working away from the home was done only by 2.7% of the mother's interviewed. The most frequent caretaker of children under two year in age was relatives. Older children and neighbors were also frequently caretakers of small children.

Health Situation and Estimated Expenditure for Health Care

Major, most recent (last two weeks) health problems occurring in the households interviewed include: respiratory, diarrhea/vomiting, fever and disabling joint problems. OB/GYN was a small percentage probably because women were not asked directly and usually they do not consider their health problems as a real problem. The household's total estimated expenditure for health services was about 53.771,008 Taka for the last month. Excluding those who recovered without spending money, the average household expenditure was 210.043 Taka per household for health services. The potential use for such funds may be

worth assessing to the potential sustainability of some health interventions of CS IV.

Breastfeeding/Nutrition

98% of the mothers declare they breastfeed their children. Exclusive breastfeeding below four months of age was reported 55.3% in this sample. 23.4% of the mothers started weaning practices when child was below 4 months of age; 63.2% of the mothers started weaning when child was between 4 and 6 months; 7.1% of children between 7 and 23 months were still being exclusively breastfed.

In general the survey findings show good levels of knowledge and practices related to nutrition and health. The mothers in this sample began nursing their babies during the first 8 hours by 75.7% and 89.7% began nursing their child within the first 72 hours.

Mother's knowledge about proper age to start weaning was found to be 46.3%. A significant number thought that weaning should begin 6 months or later (31.3%). The introduction of semisolid and solid foods with appropriate ingredients for protein was 48.7%, for carbohydrates was 74.0% and fruits and vegetables was 60.0%. Further cross tabulation is recommended for this question.

Vitamin A

46.8% of mothers reported their child had received vitamin A capsules and a relevant percentage (43.3%) knew that vitamin A would prevent night blindness.

Growth Monitoring

115 children out of the 297 (38.7%) children in the sample had a growth monitoring card. 43.8% of children were weighed at least one time.

Diarrheal Disease

24.3% (73 out of 300) of the children in the sample had diarrhea in the last two weeks. The seasonality of diarrheal disease was reported to be low during survey period. 26% of mothers whose children had diarrhea used ORS packages and 46.6% used sugar-salt solution. 57.5% of mothers used medicine and treatment for their child's diarrhea. Respectively, 27.4% and 13.5% of the mothers whose children had diarrhea gave less breastmilk and less liquid.

28.3% of the mothers in the sample knew that dry mouth, sunken eyes, and decreased urine output are important symptoms of their children's diarrhea. Profuse and prolonged diarrhea was identified as danger signs of dehydration by 44.3% and "weakness" was given by 51.3% of mothers. For the knowledge about what important actions should be taken if child has diarrhea 78.7% reported proper mixing and administration of ORS and 68.0% reported take the child to the hospital/health center. For the knowledge about what are the

important actions when a child is recovering from diarrhea 58.0% of the mothers declare they give foods with high caloric content. Further cross tabulation is recommended for the ORT usage rate.

Acute Respiratory Illness

ARI was not an intervention for CS IV but the information on ARI was collected for the CS VIII K & P baseline survey as well as for the CS IV Final survey.

The prevalence rate for ARI was found to be 28.9%. SCF staff reported that the current season is considered low for ARI. The ALRI rate of complication was reported in 91.8% of the cases (78/85); 82% (64 out of 78 cases) of the mothers whose children had ALRI sought treatment when their child was ill. 74% and 44.3% reported that they would take their child to a health facility if they had respectively fast/difficult breathing or chests indrawing.

Immunizations

41.5% of the children had immunization cards. 21.7% of the immunization cards were lost.

27.7% of the mothers in the sample knew that a child should be immunized against measles at nine months of age. While many mothers gave incorrect estimates, 51.7% did not know the correct age for measles immunization. 62% of mothers answered that a pregnant woman needed to be vaccinated against Tetanus to protect both mother and newborn. 38% of the mothers in the sample did not know the main reason why a pregnant woman needs to be vaccinated against Tetanus. 35.0% of the mothers in the sample declared that two injections were needed to protect a newborn against tetanus and 43.% answered more than two.

36.4.% of the children (12-23 months) were immunized for Measles, by card only; 44.9% of children (12-23 months) were immunized for BCG, by card only. The card immunization coverage for OPV3 was 39.3.% and for DPT1 it was 36.8%. The dropout rate (DPT1-DPT3/DPT1) was 33.61% and the overall dropout rate was 53.38%. These findings are based on a small substrata of only 124 children with cards.

Maternal Care

33.3% of the mothers had a TT immunization card; 32.7% of the TT immunization cards were lost. Among the mothers who had a maternal health card 75% (75/100) received two or more TT vaccinations.

45.3% of the mothers in the sample (excluding the pregnant women) did not want to have a child in the next three years. Among the mothers who wanted to space their next child, 80.7% are not using a modern method to avoid/postpone the pregnancy. The contraceptive prevalence rate is 19.3%. The numerator is 57 (the number of women using contraceptives) and the denominator is 296 (the number of women in the sample minus the number of pregnant women). 61% of the women

contracepting were using pills. Condom use was low, 16.7% in this sample.

41.3% of the mothers in the sample answered that after pregnancy a woman should see a health professional between 1 and 3 months. 82% of the same women did identify protein foods, 53% green leafy vegetables and 19% iron tablets as important items or food which are good to prevent pregnancy anemia. 75.3% of all the mothers visited a health center when they were pregnant. 29.7% of the mothers in the sample ate during their pregnancy same as usual. 38.7% of all mothers surveyed reported eating less than usual during their pregnancy and 31.7% more than usual. At the delivery 11% of the mothers in this sample cut and tied their own cord. In 78.71% of the deliveries in this sample, TBAs cut and tied the cord.

Education and Literacy

212 of all mothers surveyed, did not receive any formal education. 27.3% were able to read.

C. Implications of the final data

These data provides useful information in terms of assessing the knowledge and practices of mothers of children under two years old targeted by the CS IV project.

The results may also be used as lessons learned for future health program planning for the SCF/BFO and within SCF. Results should be widely shared with government institutions, local NGOs, PVOs, Johns Hopkins University CSSP and other relevant organizations in Bangladesh and internationally.

Since the CS IV project is in the process of phasing over until the end of the grant period (September 1993) this data will provide support to develop a phase-over Sustainability Strategy.

A baseline survey (CS VIII) for the new intervention area (Nasirnagar) was conducted simultaneously with the CSIV Final survey. Although the results can not be statistically compared, it is recommended that a further study is conducted to look at the trends for CS IV and CS VIII survey results. One option could be to analyze and look at trends of the data from Nasirnagar: 18 clusters of CSIV ("exposure area") and 30 clusters of CS VIII ("no exposure area").

The CS IV K & P Final Survey results should be attached to the CS IV Final Evaluation report. The FE will be conducted in July, 1993.

D. National Data

Immunization levels from this survey can not be statistically compared to the national figures because the project immunization

coverage is based on the immunization card and at national levels the immunization coverage is based both on card and history. The immunization levels in this survey are for all children 12-23 months with immunization card in this sample. The number of cards was low and a high percentage of cards was lost.

The BCG coverage for the national rate is 86%; DPT3 is 69% and for Measles 65% (Source: UNICEF, 1992).

For the Family planning activity the national contraceptive prevalence rate is 31% (source: UNICEF, 1993) while for survey area is 19.3%. The fact that in this sample the mothers surveyed were of children under two years old may bias the sample suggesting very low contraceptive rates when compared to national data.

Female literacy at the national level is 22% (source: UNICEF, 1993) and for Nasirnagar is 10% (source: Bangladesh Government, 1991) while in this sample 27.3% of mothers were able to read.

V. FEEDBACK SESSIONS/ARRANGEMENTS

There was one feedback session held with SCF/BFO staff in the SCF/Bangladesh Field Office in Dhaka. The feedback session was attended by the Field Office Director, the CSVIII Program Manager, the Senior Program Officer, the Computer Systems Manager and the SCF/Headquarters representative. These results should be discussed again during the debriefing of the CS IV Final Evaluation in July, 1993. It is recommended that MOH, USAID and staff of other NGOs should be invited for that session.

A feedback session to field-based staff in Nasirnagar was planned for February 1993. The field staff will further provide feedback to the communities surveyed.

VI. SURVEY COSTS

A baseline survey for the expansion area (CSVIII) and a final evaluation survey (CS IV) were conducted simultaneously. The costs from line 1 to line 6 are 50% of the total costs for both surveys.

1.	Preparation of Activities: (survey tools, materials, questionnaires)	$274.
2.	Survey Training	$ 47.
3.	Travel, Fuel	$224.
4.	Data Collection (Interviewers)	$374
5.	Miscellaneous	$ 65.
6.	Report writing (CS IV and CS VIII)	$ 65.
	Subtotal:	$1049.
7.	Travel costs and airfare for JHU survey trainer	$2,200.
8.	Estimated expenses for local travel, meals and lodging for JHU survey trainer	$1,457.
	Total	$4,706.

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7. UNICEF, Bangladesh. Selected Statistical Series, Feb. 1991.

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9. 1992 Statistical Book of Bangladesh. Bangladesh Bureau of Statistics. Statistics Division, Ministry of Planning, Government of People's Republic of Bangladesh.

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Appendix 1

PVO Child Survival Knowledge & Practice Questionnaire
SAVE THE CHILDREN (USA) BANGLADESH FIELD OFFICE

IDNUM: _____

All questions are to be addressed to the mother with a child under two (less than 24 months old)

Interview date __/__/93 (dd/mm) Reschedule interview __/__/93 (dd/mm)

Community or Village_____
Cluster Number_____ Household Number_____
Interviewer's name and Signature _____
Cluster Number_____ Household Interview Number_____
Supervisor's signature _____
Community _____

1. Name and age of the mother

a. Name _____ Age (years)_____
b. Member of a Women's Savings Group YES ___ NO___

2. Name and age of the child under two years old

Name _____

Birth date __/__/__ (dd/mm/yy) Age in months_____

Mother's Occupation

3. Do you work away from home? (6 or more hours for 3 or more days a week)
   1. yes [ ]
   2. no [ ]

4. Do you do any "income generating work"? (multiple answers possible; record all answers)
   a. nothing [ ]
   b. handicraft, embroidery, weaving [ ]
   c. Post harvest food processing [ ]
   d. Agricultural products for sale [ ]
   e. Vegetables and basic food production [ ]
   f. Live stock and poultry production [ ]
   f. servant/services [ ]
   g. Small trading, shop keeper, [ ]
   h. salaried worker [ ]
   i. other (specify) _____ [ ]

.ng (name of child) semisolid foods such as
, porridge or semolina?
[ ]
[ ]
sn't know [ ]

ng (name of child) fruits or juices?
[ ]
[ ]
:n't know [ ]

ing (name of child) carrot, squash, mango or
[ ]
[ ]
sn't know [ ]

ing (name of child) leafy green vegetables,
ach?
[ ]
[ ]
sn't know [ ]

ing (name of child) meat or fish?
[ ]
[ ]
sn't know [ ]

ing (name of child) lentils?
[ ]
[ ]
sn't know [ ]

ing (name of child) eggs?
[ ]
[ ]
esn't know [ ]

ther start adding foods to breastfeeding?
dding between 4 and 6 months [ ]
dding earlier than 4 months [ ]
dding 6 months or later [ ]
know [ ]

e additional foods to breastfeeding be?
s possible; record all answers)
know [ ]
porridge/chatu/rice [ ]
egg/meat/fish [ ]
vegetables [ ]
specify) _____ [ ]

tments, if any,
ord all answers)
[ ]
[ ]
[ ]
[ ]
[ ]
s [ ]
[ ]

advice or
?
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d) has diarrhea?
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ake when a child
s)
[ ]
feeds [ ]
[ ]
/good food [ ]
_____ [ ]

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5. doesn't know [ ]

34. Do you have an immunization card for (name of child)?
    1. yes [ ] (must see card)
    2. lost it [ ] ---> go to 36
    3. never had one [ ] ---> go to 36

35. Look at the vaccination card and record the dates of all the immunizations in the space below (dd/mm/yy)

BCG		__/__/__
OPV	1st	__/__/__
	2nd	__/__/__
	3rd	__/__/__
DPT	1st	__/__/__
	2nd	__/__/__
	3rd	__/__/__
Measles		__/__/__
		__/__/__

MATERNAL CARE

36. Do you have a TT immunization card for you?
    1. yes (must see card) [ ]
    2. lost it ---> go to 38 [ ]
    3. no ---> go to 38 [ ]

37. Look at the TT immunization card and record the number of TT vaccinations in the space below:
    1. one [ ]
    2. two or more [ ]
    3. none [ ]

Appendix 2

এস.সি/বি.এফ.ও– সি.এস– [৪] [৮]

আই.ডি. নং

সেভ দি চিলড্রেন (ইউ. এস. এ)
বাংলাদেশ ফিল্ড অফিস

মায়ের
শিশু প্রতিরক্ষা বিষয়ক জ্ঞান ও আচরণ বিষয়ক জরীপ প্রশ্নপত্র

(প্রশ্নপত্রটি শুধুমাত্র দুই বৎসরের কম বয়সী শিশুর মায়েদের সাক্ষাৎকারের জন্য ব্যবহৃত হবে)

সাক্ষাতের তারিখঃ ------/ ------/ ------/
দিন মাস সন

সাক্ষাতকার গ্রহণকারীর নামঃ----------
স্বাক্ষরঃ----------
পরিদর্শকের নামঃ----------
স্বাক্ষরঃ---------

গ্রামঃ----------
গুচ্ছ নংঃ----------
ক্রমিক নংঃ----------

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৯। আপনার পরিবারে প্রধান স্বাস্থ্য সমস্যা কি? (কি ধরনের অসুখ সাধারণতঃ লেগেই থাকে/বেশী হয়)

(১) সর্দি-কাশি জাঁড়ায়/শ্বাস জনিত রোগ
(২) জ্বর, খিচুনী
(৩) দাস্ত -বমি/ পেটের অসুখ
(৪) স্ত্রী রোগ
(৫) বাত-ব্যথা- বেদনা
(৬) অন্যান্য, লিখুনঃ-

। গত মাসে আপনার পরিবারে অসুখ-বিসুখের চিকিৎসায় কত টাকা খরচ হয়েছে (ঔষধ পথ্য - ডাক্তার এবং যাতায়াত সহকারে)?

(১) . . . . .টাকা
(২) জানিনা

<u>— বুকের দুধ খাওয়ানো/পুষ্টি বিষয়ক—</u>

-। আপনি কি (শিশুর নাম) কে এখনও বুকের দুধ খাওয়াচ্ছেন?

(১) হ্যাঁ - - - -> ১০ নং প্রশ্নে যান
(২) না

। আপনি কি কখনো (শিশুর নাম) কে বুকের দুধ দিয়েছেন?

(১) হ্যাঁ
(২) না - - -> ১১ নং প্রশ্নে যান

০। প্রসবের কতক্ষন/কত সময় পর সর্বপ্রথম আপনি (শিশুর নাম) কে বুকের দুধ খেতে দিয়েছেন?

(১) প্রসবের ১ ঘন্টার মধ্যে
(২) প্রসবের পর ১ থেকে ৮ ঘন্টার মধ্যে
(৩) প্রসবের পর ৮ঘন্টা থেকে ৩ দিনের মধ্যে
(৪) প্রসবের ৩দিনের পরে
(৫) মনে নেই

— ডায়রিয়া বিষয়ক —

১৮। গত ২ সপ্তাহের মধ্যে কখনো (*শিশুর নাম*) এর ডায়রিয়া/পাতলা পায়খানা হয়েছিল কি?

(১) হ্যাঁ

(২) না - - - › ২৩ নং প্রশ্নে যান

(৩) জানিনা - - -› ২৩ নং প্রশ্নে যান

১৯। (*শিশুর নাম*) এর পাতলা পায়খানা/ডায়রিয়ার সময় আপনি কি (*শিশুর নাম*) কে বুকের দুধ খাইয়েছিলেন?

(উত্তর গুলো মা কে পড়ে শোনান)

(১) সচরাচরের চেয়ে বেশী ?

(২) সচরাচরের মতই ?

(৩) সচরাচরের চেয়ে কম?

(৪) বন্ধ করেছিলেন ?

(৫) বাচ্চা বুকের দুধ খেতনা

২০। (*শিশুর নাম*) এর পাতলা পায়খানার সময় (*শিশুর নাম*) কে বুকের দুধ ছাড়া আর অন্য কোন পানীয়/তরল খাবার দিয়েছিলেন কি?

(উত্তরগুলো মাকে পড়ে শোনান)

(১) সচরাচরের চেয়ে বেশী পরিমানে

(২) সচরাচরের মতই

(৩) সচরাচরের চেয়ে কম পরিমানে

(৪) সম্পূর্ণ বন্ধ করে দিয়েছিলেন

(৫) শুধুমাত্র বুকের দুধই দিয়েছিলেন

২১। (*শিশুর নাম*)-এর পাতলা পায়খানার সময়ে, যে সব শক্ত বা আধা শক্ত খাবার (*শিশুর নাম*) কে খাওয়াচ্ছিলেন সে সব খাওয়ানো কি চালিয়ে গিয়েছিলেন?

(উত্তর গুলো মা কে পড়ে শোনান)

(১) আরও বেশী পরিমানে খাইয়েছিলেন

(২) একই পরিমানে খাইয়েছিলেন

(৩) সচরাচরের চেয়ে কম পরিমানে খাইয়েছিলেন

(৪) সে সব খাবার বন্ধ করে দিয়েছিলেন

(৫) শুধুমাত্র বুকের দুধই দিয়েছিলেন

৩৫। টিকার কার্ড দেখে নিম্নের টিকা দেওয়ার তারিখ গুলো পূরন করুনঃ

		দিন/	মাস/	সন
বি. সি. জি		-	-	-
পলিও	১ম	-	-	-
	২য়	-	-	-
	৩য়	-	-	-
ডি. পি. টি	১ম	-	-	-
	২য়	-	-	-
	৩য়	-	-	-
হাম		-	-	-

<u>—মায়ের যত্ন বিষয়ক —</u>

৩৬। আপনার নিজের টিটি টিকার কার্ড আছে কি?

(১) হ্যাঁ - - -------> (অবশ্যই কার্ডটি দেখতে হবে)

(২) হারিয়ে গেছে - - -> ৩৮ নং প্রশ্নে যান

(৩) নাই - - ------> ৩৮ নং প্রশ্নে যান

৩৭। টি টি টিকার কার্ডটি দেখুন এবং কয়টি টিকা দেওয়া আছে তা নিম্নে লিপিবদ্ধ করুনঃ

(১) ১টি

(২) ২টি

(৩) ৩টি

(৪) একটিও নয়

৩৮। আপনি কি এখন গর্ভবতী?

(১) হ্যাঁ - - > ৪২ নং প্রশ্নে যান

(২) না

৩৯। আপনার পরবর্তী বাচ্চা কখন নিতে চান?

(১) ২ বৎসরের মধ্যে

(২) ২-৩ বৎসরের মধ্যে

(৩) ৩ বৎসরের পর

(৪) জানিনা

(৫) আর বাচ্চা চাই না

৪০। জন্ম নিরোধের জন্য বর্তমানে আপনি কি এখন কোন জন্ম নিয়ন্ত্রন. পদ্ধতি ব্যবহার করছেন?

(১) হ্যাঁ

(২) না - - -> ৪২ নং প্রশ্নে যান

৪৫। (শিশুর নাম) গর্ভে থাকাকালীন সময়ে আপনি কি রকম খেয়েছিলেন?

(উত্তর গুলো মাকে পড়ে শোনান)

(১) সচরাচরের চেয়ে বেশী

(২) সচরাচরের মতই

(৩) সচরাচরের চেয়ে কম

(৪) জানিনা/মনে নেই

৪৬। জন্মের সময় (শিশুর নাম) এর নাড়/নাভী কেটেছিল ও বেঁধেছিল কে?

(১) আপনি নিজে

(২) পরিবারের কেহ

(৩) দাইমা

(৪) কোন স্বাস্থ্য কর্মি (ডাক্তার, নার্স, মিডওয়াইফ)

(৫) অন্যকেহ, লিখুন-

(৬) জানিনা

৪৭। আপনি কত বৎসরের শিক্ষা সম্পন্ন করেছেন?

(১) ০

(২) ১-৫ বৎসর

(৩) ৬-৮ বৎসর

(৪) ৯ বা ততোধিক বৎসর

৪৮। আপনি কি এই লেখাটি পড়তে পারেন?

(১) হ্যাঁ

(২) না

'এই সাক্ষাতকারে আপনার সার্বিক সহযোগিতার জন্য আপনাকে আন্তরিক ধন্যবাদ'।

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Appendix 3

TRAINING AGENDA

DAY 1
February 4, 1993

Focus:	Training of Supervisors
Time	Activity
1:30-2:00	Introductions
2:00-2:20	State purpose & objectives of the K & P survey (D.N., L.G.)
2:20-2:30	Present time frame of the survey activity, analysis of results, report writing and feedback to communnity and staff (D.N.,L.G.)
2:30-3:00	Read the questionnaire
3:00-4:00	Review sampling methodology, sample size and household selection/Role play (Nazmul)
4:00-4:15	Break
4:15-4:30	Review of starting point/Role play (Nazmul)
4:30-5:15	Explain purpose of each question (Najma)
5:15-5:30	Review role of supervisors/Assignments (Afzal)

DAY 2
February 5, 1993

Focus:	Training of Supervisors and Interviewers
Time	Activity
8:30-9:00	Review day before and Introductions
9:00-9:20	State Purpose of the K&P survey (D.N., L.G.)
9:20-9:30	Present the time frame of the survey activity, analysis of results, report writing and feedback to community staff (D.N., L.G.)
9:30-10:00	Read questionnaire
10:00-10:30	Explain purpose of each question (Najma)
10:30-10:45	Break

SAVE THE CHILDREN/US
BANGLADESH FIELD OFFICE

UNIVERSITY RESEARCH CORPORATION/BANGLADESH

Health Care Services Utilization and Behavioral Pattern in Save the Children/US Catchment Areas

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EXECUTIVE SUMMARY

1. BACKGROUND

Save the Children (USA) has been operating in four thanas of Bangladesh, namely, Nasirnagar, Rangunia, Ghior and Mirzapur, covering about 12,000 households in 10 unions. The entire program of Save the Children (SC) is focused on women's empowerment, to be achieved through program interventions in such areas as health, education, family planning and income generation activities. The health program is aimed at achieving sustained improvement in infant, child, and maternal morbidity and mortality through promotion of health protective behaviors. The health care program of SC seeks to change behaviors and attitudes at the family level that would enable families learn behaviors that are within their control. In the cases of behaviors that would necessitate support services from other health providers such as government and NGOs, the SC would facilitate linkages with the local providers to ensure availability of services. Thus, sustainability related to health behavior is expected to be achieved. This study has addressed the issue of sustainability related to health behavior (i.e., behavioral sustainability) among the MWRAs and their family members in the SC catchment areas.

2. OBJECTIVES

The major objectives of the study were to:

(a) examine the utilization of primary health care services, and behavioral pattern in respect of EPI, MCH, and family planning;

(b) identify the factors responsible for the various types of services utilization pattern and behavioral pattern, with specific focus on EPI, MCH and family planning, and

(c) assess, with special emphasis on the NGO health care approaches, the implications of services utilization and behavioral patterns on the sustainability related to health behavior among the clientele population.

3. METHODOLOGY

3.1 Sampling Plan

The study was carried out in four selected SC catchment areas (Nasirnagar, Rangunia, Ghior, and Mirzapur). The sampling frame for the study was the Project Management Information System (PMIS) of SC. According to SC PMIS, there are 11,825 MWRAs in the four study areas. By using appropriate sampling technique, the total sample size was estimated to be 384.

Based on the information available from the SC PMIS, a list of households in each area was prepared; and samples were drawn, using simple random sampling technique. The respondents were married women of reproductive age (MWRA) from each sample household.

3.2 Data Collection

Data were collected, using appropriate checklists and questionnaires, which were developed and finalized in consultation with SC. Checklists were used to obtain data about health centers, availability of health workers (both government and NGO), and availability of health services on MCH and FP. The questionnaires were used to collect data on demographic and socioeconomic characteristics of MWRAs, their awareness of and knowledge about health care facilities, behavioral pattern. utilization of health care facilities, perceived impact of health care facilities, and sustainability-related issues.

4. FINDINGS AND CONCLUSIONS

4.1 Characteristics of the Population

The mean age of the MWRAs is 29.3, ranging from about 29 years to about 32 years 28.5 and 31.5 across the four selected areas. The mean number of children ever born is 4.0, while that of living children is 3.2. Over one-third have dead children upto 2, and 13.5 percent of the MWRAs have wasted upto two pregnancies. On average, one child is either dead, or wasted during pregnancy.

Illiteracy among the MWRAs is widespread. About three-quarters have no schooling, although their husbands are relatively more educated. Over three-quarters, and about one-sixth of the MWRAs are Muslims and Hindus respectively, and Budhists are found only in Rangunia. Over three-fifths do not have any outside employment, and of those who have outside employment, a large majority are involved with poultry farming, followed by vegetable gardening. Their husbands are mostly farmers, service-holders, petty businessmen or agricultural wage labor. Among the sample MWRAs, 54 percent are WSG members and 46 percent are non-members.

4.2 Awareness and Knowledge

The level of awareness is quite high among the MWRAs related to (a) the need for health care facilities such as physicians and medicines, to meet the health problems of their own as well as their family members; and (b) the need for such health services as immunization both of mothers and children, accessibility to safe drinking water, oral saline to prevent rehydration, and check-up for pregnant mothers. However, the level of awareness related to accessibility to sanitary latrines and vitamin-A capsules, is quite low.

The knowledge among the MWRAs is almost universal in respect of primary health care components such as immunization both of mothers and children, and family planning. Also, the level of knowledge is quite high about (a) the check-up for pregnant mothers, and vitamin-A capsule; and (b) sources of health care facilities and services. The NGO clinics and the NGO workers are the major sources of both preventive and curative health services, while NGO clinics and Thana Health Complex are considered to be two important sources of competent medicare services. Government health facilities, in general, are less known. The village doctors dominate, next to NGOs, in providing curative services. The spiritual healers are not a well-known source of health care services.

The findings imply that the clientele population in the SC catchment areas have high awareness of and knowledge about the health facilities and services, thereby suggesting a high potential for sustainability of health-related behavior. However, lack of adequate knowledge about the government health centers needs be given careful consideration, if continued behavioral sustainability is to ensure.

4.3 Behavioral Pattern

In case of health-related problems of any family member, the MWRAs discuss mostly with neighbors, NGO workers, and village doctors. They attach equal preference to NGO clinics and village doctors for treatment of diseases of mothers, children, and other family members. The most widely approached sources for preventive health service, as well as for treatment of diseases at preliminary stages, are the NGO clinics and the NGO workers, followed by village doctors. However, although government health centers are given least importance for treatment, a significant proportion of MWRAs go to Thana Health Complex at critical stages of diseases.

That the MWRAs are dependent on NGO clinics for appropriate treatment of diseases is evident. Government health centers and other private providers are avoided primarily because of inadequate availability of medicine as well as non-availability of medicine free of cost, long distance from home, and inconvenience of transport. There is, thus, a need to provide health facilities at easily accessible locations either free or at affordable cost in adequate quantity, if health behavior is to be sustainable.

That the MWRAs and their family members have become quite conscious about the utility of preventive health measures, is evident from the behavioral pattern reflected in their adoption of such measures to minimize health problems. Four-fifths of mothers and children have been immunized either at own initiatives or at the initiatives of service providers. Over two-thirds of the MWRAs undertake regular check-up during pregnancy, have accessibility to safe drinking water, and use oral saline and vitamin-A capsule when needed, while less than half of them have accessibility to sanitary latrines.

Quite a high level of consciousness among the clientele population about the preventive health care services, reflected in the pattern of adoption of such services, is an indication of potential for sustainability related to health behavior. However, efforts need to be directed toward enhancing the level of consciousness about the utility of using sanitary latrines.

4.4 Health Services Utilization Pattern

The health services utilization pattern, as determined by (a) the quantum of health services received from the health workers, (b) satisfaction with such services, (c) proportion of health expenditures to other household expenditures, and (d) distance between homes and health centers, is quite interesting. The MWRAs mostly receive from NGOs such services as child delivery, check-up of pregnant mothers, deworming, treatment of diarrhoea, immunization, and family planning. The government health centers mainly provide such services as counselling on family planning, delivery of family planning methods, and immunization. However, the level of satisfaction with the health services received from the NGOs is quite high. The reverse is true in case of government health providers, suggesting that NGO health providers have been relatively more successful in providing satisfactory health services. There is, thus, a need to improve the quality of health services provided by the government health centers, if the potential for achieving sustainability related to health behavior among the clientele population is to increase. Since a dissatisfied user is likely to become a non-user, the issue of less satisfaction with the government health services needs be given due consideration.

The MWRAs and their family members spend nine percent of their annual household expenditures for health care services, indicating that the clientele population has the ability to pay for at least a part of their health needs. It is found that the MWRAs and their families in Nasirnagar attach less priority to health care in terms of health-related expenditures, compared to other areas. Furthermore, utilization of health services is adversely affected in all the areas, except Rangunia, due to long distances between the government health centers and homes, suggesting that the clientele population may not be able, when NGO assistance would be withdrawn, to avail of health services from the government centers, if such services are not made available at easily accessible locations.

4.5 Perceived Impact of Health Care Facilities

Majority of the clientele population, except in Nasirnagar, have the willingness to avail of health services from the health centers/clinics, in case government or NGO workers do not approach to provide them with such services. This indicates that sustainability related to health behavior has not been fully achieved in Nasirnagar unlike in other areas. Furthermore, the perceived ability to pay for most health services appears to be poor in Nasirnagar, compared to other areas.

According to the MWRAs, NGO clinics are the most credible service institutions, followed by Thana Health Complex. Other government health centers such as Family Welfare Center and Government Rural Dispensary appear to have much less credibility in terms of satisfactory treatment, regular availability of health personnel in need, pleasant behavior etc., thereby indicating that the NGO clinics enjoy better credibility than most government health centers.

Thus, it appears that behavioral sustainability among the MWRAs is not achievable in, particularly Nasirnagar, because of the low level of willingness as well as poor ability to avail of health services at own cost. Lack of adequate credibility of the government health centers is likely to further delay the achievement of

sustainability. There is, thus, a need to undertake (a) motivational campaign to raise the level of willingness to spontaneously avail of health services, (b) income generation program to increase the economic ability of the clientele population to enable them to pay for health expenditures, and (c) appropriate measures to improve the credibility of the Government health centers.

4.6 Sustainability Related to Health Behavior

An analysis of the findings about awareness and knowledge of health care facilities and services, behavioral and health services utilization patterns, and perceived impact of health care facilities, presented in a SWOT model, indicates that there is a certain degree of sustainability related to health behavior among the clientele population in the SC catchment areas, except in Nasirnagar and Rangunia.

It would be desirable that the SC continues its operation in Nasirnagar. The 'threat' elements, combined with low priority attached to health care as well as unwillingness to avail of health services, and high dependence on NGO clinics, suggest that it would take some more time to attain sustainability related to health behavior. It may be noted that, given the existing unfavorable socioeconomic conditions, compared to other areas, the MWRAs in Nasirnagar are quite likely to attach low priority to health care over other household necessities. Also, since they are geographically disadvantaged, it is not unusual that they would have low willingness to avail of health services at own initiatives from the government health centers located far away from their homes.

The health behavior among the MWRAs in Ghior, Mirzapur and Rangunia, as evident from SWOT analysis, is relatively sustainable, although some difficulties may be encountered with the lower socioeconomic groups in Rangunia. However, to ensure continuation of sustainability, a number of measures need to be undertaken, so that the 'threats' could be transformed into 'opportunities'.

In view of inadequate knowledge among the clientele population about the government health services and facilities, resulting in low utilization of, as well as low priority to, such services/facilities, there is a need to increase their knowledge through effective dissemination of health-related information regarding services available at the government health centers. Furthermore, in order to counteract low credibility of government health centers, there is a need to increase the efficiency of, as well as enhance the quality of service provided by, the health personnel of such centers.

Because of high dependence on the village doctors for treatment, there is a need to train them up in preventive health care as well as in the basic curative health services, so that they can deliver quality services at the village level. Such a measure is likely to contribute toward attaining sustainability, among the clientele population, related to health behavior. Also, attaining and/or continuing behavioral sustainability would necessitate providing health services at easily accessible locations either free or at affordable cost.

5. RECOMMENDATIONS

5.1. Strengthening Government Health Centers

The evidence indicates that the MWRAs and their family members have inadequate knowledge of the government health services and facilities, resulting in low utilization of, as well as low priority to, such services/facilities. There is, thus, a need to increase the knowledge among the MWRAs and their family members about the services available at the government health centers such as THC, FWC, and RD. This would require strengthening of the government health centers in the SC catchment areas through wider dissemination of information regarding health-related services available at the government health centers. Such information dissemination could be done by both the government workers and the local NGO workers. This would further be facilitated, if the NGOs work in collaboration with the government health program.

Furthermore, the government health centers enjoy less credibility than the NGO health clinics in terms of the clients' level of satisfaction with treatment, availability of adequate quantities of medicines, behavior of personnel, regular availability of service, and availability of service providers. Thus, there is a need to undertake appropriate measures to close the credibility gap. Suggested measures include motivational efforts among the Government service providers to increase their efficiency in terms of providing quality service as well as improving their personal behavior with the clientele population, and establishing accountability on the part of the service personnel.

5.2. Developing Quality of the Village Doctors

In all the project areas, village doctors are considered to be the second most important source of medicare services, thereby indicating high dependence on such doctors, particularly for curative services. It would, therefore, be appropriate to provide the village doctors with appropriate training in preventive health care as well as in the basic curative health services. The local NGOs, including the SC, may undertake the responsibility of providing medical training to the village doctors. Such training would enable the village doctors to improve the quality of their services, thereby contributing to the process of behavioral sustainability among the clientele population.

5.3. Providing Health Services at Accessible Locations

Location of the government health centers at a long distance from homes, and inconvenience of transport were reportedly the two important reasons for not availing of health services from such centers. This is indicative of the fact that if NGO services are withdrawn from the project areas, the clientele population would be adversely affected. There is, thus, a need to make health facilities available at easily accessible locations at the village level. Toward this end, the Government has introduced the concept of satellite clinics to be held close to the homes of the villagers so that they can avail of selected MCH-FP services. Also, health services should be provided free or at affordable cost in adequate quantity, if health behavior among the clientele population is to be sustained.

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5.4. Raising Awareness among the Clientele Population

Most MWRAs in the SC catchment areas are not aware of the facilities for laboratory tests such as urine, stool, blood tests, etc., and health counselling. Also, the level of awareness about such health services as sanitary latrines, and vitamin-A capsules, is low. There is, thus, a need for more intensified information, education, and communication (IEC) efforts to raise the level of awareness about laboratory tests, health counselling, sanitary latrines, and vitamin A, etc.

5.5. Special Focus on Nasirnagar

Behavioral sustainability related to such services as check-up of pregnant mothers, treatment of ARI, and family planning has not been quite achieved in Nasirnagar. Thus, the clientele population of Nasirnagar should be made special target group insofar motivational efforts related to health-program inputs are concerned. Also, it would be difficult to achieve behavioral sustainability in Nasirnagar, in view of the low perceived ability to pay for health services. Thus, there is need to intensify income-generation activities among the clientele population, so as to help improve their economic condition.

SAVE THE CHILDREN/US
BANGLADESH FIELD OFFICE

UNIVERSITY RESEARCH CORPORATION/BANGLADESH

A Study on the Impact of the Workshop on Family Planning Conducted with the Traditional and Religious Leaders in Nasirnagar Thana by Save the Children/US

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EXECUTIVE SUMMARY

1. BACKGROUND

Compared to the contraceptive acceptance rate (CAR) in Brahmanbaria District, the CAR in Nasirnagar Thana of the same district has shown an unprecedented rise during the last one year, with the CAR increasing from 35.4 percent in 1992 to 51 percent in 1993. The estimated growth rate in the CAR in Nasirnagar Thana during 1991-1992 was 8.25 percent, and the corresponding figure for 1992-93 was as high as 44 percent. Assuming the 1991-92 growth rate of CAR in 1992-1993, the 1992-93 CAR would have been 38.3 percent, instead of the actually recorded rate of 51 percent. Thus, assuming the steady-state scenario (i.e., the trend based on the 1991-92 rate), the real increase in the CAR during the last one year was 12.7 percentage points. Obviously, there would be some reasons behind this 12.7 percentage points increase in the CAR during the last one year.

There can be various reasons and factors, which can explain the unprecedented increase in the CAR in Nasirnagar Thana during the last one year. According to an official document, four factors accounted for the above change in the CAR, and these are: (a) intensive field supervision by the district level FP personnel; (b) activating local FP committees by the TFPO; (c) deployment of 7 FWVs in the vacant posts; and (d) raising of FP awareness as a result of the FP workshops conducted in each union by Save The Children (USA) in close collaboration with the local GOB FP personnel.

Since Save The Children (USA) was the initiator and implementor of the fourth factor, it was considered appropriate by Save The Children (USA) to commission a study to help explain the processes and mechanism by which the workshops may have contributed to such an unprecedented increase in contraceptive acceptance in a rural area of Bangladesh. Thus, this study was not planned to identify all the factors as well as the degree of contribution by individual factors; rather, it was planned to explain the contribution of the workshop as a process variable.

An important limitation of any study designed to assess the impact of an intervention such as a workshop is related to the problems of over-estimation or under-estimation of the impact of such an intervention. Such an impact is not easy to be measured for certain reasons such as: (a) the workshop is not the only medium from which the leaders receive information about family planning; (b) the leaders who are really motivated will be promoting the idea of FP for long time in the future, and therefore, the real extent of the impact is not easily discernible at a point in time; and (c) the workshop is not the only activity attributable to family planning performance (the problem of disaggregation of causal values).

2. OBJECTIVES OF THE STUDY

The main objective of this study was to document the impact of the FP workshops conducted with the traditional and religious leaders in Nasirnagar Thana by Save The Children (USA) on contraceptive acceptance in that thana. However, "impact", being the ultimate variable in the outcome continuum, cannot be measured for such a short-run activity as the FP workshop.

The specific objectives of the study were, therefore, to: (a) assess the trend in family planning performance before and after the workshop; (b) assess the effect of the workshop on the use of selected clinical methods of FP, namely, tubectomy, vasectomy, and injectables; and (c) document the process/mechanism by which the workshop has resulted in increased acceptance of the selected clinical FP methods.

3. METHODOLOGY

The methodology, with all its components, was designed in such a way that will satisfy the general as well as the specific objectives of the study.

Data on four broad types of variables were obtained. These include variables related to: (a) socio-economic and demographic characteristics of the sample MWRAs; (b) knowledge, sources of knowledge, and use of FP methods; (c) outcome of the workshop; and (d) changes in the CAR during the pre-and post workshop periods.

Both primary and secondary data collection instruments were used to generate relevant quantitative and qualitative information. Data collection instruments used include questionnaire for the sample MWRAs; FGD guidelines for the sample workshop participants; indepth interviewing checklists for the ATFPO and IAM; and secondary data compilation formats for the MIS Unit, and for the compilation of unionwise list of pre-and post workshop clients of tubectomy, vasectomy, and injectables.

All necessary data related to the variables under all broad groups, except group four, were collected by administering primary data collection instruments. Data related to pre-and-post workshop changes in the CAR, as well as those related to the number of pre-and-post workshop tubectomy, vasectomy, and injectable clients by unions were obtained, using secondary data compilation formats.

Initially, it was thought that in order to ascertain the effect of the workshop the eligible male samples would only be drawn, because most workshop participants were males and they are likely to interact with the males only. However, it was finally decided in the field to take the female samples instead of the initially planned males due to two main reasons: (a) compared to the pre-workshop period, the number of injectable clients (all females) in the post-workshop period increased by 6 times; and (b) in many cases, males were not available at their households, because the data were collected in July, being the lean period for males in Nasirnagar, when many males left for adjacent areas for temporary jobs.

The sample women (pre-and post workshop clients of tubectomy and injectables) were drawn from 11 out of the 13 unions in Nasirnagar. Two unions, namely, Kunda and Gokarna, were excluded, since they comprise the oldest SC program areas. The reference periods for the pre-workshop period were June 1991 to May 1992, and for post-workshop June 1992 to May 1993. The tubectomy, vasectomy, and injectable clients of these periods (pre- or post-workshop) in the 11 sample unions constitute the sample frame for the corresponding period.

The sampling technique used was 'probability proportionate to the size'. Considering the absolute size of the population, a 20 percent sample was drawn

from the pre-workshop sample frame and a 10 percent sample was drawn from the post-workshop sample frame. In drawing the samples, proportionate distributions of the population using permanent methods and injectables were ensured for both the periods (pre-and post-workshop). Also, proportions were considered in drawing samples from the unions.

Since ascertaining the process/mechanism of dissemination of knowledge acquired by the workshop participants was one of the major objectives of the study, it was considered appropriate to conduct focus group discussions (FGDs) with them. Thus, 7 FGDs were conducted:1 each with the FWAs, FPIs, elected chairman/members of the union councils, sarders/matbars, teachers, religious leaders, and village doctors. In each FGD, there were 6-7 participants.

The basic objectives of indepth interviewing were to obtain inferences regarding the mechanisms used by the workshop participants and changes which occurred in the area due to the workshop, as well as to cross-check the views of the GOB and NGO (SC) program managers regarding the possible contribution of the workshops. The ATFPO and the IAM of Save The Children were interviewed a number of times for the purpose.

4. FINDINGS AND IMPLICATIONS

4.1. Outcomes of the Workshop and its Replicability

The workshop has a positive net effect on the post-workshop contraceptive acceptance rate in Nasirnagar Thana of Brahmanbaria District. The positive effect is reflected from the extent of the workshop participants' involvement in the clients' decision-making process regarding acceptance of FP methods (mainly clinical methods). The gross effect of the workshop is discernible from the fact that 86 percent of the post-workshop clients, 81 percent of the post-workshop tubectomy clients, and 87 percent of the post-workshop injectable clients categorically stated that the "workshop participants" have "contributed most" in their decision-making process regarding acceptance of their current FP method. The positive contribution of the workshop, measured in terms of the net effect, which is a better indicator of the outcome of the workshop, is unquestionable. The overall contribution of the workshop in terms of the net-effect was 28.4 percent, being 13.9 percent for the increased use of tubectomy and 40.4 percent for the increased use of injectables. That is, out of the 12.7 percentage points increase in the CAR (actual CAR minus CAR due to steady-state situation), 3.61 percentage points was due to the net-effect of the workshop.

Besides the 'net effect' mentioned, there were other effects of the workshop (e.g., multiplier-effect, integrational effect, facilitating effect, 'kick-bag' effect, etc.). The multiplier effect has a long-term value. The immediate multiplier effect is discernible from the fact that about 86 percent of the post-workshop clients and about 70 percent of the pre-workshop clients who got FP knowledge from the workshop participants have subsequently disseminated the information to others (neighbors, friends, relatives). This effect is likely to continue for a quite long time, and according to the rule of interpersonal communication the effect will multiply.

The integrational effect has two aspects. First, the design of the workshop was collaborative in nature, with the GOB and the NGO participating in the selection

process of both the trainers and trainees, i.e., the selection process effort was a joint effort. Second, the selection of the workshop participants was done, using a "bottom-up" approach which ultimately added a significant component of the "community influentials". Thus, the integrational effect was instrumental in overcoming the factors responsible for lack of coordination among the various important actors who can promote FP in rural areas.

The facilitating effect of the workshop is multidimensional. First, the inclusion of the 'conservative' community influentials as workshop participants helped overcome their antagonistism after attending the workshop. After the workshop, these 'gatekeepers' opened their gates to the FP fieldworkers. As a result, the workers got supporters, the would-be users got workers, the FP movement got momentum, culminating into an unprecedented rise in the CAR. An indication of the impact of this factor is discernible from the fact that the Muslims constitute a much higher proportion of the post-workshop clients compared to the pre-workshop clients. Second, according to the GOB directives, the elected community leaders (chairmen/members of Union Councils) are supposed to work for family planning, and they are members of the local FP committees. These elected members, who participated in the workshop, reportedly took more active interest in the work of the family planning workers in their area during the post-workshop period. Third, FP is a sensitive topic and in the context of rural Bangladesh it is not an usual practice that the older community influentials discuss this topic with the younger members of the community. However, the workshop was able to break this norm to some extent, as reported by many of the participants who said that after the workshop the older community leaders discuss the topic with the younger members of the community. An indication of this can be found in the fact that while 21 percent of the pre-workshop tubectomy clients were in the age group of 20-29 years, it was about 39 percent in the case of the post-workshop tubectomy clients. Fourth, it is also not an usual practice that the male community leaders in rural Bangladesh discuss FP with the females. However, such male-female interactions were also reported by many respondents (females) as well as by some of the male workshop participants.

The 'kick-bag' effect, though marginal in value, should be treated as an important outcome of the workshop. This effect goes beyond the target territory (in this case, Nasirnagar). For example, a participant travelling by train/bus enters into an interpersonal communication on FP with a co-passenger, and soon afterwards the "interpersonal communication" on FP turns into a lively "group discussion".

Thus, the FP workshop, as designed and implemented in Nasirnagar Thana by the SC, can be treated as a replicable means of increasing the contraceptive acceptance beyond the steady-state increase in other parts of rural Bangladesh.

4.2. Lessons for the Future

Since about 29 percent of the increased CAR during the post-workshop period was due to the 'net-effect' of the workshop, the remaining 81 percent was due to factors other than the workshop. These factors include, among others, the deployment of seven FWVs, increased activity of the local FP committees, increased supervision by the district level personnel, better supply situation, etc. However, due to the limitations of this study, the relative shares of these contributing factors could not be ascertained. Thus, to be able to identify all the factors responsible for the increased CAR as well as to determine their relative shares, a

more elaborate study should be undertaken. If the SC replicates this type of workshops in the future, there should be ample scopes for more indepth studies, incorporating all possible variables and indicators so that the relative contributions of all possible factors can be identified. In that respect, implementation of such workshop should be planned from the perspectives of Operations Research.

A well designed workshop is always characterized by certain essential components, namely, the selection of participants and trainers, timing, placement, contents, follow-up mechanisms, etc. All these components should be designed in accordance with the "main objective" of the workshop. The quantitative and qualitative aspects pertaining to the impact of the workshop analyzed in this study show that the workshop was not adequately designed, especially with respect to the "follow-up mechanisms". In reality, the participants were given an assignment to direct their motivational efforts, especially toward those families which have five or six children, and the participants were also requested to motivate at least ten would-be users from each village. However, there was no built-in mechanism to ascertain the extent to which these assignments and requests were carried out by the participants. Also, it was reported by the participants, as well as by the ATFPO, that the workshop was treated as a 'one short' action. Thus, while planning for such workshops in the future, objective follow-up plans as well as follow-up mechanisms should be built-in components of the overall workshop plan.

It was reported by the workshop participants themselves as well as by some of the sample clients that there were some participants who were less motivated and less convinced about FP compared to the others. These 'hard core' participants should not be ignored, because if after participating at the workshop someone does not contribute to the FP motivational work in the community, the resources directed toward that participant should be considered as "wastage". Thus, to minimize waste of workshop resources in the future, this category of participants should be identified first, and then, re-motivated as a special target group.

FP is a dynamic subject-matter. Also, it should not be expected that the community influentials will know everything about FP by attending a two-day workshop. Thus, to maximize the information base of the community influentials, there should be provisions for refresher-workshops/follow-up workshops. Such workshops should deal with the issues identified by the previous-participants as problems faced by them in motivating the target groups.

Since the workshop has a positive effect on the acceptance of FP and since one of the ways of interaction was "client visiting participant's home", the participants can be considered as an "information distribution point". The effectiveness of this information distribution point would depend largely on the efficiency of the information disseminator. Thus, to be able to raise the effectiveness of the information dissemination points, the satisfied clients, among others, should be considered while selecting the workshops participants.

Appendix 7.

REPORT TO SAVE THE CHILDREN (USA), NEPAL AND BANGLADESH FIELD OFFICES, ON SUSTAINABILITY OF THEIR HEALTH AND DEVELOPMENT PROGRAMS

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December 1992

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I would like to think of sustainability in terms of long-term partnership. In Bangladesh and Nepal the partnership is three-way, between government, NGOs-donors, and the people (the poorest ones in particular). Each partner contributes essential strengths less available to the other two. Like a tripod, remove one, the system falls down. Each also receives substantial benefit from the partnership: the people in getting out of powerlessness and dire poverty, the government in becoming humane and meeting its obligations to the nation, NGOs-donors by discharging their ideological missions and satisfying their intellectual curiosity.

Anything that increases the people's capacity for self-sufficiency, including the capacity to demand their rights and to reduce injustice within their ranks, is a step toward sustainability. Anything that improves and endows the capacity of government to serve is a step toward sustainability. Anything that contributes to justice and development is another step. When one thinks from where we have come, it seems that sustainability is a continuous process, a journey, evolving in ten to twenty-year cycles, generational.

The tools for moving progressively toward sustainable development include raising awareness, increasing leverage of power by coalitions of those with little power, redress of oppression, cross-subsidies, endowment trusts, increasing total wealth to enough income for the poor to get beyond day-to-day subsistence, and health. Other aspects will include repair and maintenance of the environment.

This broadened view of sustainability has several immediate implications for SCF. First, on a national scale, staying in for the long-term is critical, but on the local scale, knowing when to leave is important. Second, serving larger and larger areas is necessary, because almost anyone can do good in a small-enough area. Third, serving efficiently is critical as one needs to improve the situation faster than the growth rate of the population. Finally, learning what works with an average set of resources is required; often this will mean letting go of favorite interventions, or intervening for everyone in need.

B. The Role of the Small NGO

SCF is often criticized for working in "too small an area." The time when a small NGO can live in its own happy valley is long gone, the problems of development are too urgent. To stay relevant, a small NGO must achieve more than what its own resources bring, by scaling up with less intense programming, by leverage of human resources ("each-one-teach-one"), by coordination with other agencies, and by influence on policy.

Influence on policy comes from valid demonstrations of new ideas and approaches. This requires a greater capacity for research: quantitative of course, but qualitative research into process and behavior change will prove more useful and more valid. More capacity is needed in writing up ideas and results for the scientific and development communities, then refining the information for policy-makers. Typically, NGOs are weakest in demonstration and documentation. SCF is changing that, particularly in Nepal and Bangladesh.

I Introduction

I undertook this consultation with some apprehension as I can scarcely think of myself as a development specialist, and my knowledge of NGOs is not from front-line experience but mainly as an onlooker. What I might accomplish is to look, listen, and ask the questions a naive learner should, and hope to strike some responsive chords among the persons who are interested in my untutored observations. The three-week visit with SCF field staff in Nepal and Bangladesh has been like a seminar in development and front-line work. I thoroughly enjoyed sharing with my new colleagues at least some of the rigors of their working lives. I appreciate their patient attention to my questions and thinking-out-loud, and their unfailing concern for my comfort.

Without question, both groups are professional, dedicated to their task, and absolutely willing to consider new ideas and new directions. This is a rare combination and speaks well for SCF's leadership.

The report is written simply. Little space is given to review of programs or documentation of events as these are already well known by the principal readers. I did read the stacks of documents each office provided me, and some outside readings in addition. My field visits are listed in Appendix 1, along with the scope-of-work, as documentation for readers outside the field offices.

In the report, I first present a few themes generic to both field offices, and then detailed recommendations for each. Much of what I present is already under active consideration by the field office staffs; some ideas are a bit outrageous or my own pets; some may be additionally useful. The report is meant to stimulate further thought and not as fixed prescriptions.

II Generic Issues

A. Sustainability

A lot of confusion exists about this word (which, until recently, was not even included in standard dictionaries!). The narrowest definition is the donor-based complaint: how will you manage after we're gone? Apart from the implied threat of abandonment (imagine a spouse saying this daily), the question itself leads to regressive behavior on the part of the recipient: cajoling, wheedling, anger, trying to milk the system for big-ticket items to be delivered now - in a word, more dependency - rather than careful long-term institution building and planning for self-sufficiency. Using the spouse analogy again, it is better for each partner to have learned skills and self-sufficiency well before the breakup of the marriage by death or divorce. The other danger inherent in the question is that the recipient usually believes the donor is bluffing: and it may be true.

Influencing policy also requires advocacy. The small NGO should put itself at some risk by calling public attention to people's needs beyond what is done to raise funds, documenting failures by any of the three partners to development, providing alternate channels of information back to the people. Strength to risk advocacy comes, of course, when a number of NGOs coordinate.

The main strength of the small NGO is flexibility: to test, innovate, respond to new situations and needs, advocate. Anything that limits that flexibility ought to be avoided. In my opinion, time-limited, target-driven, donor-driven projects seriously limit flexibility and distort the NGOs mission.

C. Targets and Indicators

My observations in Indonesia, Nepal, Bangladesh (and from conversations with NGO staff from other countries) convince me that the USAID Child Survival Projects were more a liability than an asset to SCF. The projects are top-down, force a pace of achievement that leaves people as passive recipients, distract from a study and experimentation in process, require resources inherently not replicable. It seems a bit odd to require sustainability from an effort that by definition is unsustainable. The Bangladesh Field Office has been criticized for having too many staff in the field; the obvious rejoinder is: that is what it took to achieve targets well beyond the regular government system, and within three years. Now that we know that, let's discuss efficiencies and a more human time-scale.

Targets and indicators are not ends in themselves, but indicate a numerical best-guess of how resources can be deployed against need, the objectives of the program. Some objectives have outcome targets pegged at 100% by the nature of the problem and the solution available, such as: "Eliminate neonatal tetanus," where the process target, so many vaccinations with tetanus toxoid, corresponds closely to the outcome target. Other targets are derived from historical experience: "Last year we achieved X, this year we believe Y is (needed) (possible)." Most targets are simply counts of the work that has to be done (number of workshops, trees planted) and should not be seen as anything more than a plan for using resources effectively. Such achievements should be used principally for cost-accounting and management decisions on priorities and tradeoffs, and seldom for reward or punishment of workers.

Rewards should come for the quality of work, not its quantity - except where someone is obviously goofing off, in which case one doubts the quality anyway. Quality includes the capacity to plan, self-evaluate, reset one's plans, innovate using one's own observations, and working hard. Rewarding quality means allowing a certain level of failure and mistakes as long as one learns from them. It is my belief that such focus on quality of work will see objectives that have an impact and meet the program's goals being achieved, regardless of whether targets were set or not.

D. Health Information Systems

Too often the arguments over information systems come down to which computer soft-ware is to be installed. That ought to be the last question asked (solved by technical and cost considerations, and personal opinion). The key questions of an information system are: what is it to be used for, who benefits from its use, does its use detract from other activities, and are you willing to reconsider its use after some years of experience.

As a matter of both philosophy and utility, I believe an HIS must be designed to meet the needs and circumstances of the local situation, and not the needs of higher echelons. The local situation may be as limited as one district, or a sub-district, or even a village. One could use a complete household register where it is practical to accomplish this, but less-than-complete registers where the effort is not commensurate with the payoff.

The use of a household roster for manual tracking of target-persons by health workers is one sort of information system. It allows the health worker to identify and channel the target population to needed services; in good circumstances, it can help the health worker follow up on seriously needy cases. It can be the basis for supervision as well when supervisor and health worker together visit a sample of houses and ask key questions, discuss problems and constraints.

There is nothing magical about 100% registration. In urban slums, people move in, out, and around too much; whole households change their individual census (sometimes illicitly) by the week, by the day. In exceptionally remote areas, 100% registration may require enormous effort, when 50 or 60% or even less might be more feasible and productive. Nor is there a need for every single intervention of the program to be contained on the roster. Both worker and family may be overwhelmed by the effort. Better to track a few key items well.

Neither is there anything magical about monthly visits. Data can be updated considerably less often and still be effective for channeling and identifying higher-risk persons. Major changes in behavior and outcomes don't occur monthly - usually only over one or more years - so monthly tracking is wasteful. Mini-surveys to check progress and quality of work can be done through the supervisory system (if designed properly, the results of a number of supervisory visits can be built up to the Lot Quality Assurance Sampling scheme to give some statistical and trend parameters, see attached materials on LQAS).

A second kind of information system seeks to aggregate all the individual household data into multiple reports, with statistical manipulation by different variables. It is thought this is needed for reporting to donors, for tracking overall progress, for research. The recent evidence from the London School of Hygiene and Tropical Medicine (attached), and evidence from SCF's own internal and external Child Survival Project reviews is that the carefully designed sample survey is the better tool. In a sample survey, the questions asked

are the key ones, the data are gathered more completely and more accurately, and a direct correlation with qualitative data may be made.

It is this second information system - whether obtained from the aggregate of local rosters or the results of surveys - that is usually computerized for easier handling of a lot of data. Whatever their source, the reports should be limited to "hard" indicators such as births and deaths, immunizations, and management information. It is a wasteful use of the computer and its programmers to be tracking routine service statistics such as the number of antenatal visits, each child's weight by month, or which women missed three menstrual periods: all the "soft" indicators.

Tracking household data by computerization of field reports is thought useful for research. The experience at SCF/B has not been positive in this regard (see Appendix 2). To do good research means setting up a hypothesis and a suitable research design before getting the data; and even then it's tough to do correctly. An NGO is not a research organization and its field efforts are not designed for research (although understanding and change of social processes can be researched with much less rigidity of design).

The information system can track overall progress in mortality rates, family planning uptake, nutritional status (as can sample surveys and retrospective mortality measurement techniques well known to demographers), but the NGO should not attempt to assess the differential impacts of interventions, singly and multiply. It's a swamp and everyone quarrels over the results anyway.

E. The SCF Model of Development

Both SCF/Nepal and SCF/Bangladesh are pursuing models of development that reflect their commitment to the poorest of the poor, and in particular the women of that group. Both Offices believe that strengthening of a woman's self-esteem and confidence through the solidarity and support of a group, is the main aim of their work; income generation and savings are means to that end, not ends themselves (although much income-generating activity goes on). SCF/Nepal uses non-formal education as the hook, SCF/Bangladesh uses Savings Groups. This model is different than one that makes economic development of the larger community the end result, using credit, mass employment, infrastructure development. This model tends to favor the industrious or already well-placed, and anticipates local "trickle-down."

SCF has chosen the former model over the latter. That is the strategic choice, congruent with SCF's overall philosophy. Both Offices should now do their best to document that over time women in these groups can achieve personal power and group leverage just by membership and small income generation. Both Offices will need to worry about two things: First, whether the field staff can let go of the groups, and when (being a kindly patron is too tempting; I also wonder if sponsorship delays letting go). Second, when do limitations of marketing and sales, competition from others doing the same income-

generating activities, and business failure become factors - and how does one anticipate them?

F. Joint Activities Between the Two Offices

Your greatest strength is solidarity, and your greatest leverage is learning from each other. I propose that a senior management person and a senior sector person (in rotation) from each Office meet quarterly, alternating Kathmandu and Dhaka as venues. At each site, more of the host Office staff can join in. Use the meetings to show-and-tell, but then also to "put on the other person's shoes": that is, a joint problem-solving and brainstorming session. Your intellectual isolation will be reduced, you will be sharing experiences and problems with non-threatening colleagues (siblings, really), you may even figure out joint activities. Perhaps once a year you might invite staff from Indonesia, the Philippines, Vietnam to join in.

Both Offices will receive this full report and each is invited to borrow recommendations meant for the other.

III Specific Recommendations for SCF/Nepal

A. Planning and Targets

1. *Move away from numeric outputs by available budget as the main form of planning, and towards priority planning.*

Currently the field staff takes the money allocated to each sector (done by some process not known to me), figures out all the activities that are being done (either dictated by the outside grant, or by tradition), and costs out some level per activity that will absorb the money: so many cows de-wormed, so many trees planted. This process makes sure the money is allocated to the various sectors but is not determined by current need or epidemiologic basis, or so it seems to an outsider. In this way, the status quo is locked in and piece-meal thinking is encouraged. The budget is driving the plan. Part of the problem, I believe, is that the senior staff are exhausted from the long travel; the regional sessions are too brief and too driven to be called planning.

I propose you take much more time on planning. Ignore the budget and decide on priorities first. Rank the priorities by some combination of importance and need, what is achievable, and passion about the subject. Cost out the activities to achieve each priority (being careful to be efficient, of course). The budget is then what it should be, a financial description of the plan. Then see how much money is available and begin to "spend" it by going down the priority list. If you've run out of money by priority #5, only the first four get done. There will, of course, be a lot of renegotiation on priorities and how to get them done for less money, but that's the purpose of this exercise, a variant of "zero-based budgeting."

I am talking about priorities, and about activities and resources to accomplish the priorities. Targets are set from a combination of what you believe needs to be accomplished, and what you think you can accomplish. At each planning cycle - six-monthly, annually - you review your progress and assumptions. It simply makes no sense to set, or have set for you by someone else, a long-term numeric target (80% vaccination coverage, for instance) without first understanding its implications for your program. Most anyone can achieve a target by hook *(or* by crook), but perhaps its sustainability has not been anchored; or you have put so much effort into reaching this number, other priorities suffer; or the staff burns out.

Knowing your staff, there will never be the problem that someone "sets the target too low" to be easy to achieve. But *achievement* of the target is not what the work and staff are to be evaluated on. Rather it is the quality and integrity of the planning, how resources were deployed and managed, the creative ways of doing the work, the ability to self-evaluate and change direction when needed, and the continuing relevance of the work to the people served. This is much more intense managerially, needs much more problem-solving supervision, is too dependent on local thinking and creativeness. This is why big

bureaucracies prefer rigid targets and procedures that can be imposed, standardized, and audited.

2. Negotiating *an NGO perspective with USAID and other multilateral bureaucracies.*

This is an agency-wide issue and the first people to negotiate with are in Westport. They ought to be keenly sensitive to what their field staff - the heart of the organization - is saying. If the headquarters staff is too intent on generating funds from USAID, and also unwilling to negotiate serious changes to reflect how SCF conducts a project, there will be continued frustration and some predictable consequences.

But until proved otherwise, let's assume that people at USAID and other agencies are willing to listen to a good case for how a project should be conducted, and willing to accept how objectives and targets are reset and re-evaluated (the ostensible purpose of the DIP).

(I have recently watched a brilliant poker game played here against the World Bank by a quasi-NGO for very big stakes. The WB threw in its cards. The quasi-NGO could take the tough but crucial stance because they knew their bottom line, which was that their integrity was worth more than any funding. The WB, on the other hand, needed the project. I recommend to SCF/Nepal staff a book called: *Getting to Yes. Negotiating Agreement Without Giving In*, by Roger Fisher and William Ury (Houghton Mifflin, 1981).

It is my impression that projects funded by local USAID mission may be more flexible, an approach worth exploring.

B. Going to Scale

1. *AIDS and reproductive health.*

You are already contemplating this with respect to extending services in Gorkha, and doing STD/AIDS work in many districts of the country. The model of doing a focussed piece of work over a wide geographic area is unusual for SCF. I propose you use CS VIII as the vehicle, and supplement the funds where USAID will not cover certain activities. STD treatment, condom promotion and use, anthropologic and epidemiologic work to track routes of transmission, documentation and advocacy are the most important steps. You may invent new ones as you learn. Sensitizing your own staff to AIDS and sexual matters is a crucial first step.

I suggest you contact Cynthia Myntti, health program officer at the Ford Foundation in Jakarta. She has sponsored some very interesting research through the Indonesian Epidemiology Network on potential routes of AIDS transmission in Indonesia, and a conference was held recently to present the data. The topics and approaches, and how the data were used to sensitize officials, may be of interest to you.

2. *Models for MCH outreach clinics.*

HMG intends to establish sub-health posts with a strong emphasis on outreach clinics, to be held periodically in each ward. The model is so dependent on the capacity of government to pay workers to travel, on the ability of village health workers and the new cadre of maternal/child health workers to get about with all the promised supplies, on village volunteers supposed to visit all their households. SCF can make it work but with too many staff to be realistically even replicable, much less sustainable.

You will therefore need to experiment with different operational efficiencies, beginning with how to run a mobile clinic with two to three persons.

a. I favor dropping the growth monitoring exercise altogether: it hasn't worked in most places, least of all in Nepal. There are alternative approaches:

- mid-upper arm circumference measurement (good for children 1-4 years);

- a single weight at six months used as a predictive measure;

- a high-risk profile with any of the following: a serious current illness; displacement by a younger sibling (or one coming), particularly for girls; failure to be vaccinated.

One can make the argument that a few interventions done well will have an impact on average nutrition, such as measles vaccination, vitamin A (perhaps also to breast-feeding mothers), ORS, and birth spacing. Some children will inevitably fall between the cracks, but my opinion is that growth monitoring is such an intensive effort that less attention is paid to the crucial interventions; the old saw applies: "The best is the enemy of the good."

b. I also favor dropping the time-consuming and dreary "nutrition education." People don't hear it - they're either too poor to get the necessary foods, or unused to recipes such as *sarbottom pitto*, or some other reason (which should be researched). If I had to pick a single "nutrition lesson" it would be to add oil to a child's normal diet, to give liquidy rice gruel with a bit of salt for diarrhea in the weaned child, and to continue breast feeding for as long as possible. True, the poorest families can't afford oil, and that says a lot about where the health problems lie. I would pose this problem to the staff in a brain-storming session and provide friendly gifts for interesting and testable ideas. I have three here already and will be happy to send them along after the staff have developed theirs.

New data, incidentally, suggest that introducing weaning food at four months simply replaces the calories not given in breast-feeding. Six months is probably a safer time to introduce weaning foods. Weaning foods are notoriously contaminated; an argument can be made - but has not yet been made in polite circles - that weaning in malnourished children should be held off until one year of age. (See Briend A, Bari A. "Breast feeding

improves survival, but not nutritional status, of 12-35 months old children in rural Bangladesh." *European Journal of Clinical Nutrition* 1989; 43: 603-08. Also see *Technical Literature Update*, Vol. V, No. 3, 1990, PRITECH, Arlington VA. for discussion of the issue.)

c. I would definitely drop activities that have little impact. Antenatal care to detect the imminently dangerous pregnancy, for example, is useless when blood banking, caesarian sections, affordable and gentle transport are not immediately available. Research on this point was done by Gretchen Berggren in Ghana, and others as well.

Preventing the anemia of pregnancy with iron and folate supplements has a probable good impact on reducing the risk of death from hemorrhage and other post-natal complications. This assumes that a steady supply is available to all pregnant women since anemia is so wide-spread and one cannot detect which woman will have the bad outcome.

You should try, in any case, to get evidence from your own program to determine what antenatal care has accomplished. I may be proved incorrect in my judgement. Have you records of high-risk pregnancies detected and referred, and with what outcomes? Have you evidence of pregnancies *that became complicated but were not* detected though a visit was made? Or detected but the referral service was inadequate or not used? With standard statistical methods (2X2 analyses, calculations of sensitivity, specificity, positive predictive value), you will then be best able to judge if the activity is worthwhile or not.

Attached to this report is a copy of a recent summary of the evidence for antenatal care.

d. One efficiency is to put more "M" into the MCH clinic, considering all female persons above the age of 12 who bring children as candidates for preventive and curative care. This will include older sisters, non-pregnant mothers, and pregnant women. Each visit is an opportunity to give tetanus toxoid (no number of doses is "too much" for TT), vitamin A (so that when breast feeding does take place, her stores are increased), iron and folate, among several possibilities.

e. If village volunteers are to succeed, they need some stimulus: a competition for sending in the most kids for vaccination, and for most kids completing the course on time. Basic rosters can be kept by the volunteers with carbonized copies for the mobile clinic committee.

f. Once you have learned how to work at the margin of razor-thin efficiency, perhaps a course for health workers - "Where there are no doctors and no supplies either" - might remove the learned helplessness of HMG health workers.

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g. To support the clinics, I would try raise funds by treating ac s at e mo e clinics and charge for non-essential drugs. I think charging for the growth card is probably reducing access of the poorest (this can be researched).

h. A full-time person working on clinic design would be a help, but make everyone a part of the quest by an idea-rewards system.

3. *Scaling up in agriculture.*

Although agriculture is not my area, since you taught me a lot I was wondering if one can scale up here too: Can orchards, identified by you as the most solid activity, be linked up with commercial seed suppliers and marketers? Can SCF become HMG's contract agricultural extension agency?

In both health and agriculture, you might try for extra leverage by getting the most successful mothers or farmers to act as health deliverers and extension agents to their neighbors. The model I have in mind is the farmer-trainers of Indonesia's Integrated Pest Management Program. A visit there could be instructive.

C. The Health Information System

1. An HIS must be designed based on local needs and variations rather than a generalized tool serving upper echelon needs. Since you have already invested in the SCF standard HIS in Siraha, I would continue with it. You then will have a useful comparison to be made with Nuakot where I propose you design a minimal system serving the target groups (see under the generic issues section) with sample surveys to report on outcome indicators. You will be able to compare costs, effort, accuracy, and utility of the two methods.

2. Manual rosters can be done simply. I recommend a one-page roster with a carbonized copy for the Kathmandu office (for computer entry) with only the critical, countable items such as: births, deaths, immunizations, family planning, and economic classification. One should avoid transcribing from one manual form to another, or breaking up rosters by topic as you only create errors and lose data.

3. I recommend that when a death occurs to a child or woman of reproductive age, the worker responsible for learning about the event informs her/his superior immediately and a knowledgeable team establishes a reasonable cause of death (see the various protocols for Verbal Autopsies). The death is then discussed with those persons in the community for whom such information would be compelling: elders, local politicians, local health workers, to see what lessons can be learned but not to apportion blame. That's not easy to do, but I am thinking that problem-solving returns much more control over health issues to ordinary citizens who are mostly passive recipients of health care.

4. It's time to introduce rapid assessment techniques such as the "Indirect Brass Technique" to estimate mortality of under-twos (as modified by Hill), rapid anthropologic assessments ("RAP"), the 75-Household survey for immunization, ORS and FP use (scaled down for Nepal, perhaps), the WHO cluster-sample survey, supervisory check lists, and Lot Quality Assurance Sampling (LQAS). Attached is material on LQAS. You will need some statistical help in sampling for most of these techniques but this should be locally available.

As you know, Save the Children Federation has recently issued a manual on rural participatory appraisal. This new and relatively undocumented technique recruits the people on the receiving end of services to be an integral part of the evaluation and needs assessment, perhaps even the leading part. The philosophy of the technique stresses "participatory," and therefore it is not to be used as another soft-sell of outsider's agendas. I personally object to the qualifier term "rapid," as it suggests the outsiders' timetable and not the villagers'.

Focus groups are just one method among many and can help detect the obstacles and constraints people face in getting healthy, and to explore possible solutions. We have borrowed the technique from advertising where focus groups are used simply to design the next message (employed to great effect in our recent political campaign). I think this is the wrong use for those committed to community development. Focus groups organized by SCF ought to be self-discovery sessions and problem-solving. In the advertisers' use of focus groups, they bring together strangers from a single stratum of society or profession: so people won't influence each other, and the flow of information is strictly upwards; the organizers run with the data. In the community organizers' way, focus groups bring together people who do know each other and who can solve problems together: out of solidarity if a single stratum is represented, or out of negotiation if more than one stratum. The flow of information is inward, the organizers are facilitators, and the data are shared.

Everything said in the paragraph preceding applies to discussion groups with HMG health workers; I encourage SCF/Nepal to conduct some of these, and document the results.

D. Family Planning

1. Except for birth-spacing, I recommend SCF/Nepal de-emphasize its family planning efforts. There is already too much on your plate. I was not convinced by the data from CS III that much had been accomplished by the social marketing and private sector sales approaches, beyond the predictable increase in awareness (which may be nothing more than repeating back what you've heard). This is no criticism of SCF/Nepal as the major effort in contraceptive social marketing through the private sector has also had scant success in the rural areas where you are committed to work.

The need is undoubtedly great, but so are the obstacles, and not much has been achieved in Nepal except through vasectomy camps. For SCF to be involved in any substantial way is to suppose a comparative advantage of your program and staff over

others, whether in logistics, service delivery, or promotion. Unless you intend to do family planning as your principal activity and recruit a full range of knowledgeable staff, I cannot see the utility of SCF/N involvement.

2. SCF/Nepal may justifiably claim expertness in community organization around specific activities, and development of savings groups. The linkage between tree-planting, say, or formation of women's savings groups, and increased use of contraception (as shown in the grant application to Hewlett) is a distant hope and entirely unproved. In any case, one ought not to be mixing the two, especially not as a hidden agenda.

3. SCF/Nepal's undoubted success with village theater, however, may be as good and complete a role in promoting family planning as any. In such an effort you will also not find it necessary to establish targets, an exceedingly positive event. You will, however, need to link up with a service provider in the event that demand is increased. And you will want to monitor the service delivery to be sure it is respectful and safe.

4. It would be useful for SCF/N to use the participatory appraisal to explore issues of family planning, if you recognize that communities are not monolithic and processes of negotiation over such a sensitive topic must go on within the communities themselves.

E. Research

1. Origins of research questions

During planning exercises, there ought to be some time set aside for research questions. They come from the daily observations of field workers, from conversations with villagers, from updated information on health and development issues sent to you from Westport, or Dhaka, Manila, Jakarta. They seldom should be driven by the lure of a grant, and almost never when proposed by an outside agency wanting your cooperation.

2. Researchers

Those persons with time and expertise to design research and carry it out should be drawn from the pool of knowledgeable people in Nepal, including your own staff if they can be freed up for some of their time. Outside persons should have no line authority, should not act as supervisors or consultants on programmatic issues.

3. Choice of research topics

The research question should be entirely relevant to your own needs, kept as simple and brief as possible, the results turned around in no more than three months. I personally favor the type of research done by social scientists who try to discover the in-depth and often obscure reasons why things work or not. Standard KAP research is quite nearly useless (and this is well-documented in Nepal by Lynn Bennett and others). I also like

simple operations research: you observe certain indicators, you make some change in the way something operates that should impact on those indicators, you measure the indicators again. In such research I would favor less stringent levels of statistical significance: $P < 0.1$ means the odds are 10 to 1 the change is not by chance alone. If you examine one or three indicators at most, these aren't bad odds.

4. Documentation

Some research will be good enough to publish in international, peer-reviewed journals but those will be unusual. Publication, however, should not be the driving rationale behind research. If you chose the topic wisely, all information will be useful within SCF and within Nepal. Results should be well-written and presented to interested groups.

Some of what you discover in the course of monitoring and evaluation will definitely warrant presentation.

F. Miscellaneous

1. Leverage your work with other NGOs.

Try to pool resources and activities with other NGOs in the districts you are working in. Hold annual colloquia to exchange experiences, invent new ideas. Spin off local NGOs where you are phasing out, but be ready to provide intermittent technical assistance.

2. Try ORS for animals.

It works: chickens, goats, buffalo, sheep, etc., and where the animal is the farmer's savings account, it may bring wider benefits.

3. Prepare for hunger, famine and disaster.

I am partial to food or money for work for infrastructure that will help the larger community (bridges, roads, embankments) particularly when there are near-famine conditions. The time to begin is well before the famine, before the loss of income or rise in commodity prices presage hunger.

Train up your staff for disaster relief, if not already done. Rapid assessment techniques for impending famine are well known and should be used when everyone knows a problem is looming.

4. *Non-formal education - a tool in its own right?*

Is non-formal education itself sufficient to create change in people's lives (and how much), or are larger structural changes also necessary? This question also derives from the

discussion in the generic issues section on SCF's model of development. I propose you continue the good research conducted by Mr. Bhatta, and follow up those groups that have been around for a long while: what has happened to the individuals, their children. Do a matched case-control analysis to compare to people who were not in NFE groups (from some village where the NFE was never offered).

IV Specific Recommendations for SCF/Bangladesh

A. Programs and Policies

1. Phasing out

During the phaseout from an area, or letting go of mature womens' savings groups (WSGs), it is still important that some safety net be available; either in the form of the group joining an indigenous NGO network (Grameen, BRAC, among others), or in intermittent technical assistance from SCF. The WSG should, of course, have the most to say in the matter.

Endowment funds for tuition might be set up as part of the phaseout.

I would aim at putting all SCF work into Nasirnagar, expanding as much as possible. Here you have few other NGOs, little government service, the need is great, your experience solid.

2. Womens' savings groups

WSG discussions may usefully turn to issues of gender and power relationships. I am assuming here that such consciousness-raising is acceptable in rural Bangladeshi society, and that women will have support for the risks entailed. What are the experiences of others in Bangladesh?

I am impressed that work with adolescent and pre-adolescent girls offers great possibilities for Bangladesh development in the near-term. In your areas, even having a WSG member's daughter who can read and write be the group bookkeeper-cum-secretary would be an interesting thing to try.

Leverage for the WSGs might be achieved by getting groups of them together, or at least getting the leaders together (you've done this once), and by using successful groups' more outgoing members provide stimulus and technical assistance to newly forming groups. One always wonders if this isn't a western mind-set, but so many other myths about what Bangladeshi women couldn't or wouldn't be allowed to do have been exploded in recent years.

Can the range of income-generating activities be expanded,or are you confident the current range is sufficient?

3. Raising local funds and resources

SCF is good at tapping into philanthropy. It is time to see how this can be done in Bangladesh. Perhaps others have thought of the idea and have experiences to share. I

themselves through endowments.

I am partial to infrastructure development that helps everyone: bridges, roads, embankments; especially when it provides employment locally. It certainly is most appreciated by the power elites, not a bad thing.

B. Health Interventions With the Greatest Need and Potential for Sustainability

1. Family planning is your best bet to lower maternal mortality and improve child health. Family planning acceptance is remarkably on the rise in Bangladesh and this is the best time to be deeply involved. With the density of your population and intensity of visits you are in a good position to promote and supply contraception in a respectful and safe way, with regular follow-up for support and information. I suggest you visit the MCH service area of Matlab managed by ICDDR,B to see how they operate.

2. Therese Blanchet's data suggest a maternal mortality ratio of nearly 1100/100,000 live births, and maternal mortality rate of 160/100,000 women ages 15-44, despite your long-term presence in the areas. Antenatal care to detect the imminently dangerous pregnancy, for example, is virtually useless when blood banking, caesarian sections, affordable and gentle transport are not immediately available. Research on this point was done by Gretchen Berggren in Ghana, and others as well.

Preventing the anemia of pregnancy with iron and folate supplements has a probable good impact on reducing the risk of death from hemorrhage and other post-natal complications. This assumes that a steady supply is available to all pregnant women since anemia is so wide-spread and one cannot detect which woman will have the bad outcome. Ideally, one would want to prevent anemia before a pregnancy begins. An experiment worth trying is to supply iron tablets along with oral contraceptives; I believe the Population Council in Gulshan will have data on such an approach.

You should try to document what antenatal care has accomplished in your own program. Locate the records of high-risk pregnancies detected and referred, and determine their outcomes. Have you evidence of pregnancies *that became complicated but were not* detected though a visit was made? Or detected but the referral service was inadequate or not used?

3. I propose a women's reproductive health clinic. Treatment of STDs, prolapsed uteri, vaginitis, etc. may be an excellent entry point for women's health and well-being in general, as well as for family planning and identifying groups at risk for AIDS. It should be operated by a family health worker or someone of that background.

4. I propose teaching WSGs how to do mid-upper arm circumference measurements using graded-size bangles (14.5, 13.5, 12.5 cm). This is much more likely to work than the

scale and growth chart, and puts the power of diagnosis in the mothers' hands. Then the groups should discuss among themselves what can be done to help the individual faltering child. The evidence increases that between-illness feeding to promote catch-up growth is crucial, as is sustained breast-feeding. This applies to girls more than boys (see attached abstract by Vincent Fauveau).

5. Directly linked to health is woman's daily labor and energy expenditure. AHRTAG in London, and others, have put a lot of thought into labor-saving devices for household use, perhaps some will be cherished by women if made known to them. Perhaps their manufacture could be another income-generating idea.

6. Vitamin A supplementation, tetanus toxoid, measles vaccination, ORT for diarrhea (with antibiotics for dysentery)

I suggest these four activities have the longest-term payoff for maternal and child health.

Vitamin A supplementation for breast-feeding mothers is worth a try. ICDDR,B has recent evidence on this (speak to Dilip Mahalanabis).

7. If you limited yourself to this potent package of interventions (1-6) a lot would be accomplished. They become sustainable when people realize their benefits and demand them of the authorities. Along with service delivery of these interventions, SCF/B should be raising the awareness of the village leaders to their importance and what they specifically do: why should a man lose his wife and children to ill health or death when it is avoidable? They will all recognize that small pox was once considered inevitable. The WSGs should also be thoroughly familiar with these interventions. It is important that everyone understand what each intervention actually does; the problem with EPI is that there is scant awareness of what BCG or DPT actually accomplish.

I propose at the same time that you divest yourselves of the more traditional, unproved or inefficient interventions, such as growth monitoring, routine antenatal care, primary health care clinic (see below), so as to become more efficient and focussed.

C. Operations

1. ICDDR, B is experimenting with leaner staff for wider coverage. They cite a figure of one family planning worker for 800 couples seen quarterly. You will need to rethink your own design as you expand your area.

2. ICDDR,B has also developed a FPW diary to augment the straight data-roster. This helps greatly in supervision, worth looking at. Supervision every quarter will be adequate to check the quality of work and coverage.

3. I would drop the "primary health care clinic." It is little more than a dispensary mostly for adults with non-serious complaints, takes up your resources and energies, and competes with local sources of dispensary-type care. If you need to, help your loyal health assistants setup in their own local practice. Some will stay, some not.

D. Health Information System

1. It is time to put the value of your decade-worth of data to test. I propose you enlist the interest of ICDDR,B who can compare it to the Matlab data gathered over the same time period.

2. The manual rosters can be simplified. I recommend a one-page roster with a carbonized copy for the Dhaka office (for computer entry) with only the critical, countable items such as: births, deaths, immunizations, family planning, and economic classification. You don't need all the various topical forms you now have, and every time transcription is made from one form to another, you create errors and lose data.

3. I recommend that when a death occurs to a child or woman of reproductive age, the worker responsible for learning about the event informs her/his superior immediately and a knowledgeable team establishes a reasonable cause of death (see the various protocols for Verbal Autopsies). The death is then discussed with community groups: WSGs, elders, health workers, to see what lessons can be learned, not to apportion blame. That's not easy to do, but I am thinking that problem-solving returns much more control over health issues to ordinary citizens who are mostly passive recipients of health care. I notice that childhood accidents are a major cause of death, surely an important topic for families to consider.

E. Research

1. An estimate of neonatal, infant, and child mortalities should be continued by location and updated. Some refinements might be interesting: perinatal outcomes by the trimester of pregnancy where Ramadan fell; a review of neonatal deaths by the life-day on which it occurred, displayed over the years and compared to TT2 coverage would be informative; compare stillbirth and perinatal death reports over the years (I suspect the former is more properly classified as the latter as health workers get more familiar with their work). See if ICDDR,B has already looked at such information.

2. I suggest you review the literature on eclampsia, a disease disproportionately afflicting malnourished women. Is a deficiency of potassium or trace element thought to be a key? It would be worth doing careful nutrient-intake studies on pregnant women in different trimesters; but I'm sure this has been done although perhaps not recently.

3. A thorough social-scientific study of mature WSGs would be instructive: what has happened to each member, her sense of herself, her daughters; what has happened to the group. Perhaps profiles of successful and unsuccessful groups can be drawn.

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4. Enlist ICDDR,B to help design some of these researches; the benefit to them would be a widened scope of jointly funded research, especially for their younger staff. BRAC and ICDDR,B have recently concluded such an agreement in the Matlab area. ICDDR,B may also be interested to help you review your accumulated data base, particularly to compare to Matlab. John Hagaa thought this a good idea.

5. I suggest you sponsor a major colloquium on sustainable development, bring in some outside stars to attract the Bangladeshi stars. Have a lot of panels to exchange ideas, network. Perhaps Ford Foundation would find this idea attractive. It would establish you as the serious players you really are.

Appendix 8.

FOCUS GROUP QUESTIONS

GUIDELINES/PROCESS OF DOCUMENTING FINDINGS

SAVE:CSP EVALUATION

WSG: FGD

- What health services are provided in your Community?
- How long have you been a member of WSG?
- What role does WSG play in promoting CS interventions?
- Do the services provide/services community health needs?
- Has the health of the children/women of the community improved?
- What can the community do to ensure the continuance of these services?
- Perception of usefulness of utility of FW
- Whether they disseminate health care knowledge to others & how.
- Link between WSG between GOB/NGO facilities and others
- Any changes (H.C. behavior) in their own family

VILLAGE COMMITTEE (FGD)

- What are your roles/responsibilities as VC member?
- How much time do your spend as a member? How?
- Will you continue, after the project phases out? Why? What will keep you continue working?
- When was the last time you met (as VC)? What did you discuss?
- Do you perceive that CS activities are effecting in meeting current health needs? Met previous needs?
- What activities do you want to be sustained?
- What resources can community contribute to ensure activities continue after SAVE phases out?
- What other problems you see within the community that your want to be addressed?

BFO

- Are the objectives were designed and realistic (Doc. Review)?
- Were BLS used to design objectives & strategies (doc. review & interview key informants)?
- How useful was the MTE?
- How useful was the KAP survey?
- Are the workplan realistic & technically adequate (Doc. review)?
- Are the program tech. & administrative procedures in writing and widely distributed among program staff? (instructed interview with key informants)
- Does the BFO staff & IA staff participate in planning of activities? (interview)

- Does the program strategy on community participates realistic (Doc. review & interview)
- Is there sharing of experiences/CSP operations between SAVE & others? (interview key informants)

- Role of donors in planning, operating (IA) and finding the program (Doc. review, interview key informants)

PROJ./IA STAFF (CD^2C) CDO(4) CHO(2)

- Do the staff know what is the purpose and importance of his/her work? (interview)
- Is the job description in agreement with the obj. of the program. (Doc. review & interview)
- Are the training provided in agreement with the JD? (doc. review & interview)
- Is the current level of knowledge & skill satisfactory to the program standards/requirement? (assess K+S, interview)
- Do the field supervisors know about the FW's assignments? (interview)
- What is IA staff turnover rate? (doc. review & interview)
- Relationship of IA & GOB and how they coordinate?

IA Lelve, FW's

- Does the FW know what is the purpose & importance of his/her work? (interview a few FWs)
- Is JD in agreement with the obj. of the program? (doc. review & interview)
- Is the Trg. provided in agreement with JD? (DR.)
- How frequent are the visits of supervisors to FW's
- Does the Sup. offer trg. and support during his/her visits to FW's? (interview few/sample)
- Are the incentives offered enough to motivate him/her during his/her work? (interview)
- Turn over rate of FW's? Reasons?
- How FW's perceive that the CS activities continue after SAVE's phase out?

TRAINING & TECH. ASSISTANCE

- What formal training have the staff (at different levels) received/attended since the beginning of the project? (doc. review/interview key informants at BFO)

- Did these trg. fulfill the staff needs? (doc. review & interview key informants)

- What Consultancies BFO+IA's+Field Staff received since beginning? - frequencies, topics, trg. (doc. review, interview key informants) at BFO, IA.

SUMMARY OF PROGRESS TOWARD ACHIEVEMENT OF PROJECT OBJECTIVES

Objective: By May 1989 program organizers (FC, AFC, MCHPC/MA) and a volunteer force will be in place in the new program areas, enabling the organization and implementation of CS activities.

Achievement Based on

PMIS Data Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
• By Oct.'88 FC, AFC & MCHPC/MA were in the extended villages of Gokarna Union, Nasirnagar Impact area. A group of volunteers were also identified, trained and utilized by Decc-ember, 1988.	IAM, IAC, FC, WPC, CHO(MCH), CHO(PHC), NMW, CDO, CDC & village CS, workers (PDW&VDT) were in place in old village of Kunda and Gokarna union and also in the extended villages of the 2 unions.	IAM, IAC, FC, CHO(MCH), CDC, CDO and Family Health Volunteers (FHW) were placed in 4 villages of Rangunias old 5 villages of Kunda Gokarna union, and extended new villages of Nasirnager.
• Since Nov.'89 one EPI coordinator and one MA has been working in the extended villages of Kunda Union, Nasirnagar Impact area. In June, 1990, 2 Comm. Dev. Organizers joined the team.	IAM, IAC, CDC, CHO(PHC), CHO(MCH), are in place in extended villages of Gokarna & Kunda.	Team of IAM, IAC, FC, CDO, CDC, CHO(MCH) are in place in old CS IV area and new extended villages of Kunda and Gokarna and newly expansion area.

Objective: By June 1989 Streamline the existing program management and information system so that the information flow is efficient and extend the streamlined system to cover the expanded area as new families are enrolled.

Achievement Based on

PMIS Data Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
• By April'89, the PMIS was streamlined; information flok became regular. In June'89 vital statistics of 1st phase extended villages were updated and changes computerized.	Information of the extended new villages were computerized and updated regularly.	Continued.
• Family enrollment and survey in the villages under 2nd phase of extension in Kunda & Gokarna Union are going on.	Updating of family enrollment and survey of newly extended gillages done.	Continued.

Objective: By August 1989 organize groups in the communities in new program areas which provide supervision and support in the health workers as well as a forum for health data feedback/activities.

Achievement Based on

PMIS Data Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
* Women saving's groups are being formed in new program areas. So far 14 WSG and 1 MSG have been formed in 1st phase extended villages.	91 (new ext. village Kunda & Gokarna).	91 WSG formed in new extended vilalges of Kunda and Gokarna Union.

Objective: By December 1989, 95% of families/households will have one female member competent in ORT, appropriate feeding and referral if necessary for persons suffering from diarrhoea.

Achievement Based on

PMIS Data Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
* 95% household have one female member and 50% households - a male member in the old area competent in ORT, appropriate feeding during diarrhoea and referral when necessary.	95%	

Objective: By December 1991, 80% of the functional household heads will be trained in ORT and appropriate feeding during diarrhoea so that they support or initiate the ORT.

Achievement Based on

PMIS Data Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
82.78%	80.35%	81.92%

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Objective: 70% of all mothers have under 2 children will be competent in preparation and feeding of appropriate weaning food.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
*	70% (1031) of mothers having 4-12 months old children are competent in preparation and feeding of appropriate weaning food.	79.04%	85%

Objective: 75% of <5 children will receive Vitamin A on a regular basis.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
*	VAC distribution started in 1990. 83% (5038) of 6-72 months children received VAC in 3 impact areas.		

Objective: 60% of pregnant women will be enrolled in an antenatal care/pregnancy monitoring program.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
*	46% (784) of women who gave birth during July'89 - June'90 were enrolled in antenatal care/ pregnancy monitoring	79.4%	78.2%

Objective: 90% of identified high risk pregnancies will be referred to appropriate prenatal and delivery care.

Achievement Based on

PMIS Data

Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
* On-going achieving objectives in Rangunia & Mirzapur impact areas. In Ghior and part of Nasirnagar there were disruption of pregnancy monitoring activities. 90%	90%	

Objective: 90% of identified pregnant and lactating mothers with iron deficiency anemia will receive iron and folic acid supplementation (as well as any other medical care needed).

Achievement Based on

PMIS Data

Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
80%	90%	

Objective: 90% of TBAs will be identified and trained.

Achievement Based on

PMIS Data

Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
* 77% (161) TBAs are trained.	84% (#258)	77%

Objective: By December 1990, 90% of active couples will receive training on birth spacing.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
*	66% (5670) female and 36% (3093) male partners of active couples in old areas are trained on birth-spacing.	85.73% (Female) 69.24%	90.96% (Female) 72.56%

Objective: 40% of active couples will be using modern birth spacing methods.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
•	43% (3730) active couples use modern birth spacing methods.	44.1%	44.2%

Objective: 95% of families will be provided with easy access to potable water.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
*	95% (8892) families have easy access to tube-well water. (Tube-well population ratio is 1:33) 95% (1517) tube-wells are in working condition.	96% Ratio 1:5.18 (HH)	

Objective: 50% of C&D households will be provided with water-seal latrines.

PMIS Data	Achievement Based on		
	Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
•	20% (1873) households use water-seal latrines.	25.74%	

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Objective: 80% of target children and women will be completely immunized, 80% of the new targets will receive immunization on an ongoing basis during the life of the project.

Achievement Based on

PMIS Data Up to 6/90 (MTE)	Up to 6/92	Up to 6/93 (NCE)
* 85% (1571) of 9-23 months children and 89% (10214) 15-45 years women are fully immunized in old areas. During July, 1989 - June'89, 72.3% (1078) children completed immuniza-tion by 12 months of age. [58% (96) of 9-23 months children and 78% (544) 15-45 years women in the villages of 1st phase extension are fully immunized]. [64% (810) of 9-23 months children and 70% (2572) of 15-45 years women in the villages of 2nd phase extension are fully immunized].	0-11m - 67.3% 9.23m 83% (exclu. NNN) 15-45yrs 90%	0-11m 55.13% (excl. NNN) (June'93) 15-45yrs. 87.7%

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