

PD-ABN-620

World Vision Relief & Development, Inc.

92625

**WVRD/Bangladesh FY91
FINAL EVALUATION REPORT
DHAKA URBAN INTEGRATED
CHILD SURVIVAL PROJECT
December 30, 1994**

Grant No.: PDC-0500-G-00-1065-00

**Beginning Date: October 1, 1991
Ending Date: September 30, 1994**

Submitted to:

**PVO Child Survival Grant Program
Office of Private and Voluntary Cooperation
Bureau for Food for Peace and Voluntary Assistance
Room 103C, SA-8
Agency for International Development
515 23rd Avenue, NW
Washington, DC 20523**

PVO Headquarters Contact:

**Lawrence Casazza, M.D., M.P.H.
World Vision Relief & Development, Inc.
220 I Street, NE
Washington, DC 20002**

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LIST OF ACRONYMS

AC	Area Coordinator
ACSS	Active Continuous Surveillance Sites
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BCG	Bacillus Calmette Gueirine
BWSWA	Bangladesh Women Social Welfare Association
CBDS	Community-Based Disease Surveillance
CC	Communication Coordinator
CDW	Community Development Worker
CS	Child Survival
CSSP	Child Survival Support Program
CV	Community Volunteer
DC	Development Coordinator
DCC	Dhaka City Corporation
DCH	Dhaka Community Hospital
DPT	Diphtheria Pertussis Tetanus
DVF	Domiciliary Visit Form
DUICSP	Dhaka Urban Integrated Child Survival Project
EPI	Expanded Program on Immunization
FE	Final Evaluation
FMG	Focus Mother's Group
GOB	Government of Bangladesh
HKI	Helen Keller International
HMIS	Health Management Information System
IPHN	Institute of Public Health Nutrition
KP	Knowledge and Practice
MOHFW	Ministry of Health and Family Welfare
MTE	Mid Term Evaluation
NGO	Nongovernmental Organization
NHC	Neighborhood Health Committee
NNC	National Nutrition Council
NRC	Nutritional Rehabilitation Center
OPV	Oral Polio Vaccine
ORS/T	Oral Rehydration Salt/Therapy
PHN	Public Health Nurse
PVO	Private Volunteer Organization
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VAC	Vitamin A Capsule
WC	Ward Consortia
WHO	World Health Organization
WVB	World Vision of Bangladesh
WVI	World Vision International
WVRD	World Vision Relief & Development Inc.

I PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

I.A Project Accomplishments

I.A1 & 2 DIP Objectives and Achievements

The project's DIP objectives are restated with the degree to which they have been achieved in Table 1 below. A description of the circumstances which have aided or impeded achievement follows the table.

Table 1
DIP Objectives and Achievements

DIP Indicators	Survey Findings of Achievements			Objectives
	Baseline (11/91)	MTE (9/93)	EOP (9/94)	EOP Target
% of Children 12-23 months fully immunized by 12 months (BCG, DPT3, OPV3 and measles)	43.4%	93.0% r	75.0% c 89.2% r	85%
% of women 15-45 years delivered in the past 12 months who received 2 doses of Tetanus Toxoid	32.6%	93.0% r	70.3% c 86.7% r	85%
% of all households with children 0-59 months who are competent in ORT usage	-	78.0%	-	80%
% of children 0-59 mos. with diarrhoea in past 2 weeks reportedly treated with ORT	70.5%	74.0%	89.3%	75%
% of children 12-71 months who received appropriate doses of Vitamin A semi-annually	98.3%	80.0%	85.5% c 90.6% r	90%
% of women 15-45 years who delivered in the past 12 months who received Vitamin A doses within two weeks of delivery	24.8%	-	58.0% c	90%
% of mothers with children 0-23 months who know correct weaning and infant feeding practices	57.7%	83.0%	71.9% *	80%
% of eligible couples with children under two using modern methods of contraception	39.2%	72.0%	53.0% **	60%
% of all pregnant women who received at least 3 check-ups (2 ante- & 1 post-natal) by a trained health person	30.0%	42.0%	39.9% d	50%
% of mothers with children 0-59 months able to name 2 out of 3 pneumonia signs indicating a need for treatment or referral	34.9%	18.0%	50.5%	50%

c = card only r = card plus recall d = based on domiciliary visits

* Correct weaning and infant feeding practices were defined as exclusive breast-feeding for first 4 months, introduction of appropriate weaning food after 4 months of age and breast-feeding for at least for 12 months.

** Those women who were not pregnant and said they did not want to have any children within next two years have been taken as the denominator to assess the rate of contraception use.

I.A3 Circumstances Aiding/Hindering Achievement

There are substantial differences between the data obtained from cards and that based on recall in the vaccine coverage and capsule distribution rates. There is reason to believe that card retention failure accounts for much of this but how much is uncertain. The card-based data is certainly more reliable. It suggests that coverage has not quite reached targeted levels in these areas. Most of this shortfall is probably due to the transient nature of the population and the attendant difficulties in maintaining coverage when new children are continuously added to the population.

ORT competence and reported use surpassed the targeted level. The Community Volunteers (CV) and Focus Mothers (FM) with the support of the Project's Community Health Workers (CHW) must be credited with excellent communication work in achieving these targets.

The shortfall in TT coverage among women, Vitamin A coverage among women, attendance by trained personnel for deliveries and ante- and postnatal checkups are all related to the need for upgrading TBAs and establishing a referral system for them. This is one of the lessons learned in this project and a principal recommendation of this report for ongoing programming in this project.

Contraceptive use appears to be down from the mid term but the denominator has been changed to conform to the JHU/CSSP definition. The EOP data are probably quite accurate and reflect the difficulty in promoting contraceptive use in this culture. Qualitatively, discussions with the women suggest that the practice is actively considered, awareness is high, but actual adoption will take more time. Combining contraceptive promotion with other reproductive health services as recommended for the remainder of the project is certainly worth consideration.

I.A4 Unintended Benefits

1. The project has been highly successful in meeting and documenting service delivery objectives, achieving high coverage with most Child Survival interventions. Coverage and service statistics are presented in subsequent sections.
2. Through the follow-up of the May 1994 Health Management Information Systems (HMIS) Review and the August 1994 Missed Opportunity Survey, the project has begun to respond to the MTE Team's call to take the next "natural" steps to shift focus to: a) deepen program quality through a team approach to quality assessment and assurance; b) document impact on health status through community-based disease and death surveillance.
3. Integration of project management and initiation of standardized systematic refresher training have led to a rationalization of activities in both impact areas and an apparent increase in staff morale.
4. The project has reached historic milestones in improving cost-effectiveness and initiating a phaseover plan over the next three years, e.g.

- a) Semi-annual Vitamin A distribution to children is done entirely by the Community Volunteers;
 - b) The project plans to delegate all CS service delivery responsibilities for 14,500 slum dwellers in Geneva Camp in Area B to the local clinic-based Alfala NGO from October 1994--this pioneering partnership with a local NGO in a clearly demarcated area of responsibility is highly commended.
5. Anecdotal data indicate that the training of TBAs has led to a remarkable reduction in the number of reported stillbirths, neonatal deaths, and maternal deaths. This however, needs to be properly documented.
6. The project has effectively used the Homogeneous Unit Principle (HUP) to:
- a) facilitate community organization by homogeneous neighborhoods;
 - b) promote behavior change messages through audience segmentation.
7. The project commands reputation as a demonstration site for an effective CSP by drawing an increasing number of visiting WV and other NGO CSP staff from other countries in the region.

I.A5 Final Evaluation Survey

The Survey Report accompanies this document. Below in Table 2 is a summary of the findings relative to the Key CS Indicators.

Table 2
Summary of Survey Findings on Key Indicators

	INDICATOR	EOP SURVEY 20/09/94
1	NUT: Initiation of Breast-feeding: Percent of infants/ children (less than 24 mns) who were breast-fed within the first eight hours after delivery	N=206 P=68.6% D=300
2	NUT: Exclusive Breast-feeding - Percent of infants under four months, who are being given only breast milk	
3	NUT: Introduction of Foods - Percent of infants between five and nine months, who are being given solid or semi-solid foods	
4	NUT: Persistence of Breast-feeding - Percent of children between 20 and 24 months, who are still breast-feeding (and given solid/ semi-solid foods)	N=47 P=83.9% D=56
5	CDD-ORT Usage - Percent of infants/children (less than 24 months) with diarrhoea in the past two weeks who were treated with ORT	N=32 P= 77.7% D=42
6	EPI Access - Percent of children 12-23 months who received DPT1	N=141 P=93% D=152
7	EPI Coverage - percent of children 12-23 months who received OPV3	N=130 P=93.1% D=141
8	EPI Measles Coverage - Percent of children 12-23 months who received Measles vaccine	N=125 P=88.6% D=141
9	EPI Drop out Rate - Percent change between DPT1 and DPT3 doses [(DPT1-DPT3)- DPT1] for children 12-23 months	N=11 P=7.8% D=141
10	MC: Maternal Card - Percent of mothers with a maternal card	N=240 P=80% D=300
11	MC: Tetanus Toxoid Coverage (Card) - Percent of mothers who received two doses of tetanus toxoid vaccine (card)	N=180 P=75% D=240
12	VAC: Percent of children who received appropriate doses of VAC semi-annually	N=137 P=90.1% D=152
13	MC: Modern Contraceptive Usage - Percent of mothers who are not now pregnant, desire no more children in the next two years or are not sure, who are using a modern contraceptive method.	N=156 P=55.1% D=283
14	VAC - Percent of women 15-44 years who delivered in the last 12 months who received a Vitamin A dose within one month of delivery	N=171 P=58% D=296

I.B Project Expenditures

- I.B1 Pipeline Analyses for both Headquarters and Country Project portions of the grant are attached as Appendix A.
- I.B2 The project grant included \$562,158 from USAID and \$485,549 in matching funds provided by World Vision. Overall, the project had underspent both USAID grant funds and WV match funds by September 30, 1994. Much of the underspending, as compared to the budget, occurred in category I.C of Report Form A (attached), covering "Services/Consultants/Evaluation". A portion of these remaining funds will be used for the costs of the Final Evaluation, which occurred after September 30, 1994.
- I.B3 In general, project finances were properly handled, and complete records seem to have been maintained by the project financial officer and staff. Reporting requirements were met.

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

WVRD/Bangladesh
GRANT #PDC-0500-G-00-1065-00

Actual Expenditures to Date (10/01/91 to 09/30/94) Remaining Obligated Funds Total DIP Budget (Columns 1 & 2) (10/01/91 to 09/30/94)

COST ELEMENTS	Actual Expenditures to Date (10/01/91 to 09/30/94)			Remaining Obligated Funds			Total DIP Budget (Columns 1 & 2) (10/01/91 to 09/30/94)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	32,108	\$45,993	\$78,101	(\$8,798)	\$3,631	(\$5,167)	\$23,310	\$49,624	\$72,934
B. Equipment	0	17,492	17,492	0	(12,192)	(12,192)	0	5,300	5,300
C. Services/Consultants/Evaluation	46,051	38,142	84,193	(23,350)	(38,142)	(61,492)	22,701	0	22,701
SUB-TOTAL I	78,159	101,627	179,786	(32,148)	(46,703)	(78,851)	46,011	54,924	100,935
II. EVALUATION*	0	0	0	24,091	8,572	32,663	24,091	8,572	32,663
SUB-TOTAL II	0	0	0	24,091	8,572	32,663	24,091	8,572	32,663
III. INDIRECT COSTS									
HQ/HO Overhead __20(%)	87,669	129,365	217,034	6,024	95,805	101,829	93,693	225,170	318,863
SUB-TOTAL III	87,669	129,365	217,034	6,024	95,805	101,829	93,693	225,170	318,863
IV. OTHER PROGRAM COSTS									
A. Personnel	262,399	160,676	423,075	35,621	(36,441)	(820)	298,020	124,235	422,255
B. Travel/Per Diem	19,303	9,817	29,120	13,727	1,756	15,483	33,030	11,573	44,603
C. Other Direct Costs (Utilities, Printing, Rent, maintenance, etc.)	78,485	49,318	127,803	(11,172)	11,757	585	67,313	61,075	128,388
SUB-TOTAL IV	360,187	219,811	579,998	38,176	(22,928)	15,248	398,363	196,883	595,246
TOTAL	\$526,015	\$450,803	\$976,818	\$36,143	\$34,746	\$70,889	\$562,158	\$485,549	\$1,047,707

**Evaluation costs are included in Services/Consultants.

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

WVRD/HEADQUARTERS

GRANT #PDC-0500-G-00-1065-00

Actual Expenditures to Date
(10/01/91 to 09/30/94)

Projected Expenditures Against
Remaining Obligated Funds
(10/01/94 to 09/30/95)

Total Agreement Budget
(Columns 1 & 2)
(10/01/91 to 09/30/95)

prof
22/22
9/94

COST ELEMENTS

COST ELEMENTS	Actual Expenditures to Date (10/01/91 to 09/30/94)			Projected Expenditures Against Remaining Obligated Funds (10/01/94 to 09/30/95)			Total Agreement Budget (Columns 1 & 2) (10/01/91 to 09/30/95)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	\$0	\$0	\$0	\$2,925	\$1,575	\$4,500	\$2,925	\$1,575	\$4,500
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants/Evaluation	0	0	0	4,875	2,625	7,500	4,875	2,625	7,500
SUB-TOTAL I	0	0	0	7,800	4,200	12,000	7,800	4,200	12,000
II. EVALUATION	26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
SUB-TOTAL II	26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
III. INDIRECT COSTS	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
HQ/HO Overhead 20(%)									
SUB-TOTAL III	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
IV. OTHER PROGRAM COSTS									
A. Personnel	97,188	13,523	110,711	29,899	54,909	84,808	127,087	68,432	195,519
B. Travel/Per Diem									
1. In-country	2,365	676	3,041	35,514	19,720	55,234	37,879	20,396	58,275
2. International	24,309	5,510	29,819	(12,609)	790	(11,819)	11,700	6,300	18,000
C. Other Direct Costs	927	310	1,237	4,923	2,840	7,763	5,850	3,150	9,000
(Utilities, Printing, Rent, maintenance, etc.)									
SUB-TOTAL IV	124,789	20,019	144,808	57,727	78,259	135,986	182,516	98,278	280,794
TOTAL	\$149,777	\$24,022	\$173,801	\$101,085	\$111,057	\$212,142	\$250,862	\$135,079	\$385,941

I.C Lessons Learned and Recommendations

This project has been funded by USAID for six years and granted a third phase to continue for another three years making something of a laboratory for learning about urban child survival. It has served this function well for other WV projects in the region and to some extent for the larger community of those engaged in CS activities. Lessons learned have been published and presented in a number of forums and should continue to be disseminated. What follows is based on their experience

Community Participation: The Project's success in developing Neighborhood Health Committees and mobilizing the efforts of volunteers is outstanding. These groups have contributed substantially to the work of the project (see Section II.A4). They feel confident of their ability to sustain IEC activities with minimal refresher training and some supervisory support. They also feel able to carry on a VAC distribution program using the CVs. The PVO has developed this working relationship, in part, through its willingness to respond to input on program direction from these groups. This is an obvious lesson but it is gratifying to see it learned and practiced. Selection of Cvs by the NHCs has reduced their attrition rate as has the inclusion of more married females in this cadre of workers.

Coordination with Other Agencies: World Vision has been an initiator in the formation of a GO/NGO Forum and has made significant efforts to collaborate with government and other local groups. However it is clear that additional resources from external sources will be needed to sustain services in this area in spite of efficient and well coordinated service delivery channels. World Vision will continue to be a player in this area through both Child Survival type projects and its other ADP activities. Where these have been linked and have cooperated their work has been enhanced.

Further consolidation of WV's programming should be encouraged. With continued networking with other agencies it can be expected to make the project's efforts more significant in the overall delivery of services to low income people in this area.

Cost recovery efforts have been initiated and should be strengthened in the third phase of this project within the framework of government policy.

Use of HIS Data: The project has evolved to a high level of sophistication in data gathering. The recent workshop on health and management information systems has pointed the way to increased emphasis on quality assurance and impact measurement. It has also underscored the need to make data meaningful to clients at the community level as well as serving the needs of management and the donor. Field testing of a modified community-based system is underway. The total number of report forms is to be reduced from 30 to 23 in phase three--a step based on experience with a complex HIS.

Plans for a quality assurance workshop have been made and similar training in communicating findings to the community would be appropriate. The third phase of this project which is about to begin should be used as an opportunity to refine the HIS and provide tools that could be useful in many other child survival projects. It is particularly

particularly important that this data gathering be coordinated with local government reporting systems to minimize additional reporting efforts and keep monitoring and evaluation costs within sustainable limits.

Skill in the gathering and use of more qualitative data should be developed particularly as communication strategies are designed and assessed.

Growth Monitoring: Malnutrition is a major problem of the project area as it is in all of Bangladesh. An HKI surveillance study on the Dhaka slum population reported severe undernutrition (WT/A < 60%) in 7.2% of 6-59 month old children and wasting (WT/H < -2Z) among 15.6% of this population. Given this high prevalence, the limited resources for intervention and the labor intensive nature of comprehensive growth monitoring the team felt the value of this strategy to be questionable.

We suggest instead that high risk children be identified by Cvs and CDWs, as part of their regular domiciliary visit protocol. These staff would be trained to do so on the basis of a series of indicators including mother's weaning practices, recent arrival in the area, single female headed households, and MUAC measurement. These high risk children will then be referred to the nutrition rehabilitation team for further assessment and intervention.

Current plans to revamp the Nutrition Rehabilitation Center include increased emphasis on literacy training for mothers, more play-oriented learning experiences for the children and systematic follow-up by the Cvs when mothers return to the community. We recommend that these plans go forward.

TBA Training and Support: In the project area 53.1% of deliveries were conducted by TBAs and 25% by a neighbor or relative at home; 18.8% were conducted in hospitals, health centers or clinics. (R. N. Basu. Neonatal Death Survey Report in Ward Nos. 12,13,14 & 51 of Dhaka City Corporation. World Vision of Bangladesh. 1992.) This suggests that TBAs will continue to be a vital part of maternal health care for some time to come. The project's experience with training TBAs in its area (using the Agha Khan Community Health Project training course) suggests that these trained TBAs have a much better understanding of their work and are more aware of complication and willing to refer cases to professional personnel. They also report having gained status in the community and improved income since being trained, making their services more sustainable.

Trained TBAs need ongoing supervision and facilities for referral. The Third Phase Technical reviewers of the Proposal suggest that the next phase of the project include midwives in their staff and provide some form of transport for them to work with complicated cases and provide support/supervision to trained TBAs and develop referral linkages for surgical care when needed. This recommendation is also in keeping with what project experience suggests.

Income Generating Activities: Project staff have realized a strong demand from the communities for activities which would improve their economic status. This is an obviously

genuine need and closely related to improving health conditions for children. Pilot projects for income generation were begun with community volunteers who developed savings plans and have started cooperative enterprises on a very small scale. To this point they have not turned significant profits but are entirely owned by the volunteers. No plans were made in the DIP of this phase and none are included in the proposal for the third phase.

We recommend that the CSP continue to facilitate the formation of IGA groups in the community and their access to government and NGOs that can provide training and loan facilities for groups and individuals to develop small enterprises. This will not involve the CSP directly in financing such enterprises nor require that they develop expertise in their management.

Staffing: This project has developed a number of highly skilled staff and has lost several of them to better paid and more challenging positions. Some turnover is to be expected, but has been costly in terms of continuity of leadership. Current staff are generally qualified and experienced and morale seems good.

Policies to minimize turn over among staff have been initiated and should be actively pursued.

Communication Strategies: Communication of health messages to the community has been primarily through the CDWs and Cvs. WV personnel involved in their training have learned: 1) to access existing materials from government and other sources; 2) when developing their own materials, to keep messages simple and concise and field test for audience-appropriateness; and 3) to train staff and volunteers to communicate the messages (i.e. TOT is necessary for all field staff). They have also learned, from CVs, the value of folk media such as songs and drama. Training staff are anxious to evaluate, in more depth, the relative effectiveness of their communication efforts and assess the barriers that create discrepancies between knowledge and behavior in areas such as child spacing.

Field testing of materials and methods should be further developed, audience analysis more thoroughly done, and evaluation of communication effectiveness should be pursued in the third phase of the project as part of associated operational research.

Gender Bias: WV Bangladesh has come to recognize gender bias as a fundamental problem to be dealt with in all its programming. This is reflected in its third phase proposal and staff are very much aware of and sensitive to the issue. The WVB publication on The Girl Child and their study of Dhaka street girls summarize the lessons learned about working with this most disempowered segment of society.

Strategies which capitalize on WVB's infrastructure and child sponsorship projects should be devised to maximize opportunities for girls and to develop more sensitivity to the issue at the community level. The Al-falah clinic in Geneva Camp has pioneered efforts at educating men as well as women for responsible parenthood, a strategy which should be tried and made part of operations research in the project.

II. PROJECT SUSTAINABILITY

II.A Community Participation

II.A1 Interviewees

LIST OF THE MEMBERS OF WARD CONSORTIUM INTERVIEWED ON 22ND SEPTEMBER 1994

	NAME OF MEMBER	DESIGNATION
1.	Habibur Rahman (Habib)	Member
2.	Kazi Abu Taleb	Member
3.	Abdul Karim Pathan	Vice-President (Area A)
4.	Abul Bashar	Member
5.	A.R. Subedar	President (Area A)
6.	Dr. Md. Shamsul Hoque Mian	Advisor
7.	Md. A. Zamana	Joint Secretary
8.	Md. Musa	President (Area B&C)
9.	Shah Hossain Iqbal	Secretary (Area B&C)
10.	Kh. Abullah-Al Mamun	Vice-President (Area B&C)
11.	Abdur Rob	Member
12.	Dr. Jalaluddin Ahmed	Member
13.	Shamuddin Ahmed	Member
14.	Rejia Begum	Member
15.	Setara Musa	Member (Area B&C)
16.	Hasina Shamsuddin	Treasurer (Area A)

The minutes of this meeting are included in Appendix B. Appendix D contains copies of the Interview Guides used for this group as well as guides for other interviews conducted.

II.A2 Interventions Perceived to be Effective

Interviews with Ward Committee members suggest a variety of interventions are perceived to be effective. Virtually all interviewees mentioned that the health education/mobilization of the CVs and CDWs were vital to the project's effectiveness. Community member comments about the project were very positive. There was a strong demand for the services of the CSP (i.e. immunization) to continue. The CVs and NHC conveners express confidence that they can now carry out VAC distribution on their own if capsules are provided to them. They credit their enhanced capacity to the training and support of the CSP. Notes on the meeting with WCC members are in Appendix B. That discussion and interviews with individual committee members form the basis for most of this section.

II.A3 PVO Activities to Enhance Community Capacity

The DUICSP has provided health promotion and education services through its organization of a Development Coordinator, Training Coordinator & Communications Coordinator at the project level. At the community level two Area Coordinators supervise the work of CDWs

CVs. This team has provided communication support to the services delivered by the project, principally immunization and VAC distribution; social marketing for family planning, CDD, and ARI interventions; and extensive community organization and mobilization. Specific outputs were targeted in the DIP and achievement of these is summarized in Table 3 below.

Community organization has been particularly well done in this project. Virtually all of the communities in the project area now have Neighborhood Health Committees which appoint representatives to the Ward Consortium groups. WV has developed an effective training program for the NHC and WCC members and has contributed to committee-initiated projects such as installing dustbins and small enterprise development. These groups take some responsibility for supervising the Cvs and CDWs and serve to provide feedback from the community to the project management.

Table 3
Outputs of the Project

Output/Objective	Achievements (FY92-94)	EOP Target for 9/94
Community Human Resources/Institutional Development:		
* NHCs established/functioning	99	100
* CVs trained/functioning	345	300
* Focus Mothers trained/functioning	97	160
* TBAs trained, equipped with TBA kits & functioning	71	60
* WCC members trained in leadership/management skills	--	35
* Ward Coord. Committees formed/functioning	4	4
* small-scale enterprises formed by CVs and functioning	4	4
* revolving loan fund for CVs established & functioning	2	2
* Focus Mothers participating in IGAs	—	40

II.A4 Community Participation in Project

Community participation in the planning and evaluation of this project has grown with each successive cycle of funding. Ward Consortium members served actively on this evaluation team as they had on previous teams and at the time of the DIP preparation. Participation in implementation however is probably the most notable aspect of community involvement in project activities. The degree to which this took place is evinced by the contributions made to project operations. These are summarized and their value estimated in Tables 4, 5 and 6 below.

Table 4
Cost Recovery (in kind) from Community to Implement Project Activities

	TYPE OF SUPPORT	FISCAL YEAR			TOTAL	TAKA/(\$) VALUE
		1992	1993	1994		
1.	Site for Out Reach Vaccination (estimated average 22 sessions per month and each center rent estimated taka 80 for average 6 hours occupancy.)	260	250	240	750	60,000.00 (\$ 1500)
2.	Site for Regular Meeting Place & Special Gathering (Average 80 NHC Meeting per Month and each Meeting place rent estimated Tk. 20 for 2 hours occupancy.)	965	980	992	2937	58,740.00 (\$ 1469.5)
3.	Venue for Special Gathering for Health Education & Film Show (Venue Community Center) for special gathering estimated Tk. 300 for 5 hours occupancy.	21	26	35	82	24,600.00 (\$ 615)
4.	Venue for IGA (HEMA, NCS Shop and Training Center)	—	02	02	04	72,000.00 (\$ 1,800)
5.	Materials/Logistics * Refreshment contributed at NHC meeting. Estimated Tk. 20 per meeting/person	19,300.00	19,600.00	19,840.00		58,740.00 (\$ 1468.5)
	*Stationery Paper, Pencils, Diary Books of CVs/NHCs.	5,000.00	6,000.00	6,000.00		17,000.00 (\$ 425)
GRAND TOTAL		24,300.00 (\$ 608)	25,600.00 (\$ 640)	25,840.00 (\$ 646)	419	291,080.00 (\$ 7277)

** 1 US \$ = Tk. 40.00

Table 5
Cash Contribution by Community

	TYPE OF SUPPORT	FISCAL YEAR			TOTAL TK/(\$) VALUE
		1992	1993	1994	
1.	Fee for Service	30,161.75	42,988.75	40,516.25	113,666.75 (\$ 2,842)
2.	Health Card	2,090.00	1,889.00	1,410.00	5,389.00 (\$ 135)
3.	Cleaning of Safety Tank	400.00	--	--	400.00 (\$ 10)
4.	Construction of Public Toilet/Dustbin	2,000.00	--	500.00	2,500.00 (\$ 62.5)
5.	Mosquito Control Program	4,000.00	--	--	4,000.00 (\$ 100)
6.	Tree Plantation	--	5,000.00	4,000.00	9,000.00 (\$ 225)
7.	Cleaning of Pond/ Drain	--	8,000.00	500.00	8,500.00 (\$ 212.5)
GRAND TOTAL		38,651.75 (\$ 966)	57,877.75 (\$ 1447)	46,926.25 (\$ 1173)	143,455.75 (\$ 3,586.39)

** 1 US \$ = TK. 40.00

Table 6

Time Given by the Community to Implement Project Activities from FY 92-94

	Community counterpart	Total members	Approx. time given per month	Time given per person FY 92-94	Approx. Taka per hour	Total taka value
1.	NHC Member	668	3 hours	36*3=108 hours	13	937,872.00 (\$23,446.8)
2.	WC Member	30	1 hours	12*3=36 hours	13	14,040.00 (\$351)
3.	Community Volunteer	345	7 hours	84*3=252 hours	13	1,130,220.00 (\$28255.5)
4.	Focus Mother	84	2 hours	24*3=72 hours	13	3,276.00 (\$81.9)
5.	TBA	61	5 hours	60*3=180 hours	13	14,274.00 (\$356.8)
TOTAL		1188				2,099,682.00 (\$52,492)

** 1 US \$ = TK. 40.00

II.A5 Health Committee Function

There were 99 NHCs functioning at the time of the EOP evaluation. Each committee consists of 7 to 10 members and represents 250-300 households. It is responsible for selection of CVs and facilitating their work. The community elects the NHC members and the NHC in turn elects two representatives to the Ward Consortium Committee. These committees have served as the vehicle for community involvement in planning, implementation and evaluation. They have limited resources at their command. Attempts have been made to establish income generating activities for groups of CVs. These are described in a later section, but it is clear that these activities have not reached a scale needed to sustain the endeavors these community groups would undertake to maintain project gains.

The committees appear to be quite representative of their communities. It is particularly noteworthy that half the NHC members and more than 40% of the Conveners are women (see Table 7). Several members have good connections to other professional and social groups.

The membership includes people from the local business community, The President of the Bangladesh Women Journalists Forum, teachers, social workers, and lawyers. While the majority of people in the community are less educated than these, the committees include less affluent, less educated people and a few of the "elite" members of society, probably not unlike the general population.

Table 7
Involvement of Female Members/Conveners in Neighborhood Health Committees
September, 1994

AREA	# OF NHC	# OF MEMBERS INVOLVED	# OF FEMALE CONVENERS	# OF FEMALE MEMBERS
A	50	322	14 (28%)	121 (38%)
B	26	146	15 (58%)	103 (71%)
C	23	200	12 (52%)	121 (60.5%)
TOTAL	99	668	41 (41.41%)	345 (52%)

II.A6 Issues for Health Committees

Both the NHCs and the Ward Consortium Committees are concerned with means to motivate their constituents to participate in project activities. They have been very active in communicating health messages to their communities and overseeing the work of the CVs, even doing door-to-door home visits. Discussion in committee meetings tends to focus on the particulars of project operations in the immediate neighborhood. The need for more income generating activities is actively considered, possibilities are explored, and plans made for IGAs. Another issue often mentioned is the need for better clinical services, particularly for obstetrical care.

The WCCs are actively in contact with other service providers and agencies in the area. Issues related to the city's services in their area and the potential for working with other NGOs are discussed. They also mediate any problems which may arise between CVs and people of the community. Some issues of concern to the NHCs and WCCs relate to the "orthodoxy and superstition" that create resistance to family planning messages and other changes in health-related behavior.

II.A7 Committee Direction to the Project

The NHCs and WCCs have been very active as implementers of the project, less so in its direction. This is probably due, at least in part, to the limited resources they have to contribute and a traditional deference to the "experts" who control the finances and the information within the project. There is evidence that the project staff have actively

encouraged community participation in the planning and evaluation of project activities. The participation of WCC members on this evaluation team is a good example.

II.A8 Community Resources Contributed

The resources of the community which have been contributed to project activities are listed in Section II.A4 above. These are substantial and represent real commitments on the part of community members to support the project. However, these inputs are not sufficient to cover the costs of materials transport and project personnel needed to continue project activities when donor funding ends.

II.A9 Reasons for Success/Failure

The degree to which these communities have succeeded must be attributed to the commitment of community leaders and the ability of project staff to build relationships and engender confidence. That resources are insufficient to carry on CS activities is a reflection of the larger realities of the economy of Bangladesh. Neither at the local community nor at the national level are sufficient resources available to support an adequate health care system. Hence it is not surprising to find that the communities included in this project area, which includes large slum tracts, have not been able to contribute adequate resources.

II.B. Ability and Willingness of Counterpart Institutions to Sustain Activities

II.B1 Interviewees

Dr. M. Ashraf Uddin, Chief Health Officer, Dakha City Corporation
Dr. Shawn Baker, Country Director, Helen Keller International
Dr. Jakir Hussein, Director of Primary Health Care, MOHFW, Bangladesh
Dr. Imam Shamim, Medical Director, Al-falah Clinic, ICRC Refugee Camp (Geneva Camp)
Dr. Abdul Majid, Project Director, MOHFW, Bangladesh

II.B2 Linkages to Key Agencies

The WV project has served as a center for coordinating the work of many agencies in the area and a catalyst for cooperation. The principal public agencies involved are listed with their contributions to the project's operation in Table 8 in Section IIB.9 below. This list of counterpart institutions represents active networking on the part of project staff. Most of the relationships have been to organizations that have provided services or materials contributing to the project's activities (i.e. vaccines from the DCC and VAC from the Institute of Public Health Nutrition). Some, such as the relationships to DCC and the Directorate of PHC, also provide legitimacy for the project and authorization enabling other public agencies to contribute to it. Other agencies have provided training directly to project staff. Finally, some agencies, have trained local personnel to serve the community in ways which compliment the project. An example of the latter is the training of TBAs by the Aga Khan Foundation. These TBAs were not employed by the project but worked closely with CVs and NHCs in the areas they served.

II.B3 Local Institutions Expected to Sustain Activities

Of all the linkages to other organizations, the work with the Al-Falah Model Clinic holds most promise for continuing to provide the services WV has been providing. This clinic serves the refugees who claim Pakistani citizenship but have remained in Bangladesh since 1971. The "camp" population now numbers more than 14,000 but has limited ties to the economy and social structures of Dhaka. The clinic is supported by the Red Cross and UNHCR and has established an outstanding program of community outreach as well as quality clinic services. This clinic will take over virtually all of the project responsibilities as of FY 1995.

Other linkages provide a patchwork of services which fall well short of meeting the needs of the population served by WV. As Table 8 suggests, the total inputs from these counterpart agencies is a fairly small fraction of the expenditures of the project and has little potential for increase as the project phases out. The WCCs hold promise for continuing to supervise CVs and carry on most IEC functions. The services requiring more supplies and technical expertise such as immunization and the maintenance of the HIS do not seem to be as well positioned for taken over by counterpart agencies.

The NGO Forum provides opportunity for collaboration among agencies working in this project area as well as greater Dhaka and Bangladesh. WVB has been an active member of this group and continues to interact with other NGOs through it. The Forum is, as many such umbrella agencies, relatively weak and unable to restrict overlap of services or direct services to the most needy areas.

II.B4 Activities Perceived to be Effective by MOH

The outstanding achievements of the project as perceived by the MOH, DCC and other local institutions are community organization, represented by the NHCs and WCCs; and its ability to deliver services, particularly immunization and VAC distribution. Also mentioned were the efforts of the project in CDD. Appendix C contains the comments of Dr. Jakir Hussein, Director of PHC for the MOHFW/GOB which express in detail the views of that department toward the project.

II.B5 PVO Training for Counterparts

Table 8 summarizes the training provided to the staff of other PVOs and government agencies. Among these activities a few events stand out. WV has been an active member of the NGO forum composed of NGOs involved in EPI and staff have attended their bi-monthly meetings regularly.

Table 8
Training Provided for Other NGOs and Government Personnel

Type of Training	Achievements (FY92-94)	TARGET AS OF 94
NGO Human Resource/Institutional Development: * 9 NGO staff (from 9 local NGOs) trained in program management * 9 NGO staff (from 9 local NGOs) trained in financial management and fund-raising skills * 9 NGO staff (from 9 local NGOs) trained in EPI Disease surveillance * 10 PVO sharing Workshops facilitated * 2 NGO consortia formed/functioning	 0 0 18 25 2	 9 9 9 10 2
Public Sector Human Resources/Institutional Development: * 8 DCC staff trained in EPI Disease Surveillance * 4 DCC staff trained in health program management * 40 formal school teachers trained in health communications skills and use of health education curricula and materials	 18 8 50	 8 4 40

II.B6 Ability of Counterparts to Sustain Activities

Neither government agencies, principally the DCC, nor NGOs operating in the area appear ready to assume responsibility for all the services this project has been offering. There are NGOs that have taken increasing responsibility for some of the work in some of the areas, but this is substantially less than adequate. The DCC is not in a position to assume the costs of providing the services currently provided by WVRD. Urban primary health care service is severely under funded and it is naive to assume that this will change any time soon. The WCCs, if blessed with outstanding leadership, might fill a coordinating role to explore other means to generate and control resources to provide the services now rendered by the project. Developing these organizations to assume such responsibility will be a major part of WVRD's task during the next phase of the project.

II.B7 Please see Section II.B4

II.B8 Phase-over of Project Responsibilities

The most complete phaseover of project activities has been in the Geneva Camp area where Al-fala has taken over virtually all project activities through its Model Clinic. This serves approximately 14,500 people. In addition, the semi-annual Vitamin A distribution to children is done entirely by the Community Volunteers. There are other collaborative efforts with a

number of other NGOs and the DCC which supplement the activities of the project but, as stated previously, there is limited potential for support of the full range of project activities in the entire area.

II.B9 Financial Commitments of Counterpart Institutions

The estimated amounts committed by participating agencies are summarized in Table 9. These amounts are substantial and represent serious commitment and active cooperation on the part of key players in the project area. This level of commitment can quite likely be sustained. It is not nearly as likely that it can be enhanced to support the full range of project activities.

Table 9
Counterpart Institutions' Contributions to
Dhaka Urban Integrated Child Survival (DUICSP) Activities, FY 92-94

	Counterpart Organization	Contribution/support	Approx. Cost in Taka
1.	Dhaka City Corporation (DCC)	* Communication Materials * Infrastructure * Transport 2 Trucks * Insecticide Supplies	9,000.00 10,000.00 4,000.00 20,000.00
2.	Institute of Public Health Nutrition	* VAC (35,000 per round) * Communication Materials	525,000.00 9,000.00
3.	Civil Surgeon, Dhaka	* Communication Materials * Forms/Formats	9,000.00 10,000.00
4.	Directorate of Primary Health Care/Bureau of Health Education (PHC/BHE)	* Communication Materials * Consultancy (80 hours) * Training for CVs/School Teachers/CDWs	18,000.00 16,000.00 15,000.00
5.	Directorate of Control of Diarrhoeal Disease (CDD)	* Consultancy (10 hours) * Promotional/Training Materials	2,000.00 22,500.00
6.	National Nutritional Council (NNC)	* Communication Materials	450.00
7.	Directorate of ARI	* Communication Materials * Consultancy (5 hours) * Training	3,000.00 1,000.00 4,000.00
8.	Directorate of EPI	* Training * Consultancy (38 hours) * Vaccination Equipments	60,000.00 7,600.00 30,000.00

	Counterpart Organization	Contribution/support	Approx. Cost in Taka
9.	School Health Education	* Consultancy (36 hours) * Training	7,200.00 12,000.00
10.	Telegu Community Clinic	* Curative Care for TB Patients (75 TB Patients) * Safe Motherhood Services	15,000.00 20,000.00
11.	Coalition Clinic Project Dhaka	* Safe Motherhood Services * FP Clinical Services	16,000.00 21,600.00
12.	CNU, Save the Children Fund (UK)	* Treatment * Training	18,000.00 2,000.00
13.	Family Planning Association of Bangladesh (FPAB)	* Communication Materials	10,000.00
14.	ICDDR-B	* ORS Packet * Consultancy/Training * Communication Materials	4,000.00 5,000.00 2,400.00
15.	Aga Khan Community Hospital Project	* Training	19,250.00
16.	UNICEF	* Communication Materials * Delivery Kit * VIPP Manual	18,000.00 2,750.00 1,000.00
17.	World Vision of Bangladesh (WVB)	* Communication Materials	11,250.00
18.	Ward Consortium	* Consultancy (50 hours)	7,500.00
19.	Al-Falah Model Clinic	* Safe Motherhood Services * F.P. Clinical Services	15,000.00 11,600.00
20.	World Concern (NGO)	* Training * F.P. Services	5,000.00 14,400.00
21.	Mohammadpur Fertility Services & Training Center	* F.P. Services * Consultancy (5 hours)	14,000.00 1,000.00
22.	Voluntary Health Services Society (VHSS)	* Communication Materials * Consultancy (15 hours)	4,500.00 3,000.00

GRAND TOTAL

1,037,000.00
(\$ 25,925)

** 1 US \$ = TK. 40.00

II.B10 Reasons for Success/Failure to meet Commitments

Commitments from government agencies have basically been met. Occasional delays in supply of such critical resources as vaccines have been experienced but these were within the expectations of working within the constraints of an impoverished economy. Other commitments from NGOs have, for the most part, exceeded expectations. In the case of the Al-falah Model Clinic, an outstanding job has been done in assuming the lead role within the Geneva Camp area and it is committed to continue to provide services there. In spite of the admirable level of commitment and successful follow through, unmet needs remain.

II.B11 In-Country Agencies Participating in Evaluation

At the Midterm Evaluation the following in-country agencies were represented on the team: Cambridge Consulting Corporation, John Snow, Inc., USAID, Bangladesh; Dhaka City Corporation; International Center for Diarrheal Disease Research, Bangladesh; Ward Consortium Committee.

At the End-of Project evaluation, input to the process and report came from: The Dhaka City Corporation; The Department of Primary Health Care of the MOHFW; Helen Keller International, Bangladesh; Ward Consortium Committee; BASICS, Bangladesh.

II.C Attempts to Increase Efficiency

II.C1 Strategies for Increased Efficiency

These include: (a) the May 1994 Health Management Information System (HMIS) Review and the August 1994 Missed Opportunity Survey, both of which have allowed the project to respond to the MTE Team's call to take the next "natural" steps to shift focus to (i) deepen program quality through a team approach to quality assessment and assurance, and to (ii) document impact on health status through community-based disease and death surveillance; (b) integrate project management and initiate standardized systematic refresher training have led to a rationalization of activities in both impact areas, an apparent increase in efficiency and staff morale, and to less staff-intensive ways to manage the project; (c) effective use of the Homogeneous Unit Principle (HUP) to facilitate community organization by homogeneous neighborhoods, and to promote behavior change message through audience segmentation; (d) employ an all-national staff; (e) limit project staff numbers to essential roles of training, record keeping, reports and networking; (f) involve local staff (DCC/MOHFW/NGO) in staff training; (g) limit expatriate consultants to short-term training for critical topics; (h) tap more local (local NGOs, private sector resources (WCCs, NHCs, focus mothers groups, private practitioners) for health promotion and service delivery; (i) arrange with at least one local

NGO to eventually absorb the salaries of the some the project's CDWs; (k) carefully combine data needs to limit the number and costs of surveys.

The project plans in FY 95 to test and cost different strategies to deliver CS services and choose the most cost-effective one.

Phaseover plans to increase project cost-effectiveness are mentioned in section II.B.8.

II.C2 Reasons for Success/Failure

Success may be attributed to: (a) WV Field Office senior management and DUICSP team commitment to improve the project's operational efficiency and to increase the project's allocative efficiency; (b) quick follow-up of the MTE recommendation to simplify and streamline the project's HMIS and reduce costs; and (c) project willingness to phaseover CS promotion and delivery efforts to other private sector players; (d) identification and appointment of a full-time project director to integrate the management of the two DUICSP intervention areas, especially for training and project management information systems; and, (d) the growing maturity of community organization in the impact areas.

II.C3 Lessons Learned on Efficiency

The following are lessons learned regarding attempts to increase project efficiency: (a) the importance of developing team approaches and commitment to improve project efficiency; (b) the need to act on a well defined Sustainability Action Plan to equip local community and NGO partners with the fund-raising, technical and managerial skills needed to take over responsibilities for CS interventions; (c) the usefulness of testing CS strategies; and, (d) enhancement through cost-recovery for curative CS and other PHC services.

II.D Cost Recovery Attempts

II.D1 Cost Recovery Mechanisms Implemented

Under Bangladesh's current socio-political and cultural circumstances, the project has implemented the following cost-recovery mechanisms:

(a) Phaseover of Project Responsibilities to the DCC, one local NGO, and to CVs (please refer to section II.B8 above);

(b) Increasing efficiency and cost reduction measures, as outlined in section C.1 above. This also include using skills learned from Professor William Reinke of Johns Hopkins University to test and cost different strategies to deliver CS services and to choose the most cost-effective one.

(c) Accessing contributions of goods and services (materials, training, CS services and consultancies) from local NGOs, and locally-based international technical agencies: these amounted to US\$ 25,925 for the three years of the current project (please see Table 9).

(d) Soliciting cash contributions through local fund raising (donations) from affluent individuals, companies and community organizations to defray a portion of the recurrent costs of the project. Table 6 summarizes the community cash contributions of US\$3,586.39) over the last three years from:

(i) fee-for-service for medications of Taka 5/visit per patient per visit has been levied since March 1991 for treatment of intervention-related minor ailments by the project's PHN;
(ii) introduction of fee/penalty of Taka 5 for lost immunization and home-based cards from March 1991 to recover costs and to reduce the high loss rate of these cards;
(iii) donations for sanitation and environmental control activities, including cleaning safety water tanks, constructing public toilets/dustbins, mosquito control, tree planting and cleaning of ponds and drains.

(e) Facilitating Increased Community Contributions of Time to implement CS activities. The value of this amounted to USD 52,492 in the last three years of the project.

II.D2 Estimate of Costs Recovered

II.D3 Effects of Cost Recovery Efforts

After initial client resistance, the project's careful monitoring ensured that fees-for-service are not impediments to full coverage and equity of community access to CS services. The project has introduced the following measures: (a) Cross-subsidy schemes e.g sliding fee scales for service/medicine, by which the project charges clients according to what they say they are able to pay, are a simple way of subsidizing services for poorer clients by using fees collected from more affluent clients. Nominal fees are charged for antenatal care, follow-up care and for basic medical prescriptions according to project policy guidelines; (b) The project's "Policy Guidelines on Cost Recovery Mechanisms" provides the PHNs with discretionary authority in waiving this fee for mothers who are poor.

The Management/Implementation of Cost Recovery Mechanisms:

The project's PHNs (operating out of static centers) in both impact areas collect fees for services and lost cards. Project standing orders call for (a) the PHNs to record collected fees in a register, and in the mother/patient's card the amount they receive each time; (b) the PHNs to submit all cash collected to their respective Area Coordinators (ACs) daily; (c) the ACs, in turn, to deposit them with the Finance and Administrative Office fortnightly; and (d) to maintain a separate cash ledger and bank account for this. As less than five percent of the PHNs time is used for fee collection there is no significant reduction in time and effort for CS promotion and service delivery.

The Project Director and the Area Coordinators are responsible for: (a) negotiating phaseover of project responsibilities to local partners; (b) increasing efficiency and reducing costs; (c) accessing contributions of goods and services from local partners and technical agencies; (c) soliciting cash contributions thorough local fund-raising. Their management burden for these activities is limited to less that 10 percent of their work time.

These include (a) WV Field Office senior management and DUICSP team commitment to improve the project's operational efficiency and to increase the project's allocative efficiency; (b) quick follow-up of the MTE recommendation to simplify and streamline the project's HMIS and reduce costs; and (c) project willingness to phaseover CS promotion and delivery efforts to other private sector players; (d) identification and appointment of a full-time project director to integrate the management of the two DUICSP intervention areas, especially for training and project management information systems; and the (d) growing maturity of community organization in the impact areas.

II.D4 Please see Section II.E

II.D5 Lessons Learned in Cost Recovery

Lessons learned include the importance of (a) introducing the project policy guidelines on cost recovery mechanisms; (b) careful monitoring to ensure that fees-for-service are not impediments to full coverage and equity; (c) the lasting benefits of skills and knowledge transfer by investing in the human and institutional resources of local NGOs, private sector players (CVs, focus mothers and TBAs) and public sector staff (DCC); (d) extensive partnering and networking linkages to increase resource mobilization and secure budgetary commitment among partners for CS services; and, (e) the importance of documenting community/partner contributions in time, material and cash.

II.E Household Income Generation

Income generation activities in this project were focused on the Community Volunteers rather than on the households of the beneficiaries directly. Accordingly this section of the report is not completed.

II.F Other

II.F1 Sustainability-Promoting Activities

The principal sustainability promoting activities of this project centered around the organization of community groups into NHCs and Ward Committees. In addition the project has served as something of a coordinating body for the services of a variety of agencies in the area, most of which are concerned with primary health care but also those engaged in income generation and social development. Indicators of Sustainability have been developed (Please see Appendix E) and data collection to track these indicators is on-going. These activities are described in detail in previous sections of this report. WV has been very active in networking to share lessons learned and presenting findings of their own studies in such forums as the Child Survival Impact Workshop in Bangalore. These activities have gone far toward developing local potential for sustainable activities.

II.F2 Planned/Unplanned Sustainability Efforts

The most successfully implemented planned activities were, as previously mentioned, the

training of community volunteers and organization of NHCs and WCCs. This was a carefully designed program built on the experience of the first round of funding for the previous project. Training of staff and people from other agencies through such programs as the "Missed Opportunities Workshop" was more successful than anticipated as a means of improving the quality of services delivered. Plans to continue this emphasis on quality improvement are part of the next phase of the project. The need for revision of the MHIS to monitor quality improvement has been anticipated and a workshop to train staff conducted. A summary report of this is included in Appendix F.

II.F3 Qualitative Data on Sustainability Potential

Dhaka is a very poor city as is the country of Bangladesh. The expectation that the complex, relatively expensive package of services that this project provides can rely totally on community resources is in doubt. The government is largely incapable of providing primary health care services in urban areas as whole and to anticipate that they will be able to take up the responsibilities of this NGO project is overly optimistic. These are impressions based on a impressionistic assessment of the potential for sustainability in this very low income environment. The need for some ongoing external support is generally recognized and is a recurrent theme of conversation at the level of the Ward Consortium members and community level project staff. Some of this pessemism may be self-serving in that a continued flow of external funding provides employment and is easier than eliciting local support. But it also reflects an element of realism that should be considered as sustainability plans are made.

III EVALUATION TEAM

III.A1 Team Members

Team Leader

Dr. R. Gordon Buhler Assistant Professor, Loma Linda University School of Public Health, Loma Linda, CA

Facilitator

Dr. Sri Chander Health Advisor, World Vision International, South Asia Pacific Region, Singapore

Coordinators

Sylvester Costa Project Director, DUICSP, World Vision Bangladesh

Dr. Ratu Gopal Saha National Health Coordinator, World Vision Bangladesh

Team Members

Dr. A.K.M. Jakir Hossain Director of Primary Health Care, Ministry of Health and Family Welfare, Dhaka, Bangladesh

Shawn K. Baker Country Director, Helen Keller International, Bangladesh

Dr. Shamsul Hoque Mian Community Representative, Advisor to Ward Consortium Areas B & C

A.R. Subedar Community Representative, President, Ward Consortium, Area A

III.A2 Report Authors

Principal Author: Dr. Gordon Buhler

Achievements and
Cost Recovery sections Dr. Sri Chander

KPC Survey report Dr. Iqbal Anwar, Manager, DUICSP, Dhaka

Project Expenditures Christopher Gomez, Auditor, WV Bangladesh

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

WVRD/HEADQUARTERS
GRANT #PDC-0500-G-00-1065-00

Actual Expenditures to Date (10/01/91 to 09/30/94) Projected Expenditures Against Remaining Obligated Funds (10/01/94 to 09/30/95) Total Agreement Budget (Columns 1 & 2) (10/01/91 to 09/30/95)

COST ELEMENTS

I. PROCUREMENT

A. Supplies

B. Equipment

C. Services/Consultants/Evaluation

SUB-TOTAL I

II. EVALUATION

SUB-TOTAL II

III. INDIRECT COSTS

HQ/HO Overhead 20(%)

SUB-TOTAL III

IV. OTHER PROGRAM COSTS

A. Personnel

B. Travel/Per Diem

1. In-country

2. International

C. Other Direct Costs

(Utilities, Printing, Rent, maintenance, etc.)

SUB-TOTAL IV

TOTAL

	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
A. Supplies	\$0	\$0	\$0	\$2,925	\$1,575	\$4,500	\$2,925	\$1,575	\$4,500
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants/Evaluation	0	0	0	4,875	2,625	7,500	4,875	2,625	7,500
SUB-TOTAL I	0	0	0	7,800	4,200	12,000	7,800	4,200	12,000
II. EVALUATION	26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
SUB-TOTAL II	26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
III. INDIRECT COSTS	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
HQ/HO Overhead 20(%)	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
SUB-TOTAL III	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
IV. OTHER PROGRAM COSTS	97,188	13,523	110,711	29,899	54,909	84,808	127,087	68,432	195,519
A. Personnel	97,188	13,523	110,711	29,899	54,909	84,808	127,087	68,432	195,519
B. Travel/Per Diem									
1. In-country	2,365	676	3,041	35,514	19,720	55,234	37,879	20,396	58,275
2. International	24,309	5,510	29,819	(12,609)	790	(11,819)	11,700	6,300	18,000
C. Other Direct Costs	927	310	1,237	4,923	2,840	7,763	5,850	3,150	9,000
(Utilities, Printing, Rent, maintenance, etc.)	927	310	1,237	4,923	2,840	7,763	5,850	3,150	9,000
SUB-TOTAL IV	24,789	20,019	44,808	57,727	78,259	135,986	182,616	98,278	280,894
TOTAL	\$149,777	\$24,022	\$173,801	\$101,085	\$111,057	\$212,142	\$250,862	\$135,079	\$385,941

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

WVRD/Bangladesh
GRANT #PDC-0500-G-00-1065-00

Actual Expenditures to Date (10/01/91 to 09/30/94) Remaining Obligated Funds Total DIP Budget (Columns 1 & 2) (10/01/91 to 09/30/94)

COST ELEMENTS

I. PROCUREMENT

	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
A. Supplies	32,108	\$45,993	\$78,101	(\$8,798)	\$3,631	(\$5,167)	\$23,310	\$49,624	\$72,934
B. Equipment	0	17,492	17,492	0	(12,192)	(12,192)	0	5,300	5,300
C. Services/Consultants/Evaluation	46,051	38,142	84,193	(23,350)	(38,142)	(61,492)	22,701	0	22,701
SUB-TOTAL I	78,159	101,627	179,786	(32,148)	(46,703)	(78,851)	46,011	54,924	100,935

II. EVALUATION*

SUB-TOTAL II	0	0	0	24,091	8,572	32,663	24,091	8,572	32,663
	0	0	0	24,091	8,572	32,663	24,091	8,572	32,663

III. INDIRECT COSTS

HQ/HO Overhead 20(%)	87,669	129,365	217,034	6,024	95,805	101,829	93,693	225,170	318,863
SUB-TOTAL III	87,669	129,365	217,034	6,024	95,805	101,829	93,693	225,170	318,863

IV. OTHER PROGRAM COSTS

A. Personnel	262,399	160,676	423,075	35,621	(36,441)	(820)	298,020	124,235	422,255
B. Travel/Per Diem	19,303	9,817	29,120	13,727	1,756	15,483	33,030	11,573	44,603
C. Other Direct Costs (Utilities, Printing, Rent, maintenance, etc.)	78,485	49,318	127,803	(11,172)	11,757	585	67,313	61,075	128,388
SUB-TOTAL IV	360,187	219,811	579,998	38,176	(22,928)	15,248	398,363	196,883	595,246

TOTAL	\$526,015	\$450,803	\$976,818	\$36,143	\$34,746	\$70,889	\$562,158	\$485,549	\$1,047,707
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**Evaluation costs are included in Services/Consultants.

APPENDIX B

MINUTES OF WARD CONSORTIUM MEETING WITH FINAL EVALUATION TEAM

VENUE : DHAKA URBAN INTEGRATED CS PROJECT (CONFERENCE ROOM)

DATE : 22TH SEPTEMBER, 1994

The discussion and proposals of the meeting were as follows:

- a. What are the most successful interventions?
 - * Prevention and control of diarrhoeal diseases
 - * Prevention of nutritional blindness
 - * Reduction of 6 vaccine preventable diseases.
 - * Awareness regarding health problems
- b. What will be the position of project activities after phase-over?
 - * Community partners have no logistic/Financial capability. It needs to initiate IGA for raising some fund to run the project activities.
 - * Promotional activities can be sustained by the community.
 - * Support from Govt./Non Govt. agencies should be ensured (DCC/IPHN/CS/BHE/EPI)
 - * Community volunteers can be trained up for pushing vaccination.
- c. What was the role of the project to bring the success?
 - * Training for WC/NHC/CV/FM/TBAs
 - * Promotional activities to build awareness
 - * Seed money for IGA
- d. What are the supports being given by the community?
 - * Place
 - * Time
 - * Outreach vaccination session place
 - * Supervision of CVs
 - * Motivation to the beneficiaries
 - * Negotiation with local NGOs.
- e. What are the reasons for success?
 - * Peoples have earned confidence over WC/NHCs

- * Beneficiaries have been motivated by WC/NHCs
- * Door to door social contact by the community.
- * Linkage with DCC and other NGOs.
- * WC/NHCs are participating to observe/celebrate different special events.

f. How community can increase the efficiency of work.

- * Potential drugs addicted persons can be motivated.
- * May take initiative to build up a community based health center for clinical services.
- * May establish a day care center for working mothers
- * Can introduce non-formal education
- * Can be raised awareness to buy services/advice

APPENDIX C

PROJECT PROFILE

PROJECT TITLE: World Vision Bangladesh

ORGANIZATIONAL STRUCTURE: Project Director is assisted by a Program Manager and several Program and Area Coordinators. At the community level Community Development Workers liaise, coordinate and supervise the activities of community based volunteers; who are of two types – Focused Mothers and Community Volunteers. The former are mostly illiterate mothers and the latter mostly students. Traditional Birth Attendants (TBAs) are another group of workers who also are supervised by the CDWs. Each CV looks after 50 to 80 families. In addition there are Neighborhood Health Committees (NHCs) comprised of elderly and influential people of the project area. They help the project authority in planning and implementing programs and in reviewing the strategy and the effect of the activities.

PROJECT ACTIVITIES:

1. Training of Focused Mothers, Community Volunteers and Traditional Birth Attendants.
2. Procurement of IEC and training materials and service logistics, eg. vaccines, vitamin A capsules, oral salt etc.
3. Distribution of VAC ORS etc. and administration of vaccines. Vaccines are administered at 5 fixed, rented sites 3 in Mohammadpur and 2 in Kamalapur twice weekly at each site. These sites are also used now for treating minor ailments – once weekly (twice weekly at Mohammadpur) VAC, ORS and anti-helminthic drugs are distributed at the doorstep of the community through the Focused Mothers and Community Volunteers under the guidance of CDWs. For vaccination, in addition, there are 9 outreach sites at Kamalapur and 8 or more (if required - based on demand) at Mohammadpur. These sites are established based on demand in garment factories and schools. Health education is also provided at all these sites and also during home visits. CVs are supported with electronic and print media for providing health education. They also help the project to organize rallies, exhibitions, seminars, NHC meetings etc. Family Planning materials are distributed only by the CDWs.

Different types of review meetings are held on routine basis on fixed days. Meetings are held for TBAs, CVs, FMs, NHCs, IGA and paid staff. These meetings are held usually on a monthly basis.

In addition to the above activities there are diseases based activities which are also performed by all categories of volunteers and fringe workers. These are in the form of surveillance, identification and referral, when deemed. Surveillance usually aims at measles poliomyelitis and neo-natal tetanus and births and deaths. These reports are collected by CDWs and/or Public Health Nurses (PHNs). CVs report in addition, on their performance, in prescribed forms.

TBAs also report on pictorial formate.

There are three special activities which need some mentioning. These are either IGAs or have potential of generating some income. These are described below:

* **Neighborhood cooperative store:** This has been initiated above 10 months back with the help of NHCs and Ward Consortium. Fund has been provided by the male CVs on a cooperative basis. World Vision of Bangladesh has also provided some seed money. Dealing on rice has been the initial step. Right now it is run on a non profit basis since sale is not widely advertised. In future more items will be added.

* **Handicraft Education and Marketing Association (HEMA):** This is a small scale garment producing endeavor that has been undertaken by the female CVs. WVB has provided in kind contribution in the form of clothes, machine and training.

* **Survival Association for Community Volunteers (SAC):** This has two branches. From Kamalapur group a monthly magazine titled as "Sechashebi Shongbad" - Volunteer's news and from Mohammadpur group another magazine titled as "Sechashebi Dorpon" - Volunteer's mirror, are printed.

Comments on the quality of the Service: The CDWs and CVs are very committed, intelligent and motivated community values their contribution specially in the field of health education and school based programs. Mass awareness on health related issues in the community has been found to be very high.

There is a demand however, from the community for vaccination through home visits which however, does not appear to be feasible and practical. Distribution of iron - folate to pregnant mothers should be added to the present activities.

A deterrent to the vaccination activity is the alleged annoyance that is expressed by project staff when vaccination cards are lost by the recipients or when parents report for vaccination. Late after the expiry of due date. This has been suggested by some parents as one of the causes of drop out. The vaccination rate nevertheless is quiet high -- almost 90% among 12-23 months old babies. This is slightly above the national average of 84%.

Activities in the other fronts, such as, ORT (78%), nutrition (breast-feeding, weaning and VAC distribution) all are above the national average. Contraceptive prevalence rate however, is not very different from the national average. Pre-natal care, acute respiratory tract (ARI) infection identification and VAC distribution among post-partum mothers need further improvement.

The reason for the high quality service that is provided by the project, according to the CDWs are the :

- i) Scope in the project for skill enhancement of the workers and volunteers
- ii) Commitment of CVs and
- iii) Support from management.

On aspect, that has been ignored by and large, according to both the community and the workers is the absence of clinical back up support and clinical service in general. This has been stated recently in the fixed site but there had been suggestions to extend this to outreach sites.

APPENDIX D

INTERVIEW GUIDES

WVB DUICSP Management

- II.B2 Please describe linkages you have developed with other NGOs, local government agencies and national gov. agencies?
- II.B3 What other NGOs do you expect to take part in sustaining project activities?
- II.B5 What have you done to build skills for CS interventions in the MOH or collaborating NGOs?
- II.B5 Did you teach them to train CHWs or manage CS activities?
- II.B6 What other agencies do you see able to sustain project activities when CS funding ends?
- II.B8 How have major project responsibilities been phased over to local institutions? What is the plan and schedule for this?
- II.B9 Did any counterpart agencies make financial commitments to sustain project benefits? Were these commitments met?
- II.B10 What were the reasons for success/failure to keep these commitments?
- II.B11 What agencies have worked with you on planning, implementation and evaluation of the project?

Collaborating NGOs

- II.B4 What activities of the project do you consider to have been most effective?
- II.B5 What have has the project done to build skills for CS interventions in your NGOs?
- II.B6 What interventions or areas will you be able to sustain once CS funding ends?
- II.B9 Did your agency make financial commitments to sustain project benefits? Were these commitments met?
- II.B10 What were the reasons for success/failure to keep these commitments?

MOH, DCC

- II.A5 How has the project supported the development of your staff in CS-type of interventions?
- II.B4 What activities of the project do you consider to have been most effective?
- II.B6 What interventions or areas will you be able to sustain once CS funding ends?

Focus Mothers

- II.A2 What CS activities have been most helpful and effective for your community?
- II.A9 To what extent do you think this project has been successful? What has made it a success?

How can it be made more INTERVIEW GUIDES

CVS

- II.A2 What CS activities have been most helpful and effective for your community?
- II.A8 What Activities do you expect to be able to carry out without the help of the CSP?
- II.A6 What are the significant issues addressed by your committee?
- II.A3 What has the CSP done to help you to meet your own basic health needs?
- II.A3 How has the CSP helped you to continue to meet your needs when the project ends?
- II.A8 What resources has your community contributed for continuing project activities?
- II.A9 To what extent do you think this project has been successful? What has made it a success?
- II.A9 How can it be made more successful?
- II.E1 What type of income generating activities have been undertaken with the help of the project?
- II.E2 What additional income has this brought to the household that participated? (Try to estimate this on an annual basis.)
- II.E4 To what extent was the IGA successful in your area? How could its success be increased?

NHCs

- II.A2 What CS activities have been most helpful and effective for your community?
- II.A3 What Activities do you expect to be able to carry out without the help of the CSP?
- II.A3 What has the CSP done to help you to meet your own basic health needs?
- II.A3 How has the CSP helped you to continue to meet your needs when the project ends?
- II.A5 Number of functioning NHCs in project?
Number of meetings in last six months
Are committees representative of the communities?
- II.A6 What are the significant issues addressed by your committee?
- II.A7 What methods have been used by your committee to provide guidance or direction to the project?
- II.A9 To what extent do you think this project has been successful? What has made it a success?
- II.A9 How can it be made more successful?
- II.E4 To what extent was the IGA successful in your area? How could its success be increased?

Ward Consortium (Local Leaders)

- II.A2 What CS activities have been most helpful and effective for your community?
- II.A3 What Activities do you expect to be able to carry out without the help of the CSP?
- II.A4 How did the community participate in the design, implementation and evaluation of the CSP?
- II.A3 What has the CSP done to help you to meet your own basic health needs?
- II.A3 How has the CSP helped you to continue to meet your needs when the project ends?
- II.A6 What are the significant issues addressed by your committee?
- II.A7 What methods have been used by your committee to provide guidance or direction to the project?

- II.A8 What resources has your community contributed for continuing project activities?
- II.A9 To what extent do you think this project has been successful? What has made it a success?
- II.A9 How can it be made more successful?
- II.E4 To what extent was the IGA successful in your area? How could its success be increased?

Core Team

- II.A4 How did the community participate in the design, implementation and evaluation of the CSP?
- II.A8 What resources has the community contributed for continuing project activities?
- II.A7 What methods have been used by the committees to provide guidance or direction to the project?

Project Staff

- II.A4 How did the community participate in the design, implementation and evaluation of the CSP?
- II.A5 Number of functioning NHCs in project?
Number of meetings in last six months
Are committees representative of the communities?
- II.A8 What resources have the communities contributed for continuing project activities?
- II.A9 To what extent do you think this project has been successful? What has made it a success?
- II.A9 How can it be made more successful?
- II.E3 How much income has come to the project from local sources? What fraction of the total cost of project activities has been locally generated?

Project Records

- II.A5 Number of functioning NHCs in project?
Number of meetings in last six months
Are committees representative of the communities?
- II.E3 How much income has come to the project from local sources? What fraction of the total cost of project activities has been locally generated?

Project Management

- II.A4 How did the community participate in the design, implementation and evaluation of the CSP?
- II.A9 To what extent do you think this project has been successful? What has made it a success?
- II.A9 How can it be made more successful?

APPENDIX E

INDICATORS TO TRACK SUSTAINABILITY

A. Sustainability Plan

1. Development and use of a Sustainability Action Plan with specific objectives, targets, and milestones.
2. Percent of memoranda of understanding (with project partners) which have incorporated agreement on sustainability.
3. Percent of project staff with job descriptions spelling out responsibility for actively facilitating sustainability.

B. Institutional Sustainability

B.1 Community Capability

1. Number of community members who participated in the DIP workshop, and in the midterm and final evaluations.
2. Number and percent of documented changes of the DIP in which the community was involved and informed.
3. Number, percent, and representatives of functioning NHCs.
4. Number and percent of NHCs' meetings with documented minutes.
5. Number and percent of NHCs' meeting decisions made related to the institutional and financial aspects of sustainability.
6. Number, percent, and representatives of functioning women's focus groups.
7. Number and percent of CVs trained and functioning.

B.2 Private/Public Sector Capability

1. Number and percent of TBAs trained and functioning.
2. Number of NGO/WV "Lessons Learned" workshops focusing on Public Health management.
3. Number of DCC staff by category trained to enhance technical and management skills.

B.3 Political Support

1. Number of MOHFW/DCC/government officials who participated in the DIP workshop, and in the midterm and final evaluations.
2. Number of MOHFW/DCC/government officials who participated in the NGO and PVO-sharing workshops.
3. Willingness of EPI Directorate to provide vaccines regularly, freely, and promptly.
4. Willingness of the IPHN to provide VAC regularly, freely, and promptly.

C. Managerial Sustainability

1. Number of NGO staff trained in program/technical skills.
2. Number of NGO staff trained in small enterprise development skills.
3. Number of DCC staff trained in management skills.

D. Financial Capability

1. Number and percent of savings groups functioning by end of: (a) first year, (b) second year, and (c) third year.
2. Number and percent of disbursed loans (to CVs/Focus Mothers for income-generation activities) with timely repayment.
3. Percent of the project's recurrent costs contributed by the community.
4. Percent of the project's recurrent costs contributed by counterpart institutions.
5. Percent of CS activity costs met by revenue.
6. Number of NGO staff trained in fund-raising/financial management skills.

APPENDIX F

HEALTH & MANAGEMENT INFORMATION SYSTEM DHAKA URBAN INTEGRATED CS PROJECT

For any Child Survival Project, it is important to develop a Health Management Information System (HMIS) to track the progress of the activities and effectiveness in achieving project objectives. The Dhaka Urban Integrated Child Survival Project has been highly successful in meeting service delivery objectives, having achieved high coverage with most CS interventions which are well documented through the development of an elaborate and scientifically agile HMIS.

However, data needs also change as the progress is made in Child Survival Project implementation. The very high level of achievements of the project to date open up an opportunity to consolidate and build on successes and to place new emphasis on quality and impact of the program. The Mid-Term Evaluation of the project which took place in 1993 have also recommended a review of the HMIS in order to reflect this shift in emphasis to assuring the quality in project services and documenting impact on health status. Recent developments in Bangladesh at the national level have also underlined the need for the review/revision of the HMIS.

A three-member team consisting of Sally K. Stansfield, Assistant Professor of McGill University, Addis Ababa, Dr. Henry Kalter, Technical Specialist at Johns Hopkins University's, PVO Child Survival Support Program and Dr. Sri Chander, Regional Health Advisor, South Asia Pacific Region, World Vision International assembled here at the project in April '94 to facilitate the review of the HMIS.

The review and revision of the HMIS also provided an opportunity to ascertain that the data needs for the proposed Operational Research (OR) would be met by the HMIS or to define the need for any additional data collection instruments for temporary use during implementation of the research.

In collaboration of the project staff the HMIS review team conducted an assessment of the data needs for management of project activities in the light of new objectives of the third phase of the project. Current HMIS instruments and information management activities were also reviewed. It was decided that 30 cluster RKAP survey would continue to be the primary method used to document project's output and effectiveness indicators.

Basic principles guiding the review and revision of HMIS were as follows:

- * Perceived need to streamline and simplify the HMIS reducing the duplication and freeing HW at every level of service delivery activities.
- * Concern for the sustainability and simplify the HMIS especially through ensuring that data collection by the most peripheral health workers served immediate decision making needs at that level, rather than senior management's needs to report achievements to donors.
- * Emerging need for impact or health outcome data, particularly in the area of immunization activities, where high coverage figures suggest a need to move toward collection of disease surveillance data.

All the forms to be used in reviewed HMIS including reviewed/ revised ones are attached as appendices.

Activities to be/have already been under taken for the reviewed/revised HMIS are:

- * Field testing of the newly developed and revised instruments which has already been started from the beginning of August '94 Prior to this a detailed POA was prepared in presence of Dr. Henry Kalter.
- * Training for the orientation of the relevant staff/community people to the use of the new forms and additional data entry and analysis skills for the M&E people.
- * Development of strategy to assure completion of DV in areas where the CV is not currently active or there is no Cv.
- * Development of system for feedback to the communities e.g. NHC of selected information from the HMIS e.g. maternal and child deaths.

APPENDIX G
RECOMMENDATIONS OF MID-TERM EVALUATION
AND IT'S FOLLOW-UP

SL. #	AREAS OF RECOMMENDATIONS	MEASURES TAKEN/TO BE TAKEN
1.	Shortage of IEC materials for ARI/Safe Motherhood	The IEC materials so far produced by the concerned Govt. Agencies are not very much appropriate for project's use at the community level. Furthermore, they are not adequately supplied to different public/private sector players engaged either in service delivery or promotion of ARI/SMH
2.	Single computer	Procurement and setting up another computer has already been completed
3.	Re-institute of CS Forum	Two sharing session have been arranged on November '93 and February '94 with the participation Govt. & Non-Govt. Agencies.
4.	Linkages with World Vision of Bangladesh (WVB) sponsor projects	We have already initiated the process by involving senior management of WVB with the hope that the result will trickle down at the project level
5.	Relationship with DCC, Zone - 6	Relationship with Zonal office-6 of Dhaka City Corporation has been strengthened through some specific activities like on GOB/NGOs forum meeting, observance of EPI week, population day, MCS fortnight jointly, regular feedback on EPI program etc.
6.	Referral relationship	For the development of an effective and appropriate referral system, the issue has been discussed in the GOB/NGOs forum meeting where it has been decided that the participating agencies will utilize each other services which are not being provided by any of the member agencies will be referred to the concerned Govt. and Non-Govt. agencies e.g. CNU, SCF (UK), Dhaka Shishu Hospital, Azimpur Maternity Hospital etc.

SL. #	AREAS OF RECOMMENDATIONS	MEASURES TAKEN/TO BE TAKEN
7.	Out come of the referral should be followed up	The process has already been started where the concerned PHN/CDW follow-up the referred cases at the respective hospital, clinic or at the household level when they return home after recovery
8.	Ganja need to be shifted from Project Office	Ganja, a centrally small scale income generating enterprize was established by the CVs of Areas B&C in 1992. It used be run by the CVs being based at the project office. But following the decentralization of IGA in March'94 the Ganja has been ceased to function as it did in the past.
9.	Maternal care by TBAs	Some TBAs have been given training and they are actively performing their job
10.	Training for Ward Consortium members	A four day long training on "Leadership and Management was organized at BARD, a well reputed institution for national and international level training/workshop in Bangladesh from 13 to 16 June '94. A total of 15 members of the Ward consortia of both the areas participated in the training which has been found to be extremely useful and lively
11.	Identification of a Full-time Director	Identified and assigned
12.	Technical assistance for reviewing HMIS	It has been reviewed by a team of technical experts and field testing of the revised/reviewed HMIS tools are going on
13.	Involvement of community partners for Disease Surveillance	The CVs, TBAs and FMGs, the front-liner of the community partners in combating the major child health problem through raising awareness among the community people have been involved in the community based disease surveillance activities. The PHN/Physician will act on their information on targeted diseases for surveillance and deaths of children/women

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	AREAS OF RECOMMENDATIONS	MEASURES TAKEN/TO BE TAKEN
14.	Strengthen linkages with other CSPs of WVB	The process has been strengthened through participation in each others special events experience sharing session and visits
15.	Develop a strategy for operational research	It is yet to be started at DUICSP, but relevant ground work has been initiated at the time of HMIS review
16.	New intervention - Girl Child - Endemic Social problem	The project so far has got its primary data on street girl child issue and is to planning incorporate some question so social indictor in the ensuing baseline survey questionnaire. Furthermore, the project is trying together some information on these issue from some other organizations. Hopefully, based on all these data the project could come up some new interventions like girl child issue etc. to be incorporated with existing ones.
17.	Register/un-register target families	Necessary steps have been taken to serve all families without any discrimination