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**CARE Bangladesh**

*Sylhet District/Sylhet Division*

**Child Health Initiatives for Lasting Development (CHILD-II)  
Child Survival Grant XI- FAO-0500-A-00-5035-00**

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**Final Evaluation Report**

CARE-Bangladesh

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## Glossary

AFP	Acute flaccid paralysis
AHI	Assistant Health Inspector
BATCHA	Building Appropriate Training for Community Health Activities (Project)
CBHQ	CARE/Bangladesh Headquarters
CDD	Control of diarrhoeal diseases
CHILD	Child Health for Lasting Development (Project)
CS	Civil Surgeon (MOHFW)
CtC	Child-to-child
DD-FP	Deputy Director, Family Planning (MOHFW)
DFID	Department for International Development (of the United Kingdom)
DG	Director General (MOHFW)
DIP	Detailed Implementation Plan
DPT	Diphtheria, pertussis and tetanus (vaccine)
EPI	Expanded Program on Immunization
FPI	Family Planning Inspector
FPMDD	Family Planning and Management Development (a USAID-supported project of MSH)
FT	Field Trainer
FW	Field Worker
FWA	Family Welfare Assistant (MOHFW)
FWC	Family Welfare Center
FWV	Family Welfare Visitor (MOHFW)
GOB	Government of the People's Republic of Bangladesh
HA	Health Assistant (MOHFW)
HI	Health Inspector (MOHFW)
HIS	Health information system (of the CHILD-II Project)
HPSP	Health and Population Sector Program
IEC	Information, education and communication
IPC	Interpersonal Communication
KPC	Knowledge, practice and coverage
LIP	Local Initiatives Program
MCH	Maternal and child health
MIS	Management information system (MOHFW)
MNT	Measles and neonatal tetanus
MSC	Merged Satellite Clinic
MSH	Management Sciences for Health
MTE	Mid-term evaluation
NGO	Non-governmental organization
NID	National Immunization Day
OPV	Oral polio vaccine
ORS	Oral rehydration solution
OR	Outreach
ORT	Oral rehydration therapy
PAL	Participatory action learning

## Glossary (cont )

PO	Project Officer
PVO	Private voluntary organization
SC	Satellite Clinic
TBA	Traditional birth attendant
TFPO	Thana Family Planning Officer (MOHFW)
THC	Thana health complex
THFPO	Thana Health and Family Planning Officer (MOHFW)
TT	Tetanus toxoid (immunization)
UFHP	Urban Family Health Partnership (a USAID-supported project of John Snow, Inc )
UP/UC	Union <i>Panshad</i> /Union Council
USAID	United States Agency for International Development
VAC	Vitamin A capsule

## Other Information

### Geographic locales

**Dhaka** Capital of Bangladesh

**Sylhet** One of the six divisions in Bangladesh The others are Dhaka, Chittagong, Khulna, Rajshahi, and Barisal

**Sylhet District** One of the four administrative districts in the Sylhet Division

### Government administrative units

**Thana** Administrative unit of approximately 200,000 persons There are 11 thanas in Sylhet District

**Union** Administrative unit serving approximately 25,000 persons There are 98 unions in Sylhet District The Union *Parishad* is the locally elected council of representatives from the union

**Ward** Sub-division of a union (with nine wards per union) having approximately 2,500 persons There are 882 wards in Sylhet District

### MOHFW Field Staff

**Health Assistant (HA)** Field worker of the Health wing (Directorate of Health Services) of the MOHFW who registers all children through periodic home visits, vaccinates children and mothers, and provides education and training about control of diarrhoeal disease, acute respiratory infections, and other common illnesses There are normally 4-5 HAs in a union, and one HA serves approximately 6,000 persons

**Family Welfare Assistant (FWA)** Field worker of the Family Planning wing (Directorate of Family Planning) of the MOHFW who visits all married women of reproductive age at their homes every two months, maintains a couple registration book, promotes family planning, promotes immunizations, and refers clients for services as needed There are normally 4-5 FWAs in a union, and one FWA serves approximately 6,000 persons

**Assistant Health Inspector** Supervisor of Health Assistants

**Family Planning Inspector** Supervisor of Family Welfare Assistants

## Other Information (cont.)

**Family Welfare Visitor (FWV)** Paramedic of the Family Planning wing of the MOHFW who works at a union Family Welfare Center but who also attends Satellite Clinic sessions in her union. There is normally one FWV in a union.

### MCH-FP outreach activities

**EPI Outreach Site sessions** These are normally held once a month in front of or inside of the home of a local community leader. The sessions are organized by the HA. A "joint" EPI Outreach Session is one in which the FWA attends along with the HA. Immunizations of mothers and children are provided at the sessions along with vitamin A (200,00 international units) for children who are nine months of age. In each union there are normally 24 EPI Outreach Sites. About one-third of the EPI Outreach Site sessions should be merged with Satellite Clinic sessions (see below), and two-thirds should be "stand alone" Joint EPI Outreach Site sessions.

**Satellite Clinic Site session** These are normally held once a month at a common community site such as a school. They are attended by the FWV and the FWA. In each union, there are normally eight Satellite Clinic Sites and one session is held at each site each month. Usually in each ward a Satellite Clinic session is organized each month. The ward in which the Family Welfare Center is located does not have its own Satellite Clinic session, however. The services provided include family planning (such as injectable contraceptives and contraceptive side-effect counseling), MCH services such as antenatal care, and the treatment of minor ailments.

### **Merged EPI Outreach/ Satellite Clinic session**

At the time of a Satellite Clinic Site session, an EPI Outreach Session should also be held at the same time and place. Since there are three times more EPI Outreach Site sessions than Satellite Clinic Site sessions, all Satellite Clinic Site sessions should be merged with EPI Outreach Site sessions, but only one-third of the EPI Outreach Site sessions should be merged with Satellite Clinic Site sessions. These merged sessions offer the advantage of linking EPI services with other basic family planning and MCH services.

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## Executive Summary

In October 1995, CARE/Bangladesh, in partnership with the Ministry of Health and Family Welfare (MOHFW) and with funding from CARE/USA and from USAID, began the second phase of the Child Health Initiatives for Lasting Development (CHILD-II) Project in Sylhet District. Based on the lessons learned from the CHILD-I Project, which was carried out in five out of eleven thanas (sub-districts) of Sylhet District between 1991 and 1995, the CHILD-II Project was undertaken in three other thanas of Sylhet District in remote locations (Companigonj, Gowainghat, and Kanaighat) having a total population of 520,487 persons and 189,722 beneficiaries. A limited presence of the CHILD-II Project staff was maintained in the five CHILD-I thanas between 1995 and 1999. The same child survival interventions of the CHILD-I Project—immunizations (EPI), control of diarrhoeal diseases (CDD), family planning (FP) and vitamin A capsule distribution—were continued in the CHILD-II Project.

The Sylhet District is one of the lowest performing areas of Bangladesh in terms of coverage of basic maternal child health (MCH) and family planning (FP) services. The main reasons for low performance are due to insufficient technical and communication skills of the MOHFW service providers at different levels, inadequate management skills for ensuring effective supervision and monitoring of field programs, and local socio-economic, cultural and geographic constraints. The area has among the lowest levels of literacy in the country. The area is also one of the most conservative in religious customs, thereby making progress in the utilization of family planning more difficult. Much of the district is flooded during the monsoon season, making access possible only by boat. The vacancy rates for MOHFW positions in the Sylhet District are typically considerably higher than in other areas of the country.

The main strategy of the project was to strengthen the capacity of the MOHFW to provide quality services and to promote community involvement and demand for services using different innovative methods. The project staff did not provide services directly. The resources provided by CARE were used for technical support in terms of planning, supervision and community mobilization along with some limited support for transportation and for occasional emergency expenses to maintain field activities.

### Summary of Findings and Results

- The project has greatly enhanced the capacity of the MOHFW at the thana and union level by organizing regular monthly meetings of staff, by coordinating meetings between staff of the Health and FP wings of the MOHFW, and by organizing need-based training courses for 167 field workers (Health Assistants and Family Welfare Assistants). An advanced schedule for the dates of outreach sessions was developed for the entire calendar year in each of CHILD-II thanas.
- The project staff regularly monitored field activities, provided supervisory training to 79 supervisors of MOHFW staff, developed a supervisory checklist that also served as a quality assessment checklist for outreach sessions. Supervisory performance was analyzed at monthly staff meetings. A management information system (MIS) board was established at each Thana Health Complex to monitor thana performance of outreach activities.

- The project assisted the MOHFW to involve the community in outreach activities by selecting and training 627 'Information Banks' who are traditional birth attendant (TBAs), family planning volunteers (also called LIP volunteers), school teachers, other local leaders, or persons who have offered their house as a site for EPI Outreach sessions. These volunteers received training about the health services available for the local population, they assisted in mobilizing mothers and children to attend outreach sessions and also mobilized the mothers to participate in special events such as National Immunization Days and Vitamin A Week.
- All the Union *Parishad* (Council) Members (including the Chairmen) for the three project thanas were given orientation on different health issues and on how they could support different local health and family planning activities. A total of 210 participants took part at the orientation sessions, including 60 female members. As a result of this activity, some responsibilities for community mobilization were undertaken by these persons, and resources (cash or in-kind) were mobilized for implementing different services.
- The number of EPI Outreach Site sessions held, the number of Satellite Clinics held, the attendance at these sessions, the percentage of EPI Outreach Site sessions attended by an FWA, and the percentage of Satellite Clinic sessions merged with an EPI Outreach Site session have all increased markedly in the three project thanas. The achievements in the five thanas where the CHILD-I Project worked from 1991-1995 have been sustained and, in fact, improvements there have continued since 1995.
- The percentage of completely vaccinated children 12-23 months of age (card-documented) increased from 16% to 72%. The percentage of children receiving high-dose vitamin A capsule increased from 52% to 74%. The use of oral rehydration therapy (ORT) among mothers of children with diarrhoea during the previous two weeks increased from 30% to 84%. The percentage of couples with a child 0-23 months of age not wanting another child during the next two years who practice family planning increased from 8% to 41%.

### **Summary of Conclusions**

- The CHILD-II Project has cooperatively and effectively facilitated increases in the management capacity of the MOHFW at the thana level and below in the three thanas where it has worked from 1995-1999 and in the five thanas where the CHILD-I Project worked from 1991-1995 (where the CHILD-II Project provided limited support from 1995-1999).
- The MOHFW has cooperated effectively with the CHILD-II Project.
- The partnership between the MOHFW and the CARE/CHILD-II Project has led to effective community involvement in the delivery of MCH-FP outreach services.
- The high level of acceptance of the CHILD-II Project by the MOHFW in Sylhet District has been due to joint planning and to joint monitoring and supervision of field activities (which increased the transparency of the relationship between two partners), the mutual trust and respect which has been developed between the two partners, and the willingness and ability of CHILD-II Project staff to blend almost invisibly (from the community's standpoint) into the MOHFW system.

- There is still a need for further improvements in the range and quality of MOHFW outreach services in the CHILD-II thanas, but remarkable progress has been made nonetheless
- The CARE/CHILD strategy is effective, and (on the basis of the findings in the CHILD-I thanas) the improvements in services, which the strategy helps to make possible, appear to be sustained
- Equally important are the findings that EPI coverage in the CHILD-I thanas continued to increase during the 1995-1999 period and EPI coverage in the two non-CHILD thanas also improved over the period of the CHILD-I and the CHILD-II Projects. Thus, the capacity-building activities of the Project in the Sylhet District appear to lead to continued improvements even as CARE's involvement diminishes, and this capacity-building approach appears to "spill over" into neighboring thanas in the Sylhet District
- However, continued sustainability of these improvements as well as further improvements in services as called for by the Government of Bangladesh's program of health sector reform (called the Health and Population Sector Program) will require a continued, long-term collaboration between CARE and the MOHFW in the Sylhet District

In summary, a mutually respectful partnership between the MOHFW and the CARE/CHILD-II Project has been developed and has made possible sustainable improvements in outreach service coverage, management capacity of the MOHFW at the thana level and below, and increased community participation and utilization of services

### **Key Recommendations**

- The partnership in the Sylhet District between the MOHFW and the CARE/CHILD-II Project should continue
- Emphasis should be placed on low performing, hard-to-reach areas within the district
- The project should consider expansion beyond EPI, vitamin A, CDD, and FP to include control of acute respiratory infections (ARI) and malaria, surveillance for acute flaccid paralysis (as part of Bangladesh's polio eradication activities), safe motherhood, and arsenic decontamination of tubewells
- The project should consider a broader involvement in strengthening MOHFW management at the thana level and below in the Sylhet District since the success of health sector reform will depend in part on stronger management capacity
- The CHILD strategy should be replicated in other low-performing areas of the country
- Any other NGOs, which work as partners with the MOHFW in implementing the strategy in other geographic areas of Bangladesh should have the strength to attract highly capable staff, provide them with high-quality training, and to develop a mutually respectful long-term partnership with the MOHFW
- The project achievements are sufficiently important to merit widespread dissemination and possible replication

**Table 1 Project Indicators, Targets and Achievements**

Project Intervention	DIP Indicator	Target at the End of Project	CHILD-II Baseline Survey, 1995*	CHILD-II MTE Survey, 1997	CHILD-II Final Evaluation Survey, 1999	
EPI	Completely vaccinated child (card only, 12-23 months of age)	65%	16%	9%	72%	
	Completely vaccinated child (card + history)	none	22%	32%	91%	
	DPT3 coverage (card only)	70%	21%	21%	73%	
	Measles coverage (card only)	65%	19%	19%	75%	
	Child immunization card retention (0-23 months of age)	65%	26%	26%	80%	
	Reduce drop out rates	DPT1-DPT3 drop out rate	10%	35%	13%	5%
		BCG-measles drop out rate	15%	43%	21%	2%
	Maternal TT2 coverage (card only, women 15-49 years of age)	50%	8%	10%	46%	
	Maternal TT2 coverage (card + history) during last pregnancy	none	41%	46%	86%	
Maternal TT card retention (women 15-49 years of age)	50%	13%	11%	49%		
CDD	Children's feces disposed in a fixed place (assessed only in CtC areas)	50%	15% (baseline, 1996)	47% (MTE, 1998)	47% (final, 1999)	
	Household members wash hands before eating (assessed only in CtC areas)	80%	72% (baseline, 1996)	95% (MTE, 1998)	99% (final, 1999)	
	Continuation of breastfeeding (among mothers of children with diarrhoea during the previous two weeks)	70%	46%	65%	75%	
	Use of ORT (among mothers of children with diarrhoea during the previous two weeks)	65%	30%	40%	84%	
	Use of same or more fluids (among mothers of children with diarrhoea during the previous two weeks)	50%	35%	43%	83%	
	Use of same or more food (among mothers of children with diarrhoea during the previous two weeks)	30%	10%	27%	66%	
Vitamin A	Provision of Vitamin A capsule during the previous 6 months to children 12-23 months of age	70%	52%	65%	74%	
Family Planning	Family planning use among mothers of a child under two years who don't want a child in next two years	30%	8%	7%	41%	
Total sample size of surveys and percentage and number of children in two age groups during the previous two weeks)	Total sample size		300	300	300	
	0-11 months		62.3% (n=187)	53.3% (n=160)	63.3% (n=190)	
	12-23 months		37.7% (n=113)	46.7% (n=140)	36.7% (n=110)	

## **1. Introduction and Background to the Child-II Project**

In October 1995, as part of the Government of Bangladesh (GOB) initiative to improve the overall health status of children and women of reproductive age, CARE began the second phase of its project to improve maternal and child health in the Sylhet District. This project, Child Health Initiatives for Lasting Development-II (CHILD-II), assisted the Ministry of Health and Family Welfare (MOHFW) to improve its capacity and effectiveness in providing key child survival interventions at the community level in three thanas having a total current population of approximately 520,487 persons, and a total target population of 189,722 beneficiaries (children 0-72 months of age and women of reproductive age).

The project also provided a limited presence in five other thanas of the Sylhet District, with a population of 1,566,623 persons and 488,024 beneficiaries, where the CHILD-I Project worked with the MOHFW from 1991-1995. CARE's level of involvement in these thanas declined substantially with the beginning of the CHILD-II Project.

Funding for CHILD-II (as well as for CHILD-I) was provided by the United States Agency for International Development (USAID) and CARE-USA.

### **1.1 Interventions**

The key interventions of the project were to increase the availability of, demand for and utilization of the following services:

- Immunizations for children and mothers (35% of project effort)
- Prevention of vitamin A deficiency (15% of project effort)
- Prevention and management of diarrhoea (25% of project effort)
- Family planning (25% of project effort)

In order to enhance the cost-effectiveness and long-term sustainability of the project, CARE adopted a strategy designed to assist MOHFW mid-level managers and lower-level field workers in strengthening and expanding their outreach programs and in assisting them to develop increased community support for basic health and family planning services.

## **1 2 Goals of the Project**

The overall project goals were as follows

- Improved health status of 100,396 children under 6 years of age and 89,326 women of reproductive age in three new thanas (having 20 unions) in the Sylhet District in Bangladesh
- Continued development and technical assistance to the MOHFW in five thanas (having 55 unions) in the Sylhet District where the CHILD-I Project functioned so that the health status of 242,910 children under age 6 years of age and 245,114 women of reproductive age can continue to improve

## **1 3 Objectives of the Project**

The overall project objective is to strengthen the MOHFW's capacity so that it can deliver high quality, sustainable and integrated outreach services by establishing closer linkage between MOHFW field workers and the community. As a result the availability, accessibility, utilization, coverage and quality of the services with emphasis on immunization, vitamin A distribution, family planning and home treatment of diarrhoea will be increased

The intervention objectives and DIP indicators are as follows

### **Immunizations**

- Increase full immunization coverage among children 12-23 months of age by reducing dropout rates
- Increase the coverage and the quality of immunization services by improving the management and organization of merged outreach sites in the project area, and by improving the managerial, technical, and communication skills of MOHFW service providers

### **DIP Indicators**

- Increase card-documented immunization coverage from 16% to 65% in children of 12-23 months of age
- Increase card-documented DPT3 coverage from 21% to 70%
- Increase card-documented measles coverage from 19% to 65%
- Increase retention of child immunization card (also called EPI card, for Expanded Program on Immunization) from 26% to 65%
- Reduce dropout rate for DPT1 to DPT3 from 35% to 10%
- Reduce dropout rate for BCG to measles from 43% to 15%
- Increase card-documented coverage with two or more doses of tetanus toxoid (TT) immunization from 8% to 50% in women 15-49 years of age
- Increase retention of maternal immunization card from 13% to 50%

## Vitamin A

- Increase vitamin A capsule (VAC) coverage among children 0-72 months of age

### DIP Indicators

- Increase from 44% to 70% the percentage of children aged 0-72 months of age who received a vitamin A capsule during the previous six months

## Diarrhea Prevention and Treatment

- Increase oral rehydration therapy (ORT) use among mothers of children under two years of age by training MOHFW field workers in hygiene practices and ORT promotion, by developing innovative participatory learning extension approaches at the community level, and by supporting emergency responses of the MOHFW during diarrhoea outbreaks
- Develop and implement an integrated CDD (control of diarrhoeal diseases) approach by providing broader hygiene education and by establishing linkages with water and sanitation hardware providers in diarrhoeal-prone areas

### DIP Indicators

- Increase the performance of at least two diarrhoea-prevention actions (ingestion of safe water and hand washing with soap or ash after defecation and before eating) to 50% among mothers of children under two years of age
- Increase to 80% the percentage of mothers of children under two years of age that can name at least three actions to prevent diarrhoea
- Increase from 46% to 70% the percentage of mothers of children under two years of age that continue to breastfeed (among breastfeeding mothers whose child developed an episode of diarrhoea during the previous two weeks)
- Increase from 41% to 65% the percentage of mothers of children under two years of age who use ORT when their child develops diarrhoea
- Increase from 35% to 50% the percentage of mothers of children under two years of age who give the same or more fluids when their child develops diarrhoea
- Increase from 10% to 30% the percentage of mothers of children under two years of age who give the same or more food, including more frequent meals when their child develops diarrhoea

## Family Planning

Increase access to and use of community-based family planning services of the target population (namely, women with a child 0-23 months of age who do not want to have another child for two years) through multiple outreach service opportunities

### DIP Indicators

- Increase the use of family planning from 8% to 30% among women with a child 0-23 months of age who do not want another child during the next two years

## **14 Project Location and Funding**

CARE began working in Sylhet District in 1991 because the area was lagging behind other parts of Bangladesh in all health and family planning activities of the MOHFW. At that time, only 6% of children in the five thanas where CARE began the CHILD-I Project in 1991 had been fully immunized compared to 52% of children nationally. The continuation of Project activities in 1995 was highly appropriate because

- The CHILD-I Project provided assistance in only five of the District's 11 thanas
- Continued low-level assistance was still needed in the five thanas covered by the CHILD-I Project
- The other six thanas continued to be low-performing areas
- CARE had been successful in developing an effective partnership with the MOHFW in this District

More recent data also show that the Sylhet Division is still lagging behind the other five divisions of Bangladesh in EPI coverage and in the use of family planning methods (see Table 2). The division has the highest rate of illiteracy in the country (67%), the lowest coverage levels for measles, for complete child immunization and for maternal TT2 immunization. Even more striking is the much lower contraceptive prevalence rate (for any method). The rate in the Sylhet Division is 20% compared to rates of 37 - 62% in the other divisions of the country.

CARE is the only NGO working in the Sylhet District to strengthen the institutional capacity of the MOHFW to deliver integrated child survival and family planning services. Within each thana there is a MOHFW Thana Health Complex, which is a set of buildings for offices, outpatient clinics, and an inpatient facility of approximately 30 beds. All most in every union there is a Family Welfare Center of the MOHFW.

In the Sylhet Municipality, there is a Medical College Hospital as well as a Maternal and Child Welfare Center, both operated by the MOHFW. There are a number of private clinics and private physicians in Sylhet Municipality as well.

**Table 2 Maternal and Child Health Indicators for Sylhet District and Sylhet Division Compared to Other Divisions in Bangladesh, 1996-7**

Performance Indicator	Sylhet District	Sylhet Division	Barisal Division	Chittagong Division	Dhaka Division	Khulna Division	Rajshahi Division
Percentage of mothers with no education	48	67	30	51	58	48	61
Percentage of children 12-23 months of age with measles immunization (card + history)	45	56	78	66	65	87	75
Percentage of children 12-23 months of age with complete immunization coverage (card + history)	not available	42	62	51	49	68	58
Percentage of mothers with 2+ TT immunizations during previous pregnancy (card + history)	63	49	58	56	61	66	63
Percentage of couples of reproductive age using any form of family planning	not available	20	49	37	50	62	59

Source: Bangladesh Demographic and Health Survey, 1996-1997, Progotir Pathey, 1998

## 15 Project Design

The CHILD-II Project has worked with district and thana managers of the MOHFW and union MOHFW supervisors to reinforce their management and supervisory skills. The major focus is the MOHFW community-level field worker both the Health Assistant (HA) and the Family Welfare Assistant (FWA). Technology transfer and motivational enhancement have been provided by the CARE/CHILD-II staff using participatory and performance-based training as well as through a unique partnering to give MOHFW workers on-the-job training experiences. The project does not create new or parallel systems for outreach service delivery nor does it initiate activities that are unsustainable after the project has ended.

## 16 Staffing

At the time of the Final Evaluation, the CHILD-II Project employed 19 staff members (Table 3). The project is managed primarily from the CARE sub-office in Sylhet Municipality (see organizational chart, Appendix B). Ten project staff members are based in CARE-II thanas, and five are based in Sylhet Municipality at the CARE office there. Another four staff members are based at the CARE national headquarters office in Dhaka. Thirty-five percent of the project staff is female. Normally, the Project Coordinator and the Assistant Project Coordinator are based in Dhaka and each spend one week a month in Sylhet. The Public Health Physician is based in Sylhet and spends the majority of his time in the field supervising field activities.

The Field Trainers are multipurpose workers, working with outreach staff of both wings of the MOHFW to strengthen service delivery and community mobilization. Three Assistant Project Officers are based at the thana level. Each one is responsible for the project field activities in that thana. It is important to point out that the MOHFW has provided the CARE staff based at the thana level with living facilities at the Thana Health Complex.

**Table 3 Staffing of the CHILD-II Project, August 1999**

Base of Operations	Job Title	Responsibilities	Incumbent
Dhaka	Project Coordinator	Provide leadership for project activities	Dr Wahidul Islam
	Assistant Project Coordinator	Assist the Project Coordinator at the operational level for planning, implementing, supervising and monitoring project activities	Dr Shamim Imam
	Project Development Officer	Supervise administrative and financial activities	Mr Sazzad Hossain
	Administrative Assistant	Assist the Dhaka office as needed	Mr Azizul Haque
Sylhet	Public Health Physician	Supervise field activities, liaison with MOHFW district managers	Dr Rasheduzzaman
	Project Officer	Assist the Public Health Physician in field supervision, reporting and local level liaison	Ms Zahanara Begum
	Project Development Officer (Research)	Supervise data collection, carry out data analysis for project monitoring and for special surveys	Mr A B M Shameem ud-Dawla
	Assistant Project Officer	Assist the Public Health Physician in field supervision, reporting and local-level liaison as well as provide limited assistance to Sadar Thana	Ms Ruksana Bequm
	Administrative Assistant	Assist the Sylhet office as needed	Sk Mofizul Islam
CHILD Thanas	Assistant Project Officer (1 in each of the 3 CHILD II thanas)		Ms Taposhi Shaha Ms Shamima Akhter Mr Nazrul Islam
	Field Trainer (2-3 in each of the CHILD-II thanas)		7 Field Trainers altogether

## **2 Project Accomplishments**

### **2.1 Service Coverage**

#### **2.1.1 Immunizations**

- 167 MOHFW field workers were trained, registration books were updated in 60,000 households, these registration books were used to locate children for immunizations
- Social mobilization activities were carried out. This was accomplished by training and involving 627 volunteers, orienting 210 Union *Parishad* (Council) members, and involving community members in different routine and special events
- Appropriate plans were developed and implemented. These included developing schedules for outreach services six months in advance, supervising the planning activities of all the field-level supervisors, making plans for services in low-performing hard-to-reach areas, and establishing control rooms and MIS boards in each thana
- Joint action plans involving both the health and FP wings of the MOHFW were developed for annual activities. More than 90% of outreach sessions were merged, and 40% of EPI Outreach Sessions were attended by FWAs
- More than 20 meetings per month were held at the thana and union levels with field workers and supervisors to assess performance of field workers. Documentation of these meetings was also carried out
- Quality of the EPI outreach sessions was monitored every monthly using a health information system (HIS) checklist. More than 80 EPI Outreach Sites were visited each month by project field staff
- Four National Immunization Days (NIDs) were organized successfully, ensuring a high level of oral polio vaccine (OPV) coverage. A total of 627 volunteers were formed and 45 traditional birth attendants (TBAs) were trained in each of the project thanas in order to bring the target children and mothers to the NID sessions
- A measles and neonatal tetanus (MNT) campaign was held each year. Need-based measles catch-up campaigns were organized also

**Table 4 EPI Achievements of CHILD-II Project**

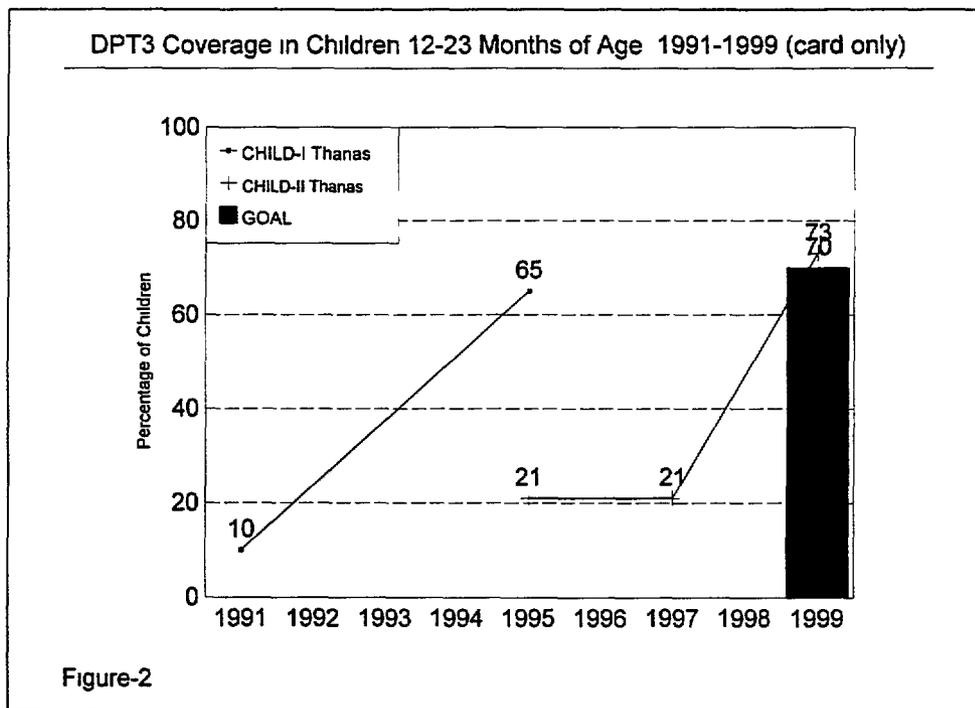
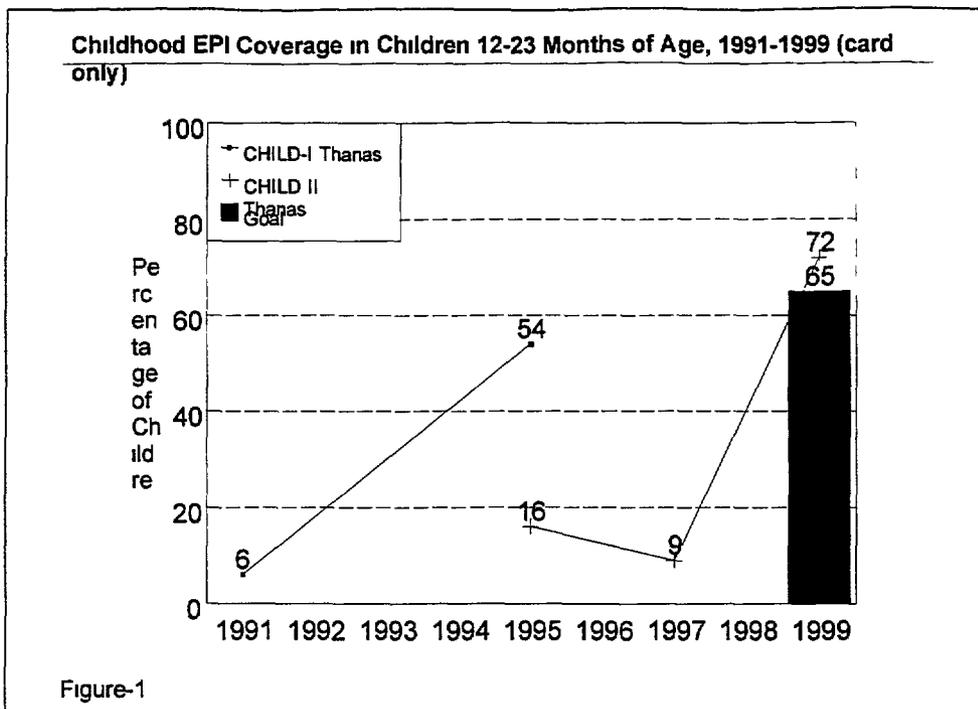
DIP Indicator	End of Project Objective	CHILD-II Baseline Survey, 1995*	CHILD-II MTE Survey, 1997	CHILD-II Final Evaluation Survey, 1999
Completely vaccinated child (card only, 12-23 months of age)	65%	16%	9%	72%
Completely vaccinated child (card + history)	none	22%	32%	91%
DPT3 coverage (card only)	70%	21%	21%	73%
Measles coverage (card only)	65%	19%	19%	75%
Child immunization card retention (0-23 months of age)	65%	26%	26%	80%
DPT1-DPT3 drop-out rate	10%	35%	13%	5%
BCG measles drop-out rate	15%	43%	21%	2%
Maternal TT2 coverage (card only, women 15-49 years of age)	50%	8%	10%	46%
Maternal TT2 coverage (card + history) during last pregnancy	none	41%	46%	86%
Maternal TT card retention (women 15-49 years of age)	50%	13%	11%	49%

\* CHILD II Baseline Survey based on results from the 6 thanas, which were not included in the CHILD-I Project (namely, Bianibazar, Companigonj, Fenchugonj, Gowainghat, Kanaighat and Zakigonj)

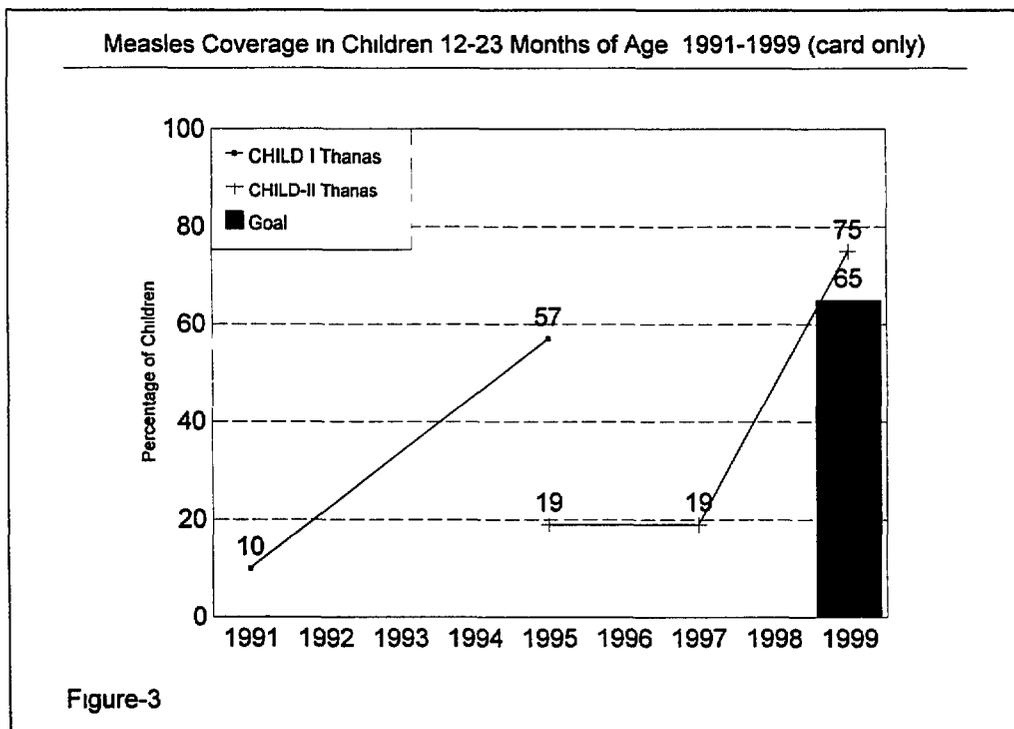
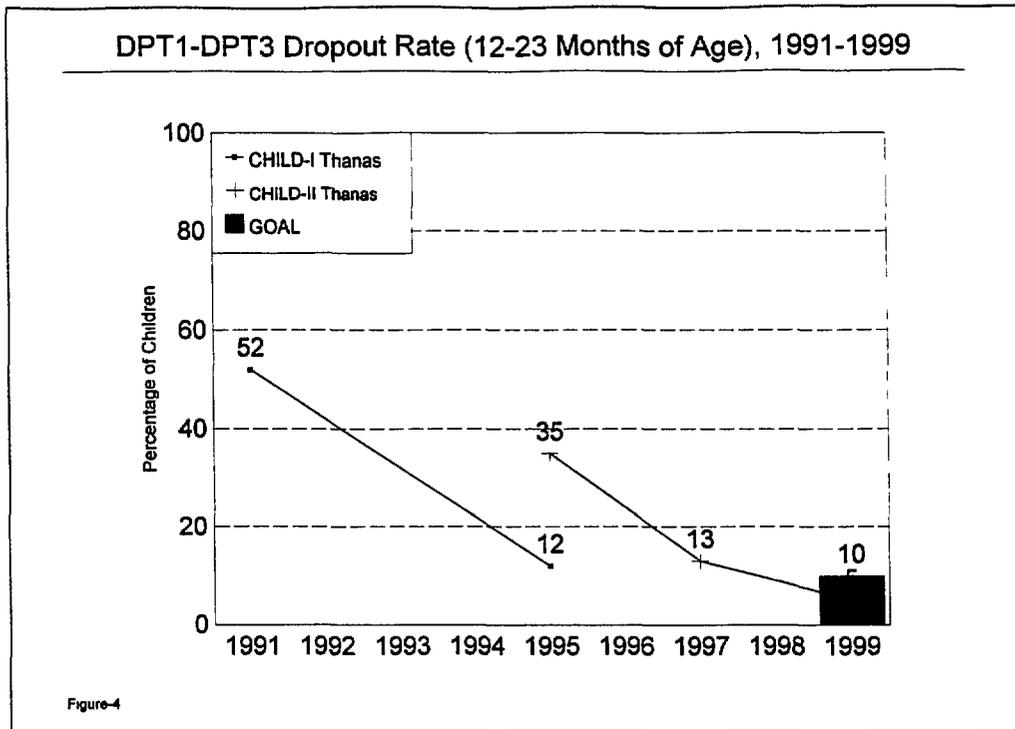
\*\* These data are unweighted averages

Table 4 and Figures 1 - 8 show that remarkable progress has been made in the CHILD-II areas, particularly since the mid-term evaluation (MTE) in 1997. All of the childhood immunization goals were achieved, and the maternal immunization goals were nearly achieved. Improvements in coverage in the CHILD-I thanas are also apparent since the final KPC survey in 1995.

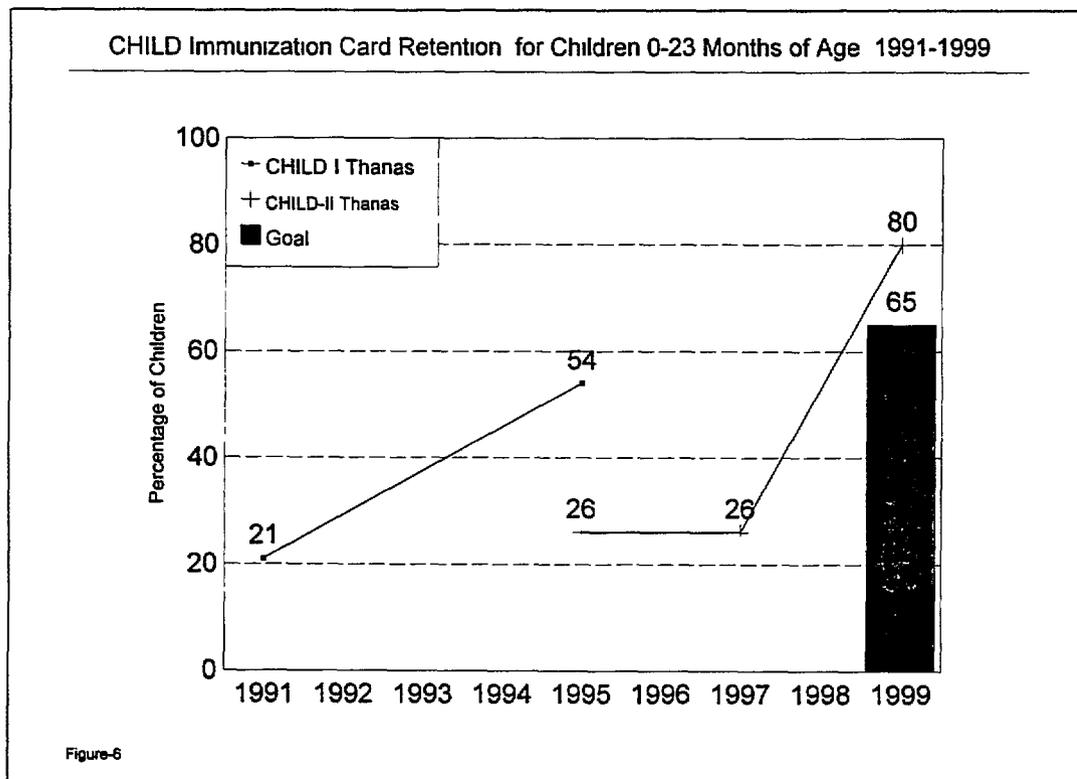
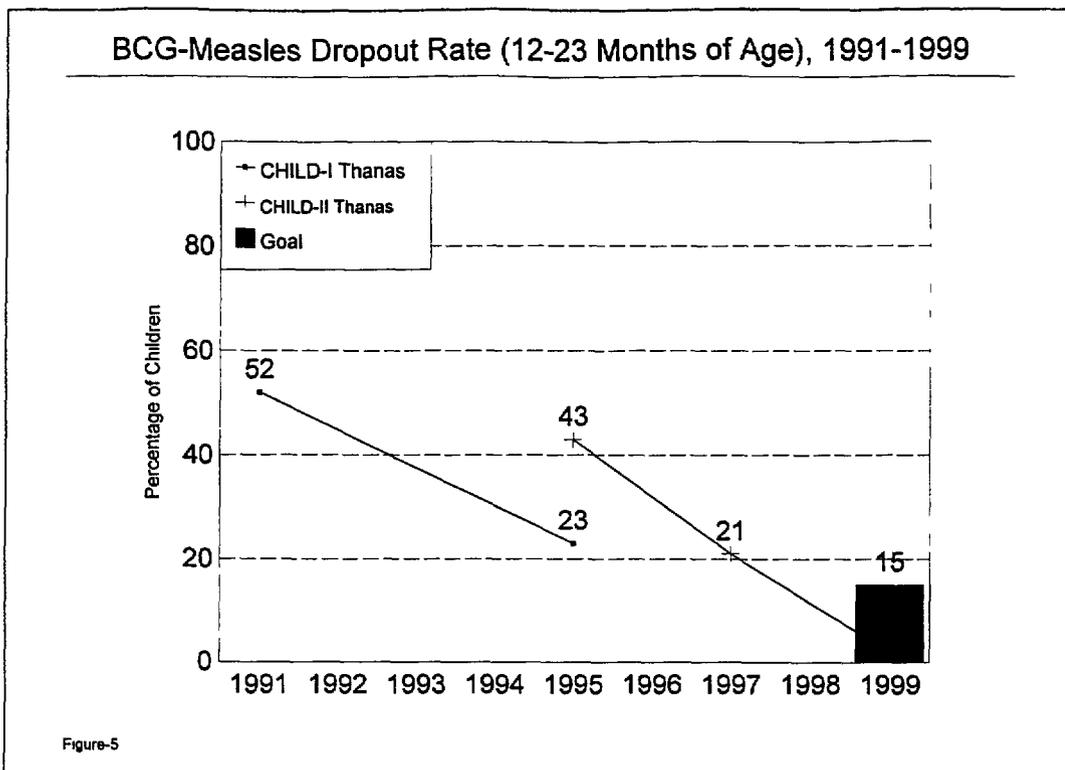
Figures 1-2



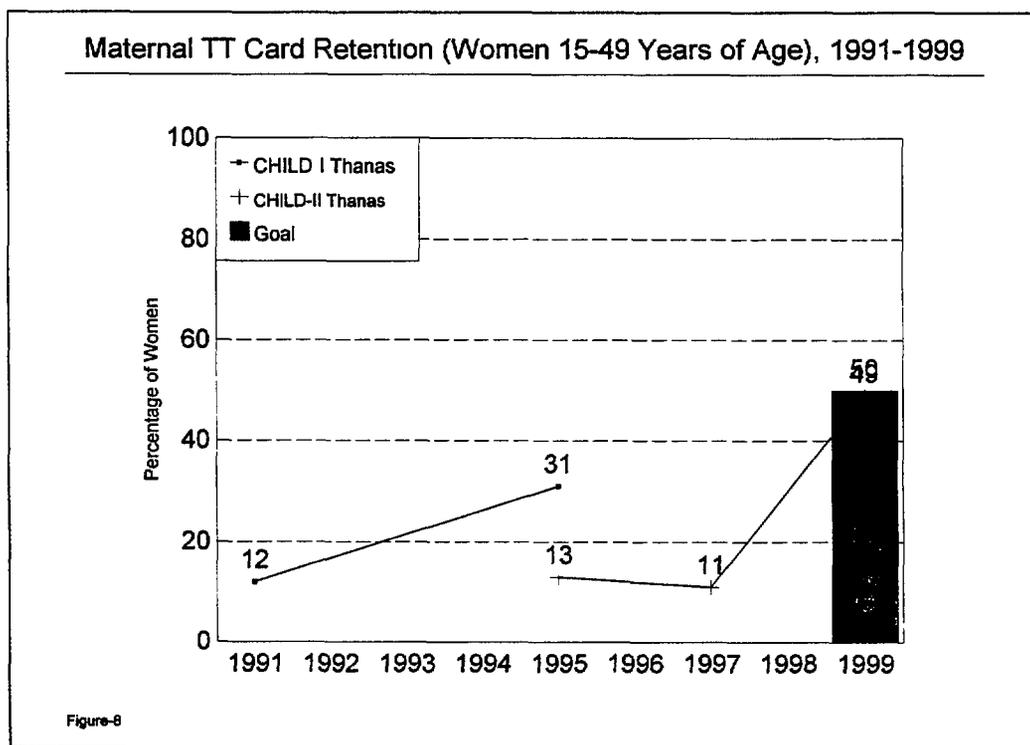
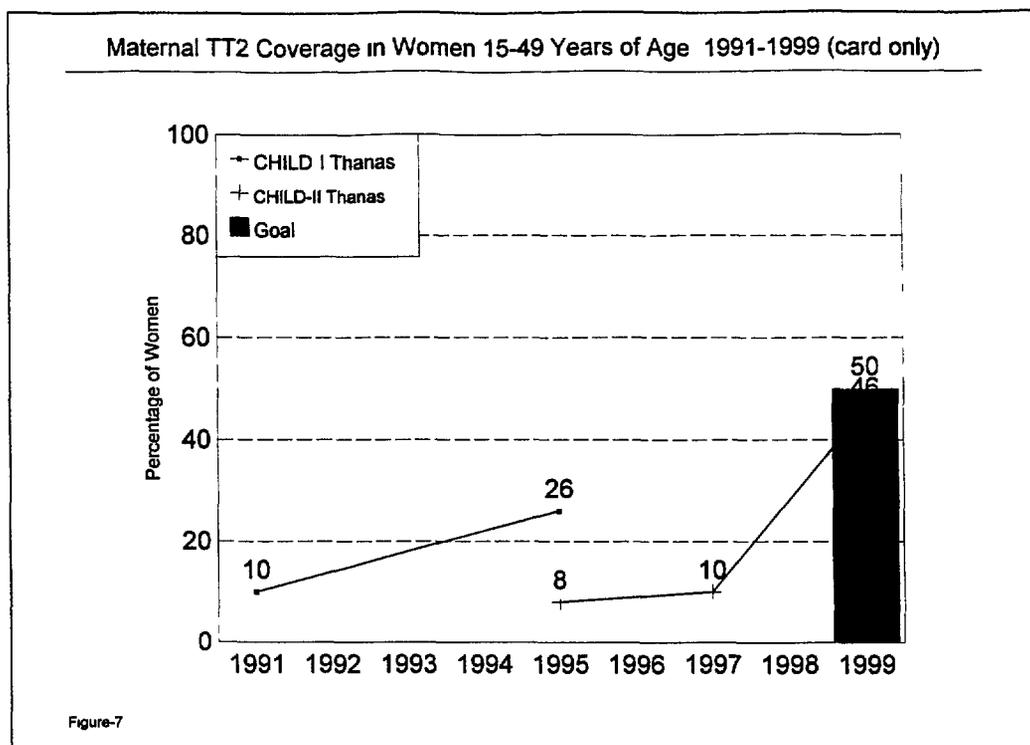
Figures 3-4



Figures 5 6



Figures 7-8



## 2 1 2 Control of Diarrhoeal Diseases

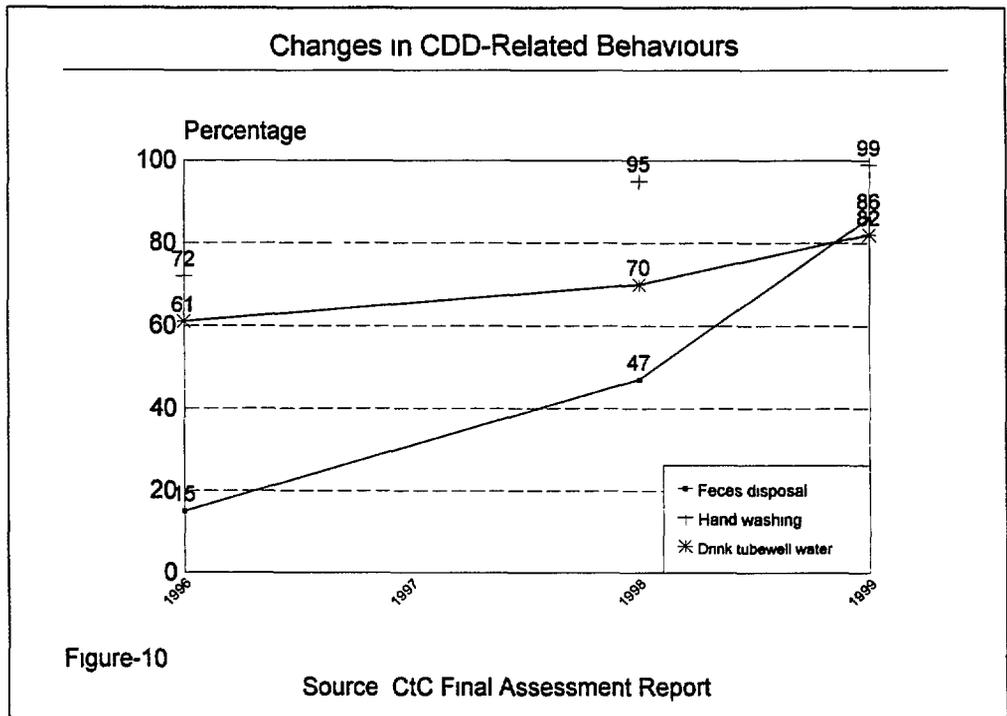
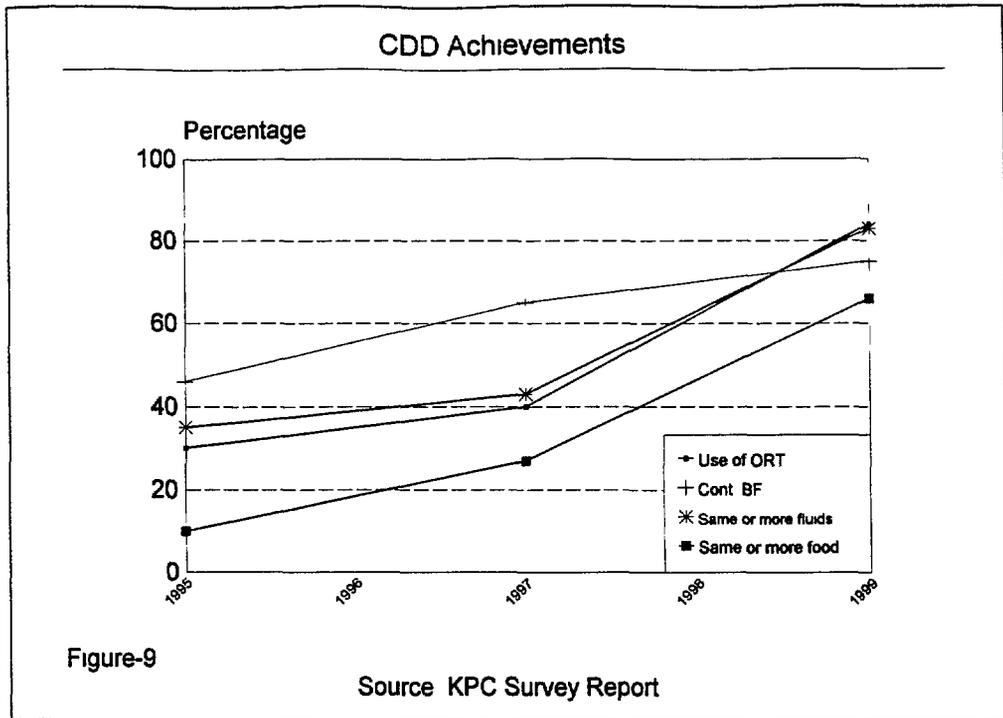
- More than 300 Child-to-Child (CtC, see section 2 3 1), 150 Participatory Action Learning (PAL)/Simulation, and 700 ORT sessions for health education were organized by the MOHFW workers each year with the assistance of project staff
- A total of 52 MOHFW field workers received training on the CtC and PAL methodology
- Village doctors who were oriented by the MOHFW National CDD Program received periodic follow-up from project staff

Table 5 and Figures 9-10 show that the objectives for which there are measured indicators were all exceeded by a considerable margin

**Table 5 CDD Achievements of the CHILD-II Project**

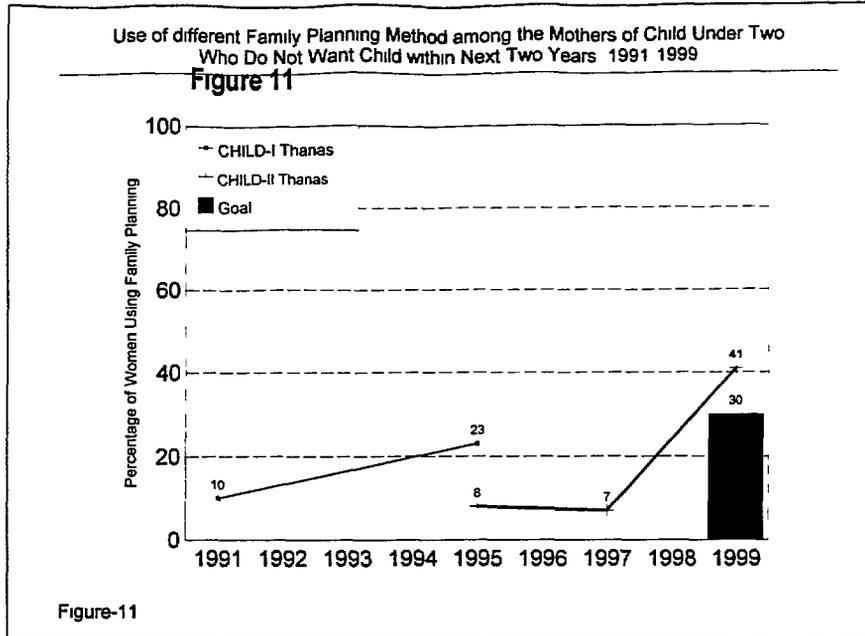
DIP Indicator	End of Project Objective	CHILD II Baseline Survey, 1995*	CHILD II MTE Survey, 1997	CHILD II Final Evaluation Survey, 1999
Children's feces disposed At a fixed site	50%	15% (1996, CTC areas)	47% (1998, CTC areas)	86% (CTC areas)
Household members wash hands before eating	50%	72% (1996 CTC areas)	95% (1998, CTC areas)	99% (CTC areas)
Knowledge of three actions to prevent diarrhoea (among mothers of children 0- 23 months of age)	80%	not assessed	not assessed	not assessed
Continuation of breastfeeding (among mothers of children with diarrhoea during the previous two weeks)	70%	46%	65%	75%
Use of ORT (among mothers of children with diarrhoea during the previous two weeks)	65%	30%	40%	84%
Use of same or more fluids (among mothers of children with diarrhoea during the previous two weeks)	50%	35%	43%	83%
Use of same or more food (among mothers of children with diarrhoea during the previous two weeks)	30%	10%	27%	66%

Figures 9-10



## 2 1 3 Family Planning

- 52 MOHFW staff members were trained in conducting participatory health education sessions
- 85 FWAs were trained in maintaining field registers and on counseling concerning method choice, contraindications, side effects, and referral
- Yearly advance planning for merged sessions was held and more than 90% of the merged sessions were held as planned



- More than 100 FP performance analysis meetings were held at the FWC level with FP field workers (FWAs) and Supervisors (FPs)

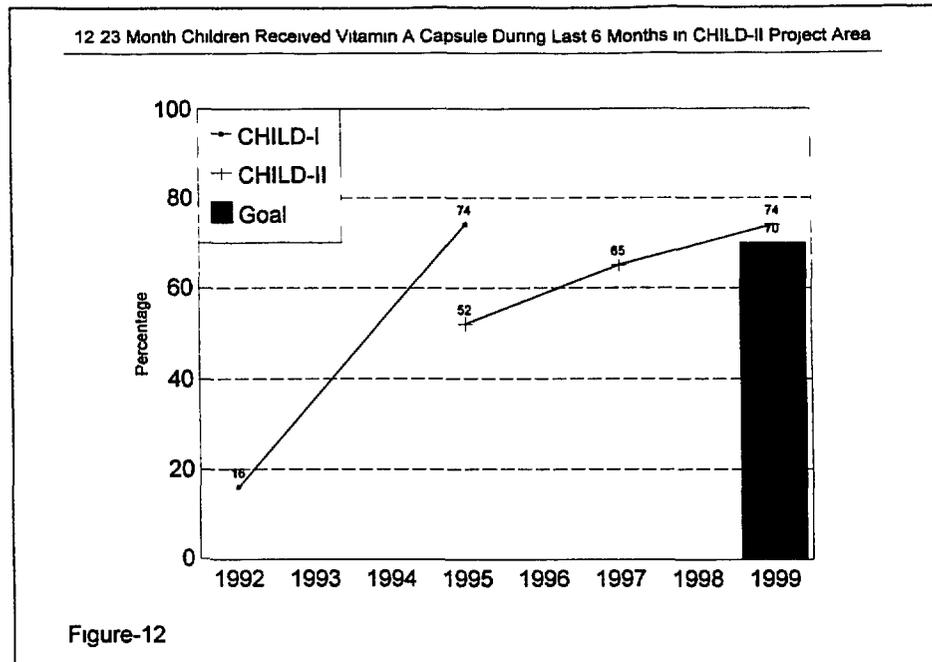
As shown in Figure 11, the project objective for family planning was surpassed by a considerable margin. The use of contraception among mothers of 0-23-month-old children who do not desire any additional children during the next two years increased almost four-fold.

## 2 1 4 Vitamin A

- Advocacy meetings were held at the district, thana and union levels, supervisory plans were formulated and distribution of vitamin A capsules was monitored
- Social mobilization activities were carried before and during National Vitamin A Week
- 246 MOHFW workers were trained regarding vitamin A distribution
- 100% of VAC rounds were carried out according to national guidelines
- Vitamin A was administered appropriately at 100% of routine EPI outreach sessions
- Health education sessions on Vitamin A were designed, and approximately 20 sessions per month were held on a regular basis at the community level

Figure 12 shows that the percentage of children 12-23 months of age who had taken a high-dose vitamin A capsule during the previous six months increased from 52% to 74%

Figure 12



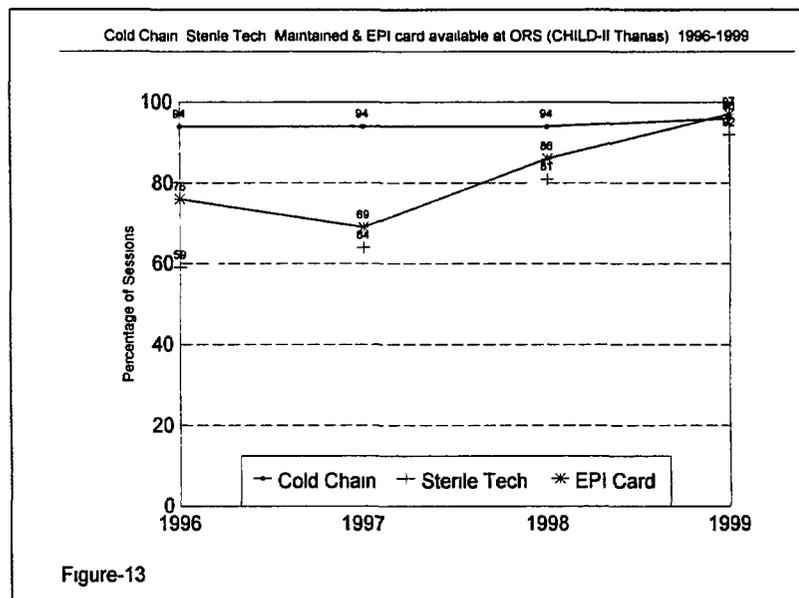
### 2 1 5 Monitoring of the Quality of Services

The project has a very well-developed HIS and it also tracks closely the data entered into the MOHFW's MIS of the CHILD-II and CHILD-I thanas where it is working. On the basis of the data in this system, there is clear evidence that the output of the project in terms of increases in the quality and quantity of outreach services is clearly impressive.

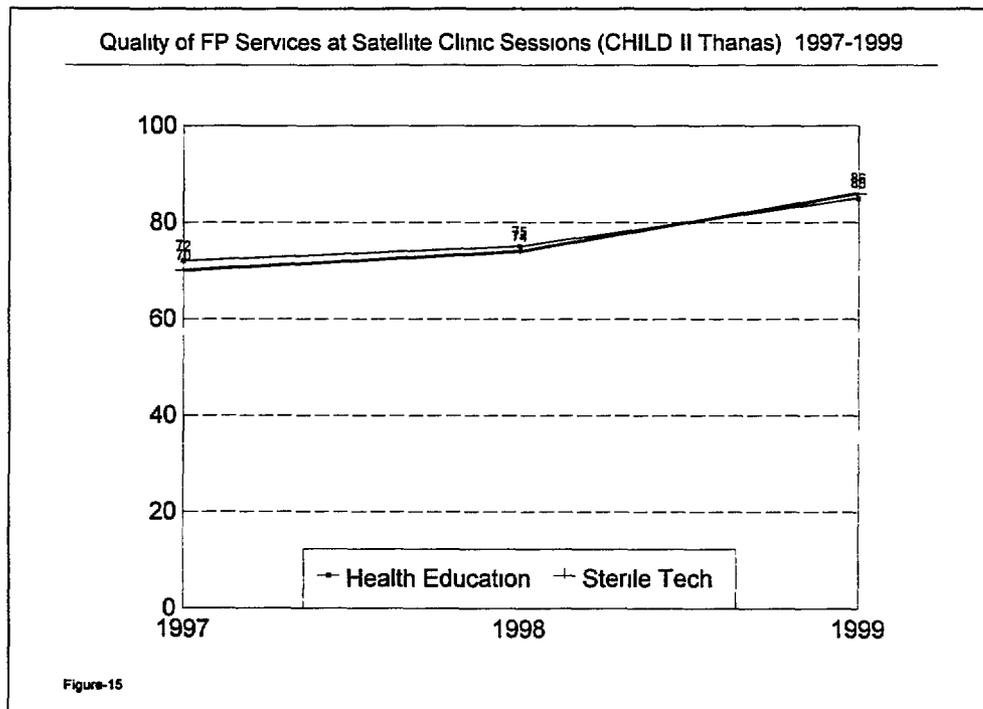
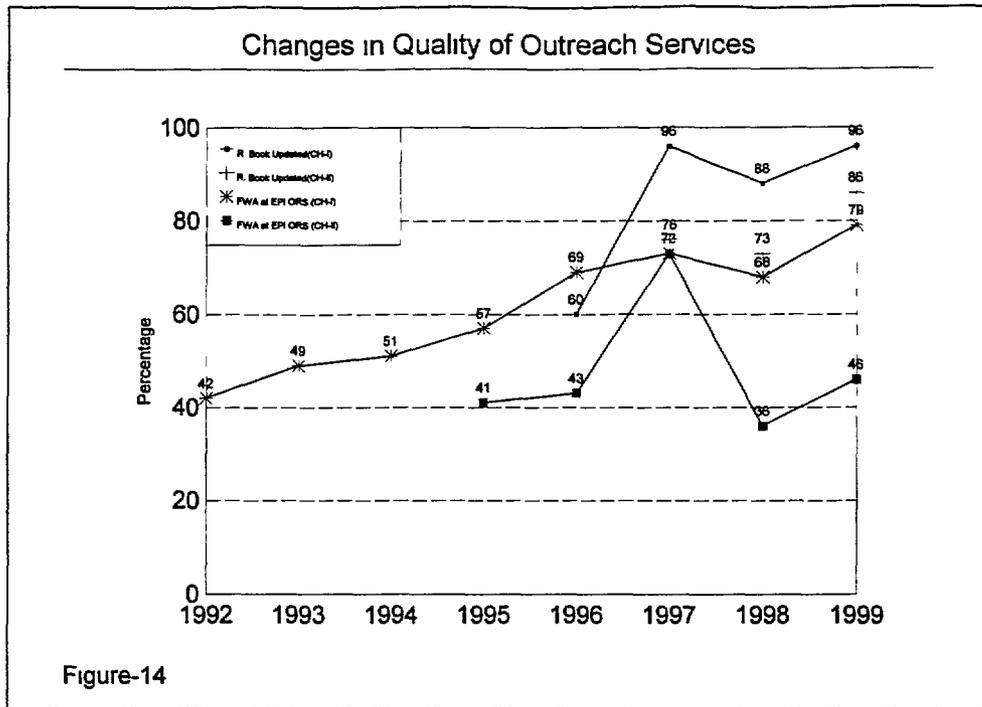
The project monitored a series of activities very closely, including the quality of EPI services provided at outreach sessions. The number of children expected to come and the number who actually came was also recorded.

The indicators measuring the quality of services provided at outreach sessions are shown in Table 6 and Figures 13-15. The actual monitoring forms used are contained in Appendix L.

Figure 13



Figures 14-15



**Table 6 Quality Monitoring of Outreach Sessions List of Indicators Measured**

Indicator	EPI Outreach Site Session	Satellite Clinic Session
What MOHFW staff were present	√	√
What logistic supplies were present at the session	√	√
Whether the quality of the educational session provided was adequate	√	√
Whether counseling of clients was adequate	√	√
Whether sterilization of needles and syringes was performed correctly	√	
Whether the cold chain was properly maintained	√	
Whether the method of vaccination was proper?	√	
Whether the completion of all forms was correctly carried out	√	√
Whether privacy was maintained		√
Number of children targeted for the session	√	
Number of children who actually attended	√	

## 2 2 Capacity Building

### 2 2 1 Capacity Building of the MOHFW

The evidence is overwhelming that the CHILD-II Project has succeeded in enhancing the capacity of the MOHFW to deliver outreach MCH-FP services in the three thanas where it has been working intensively between 1995 and 1999. This has been achieved by organizing at the thana and union levels regular monthly coordination meetings of staff members from both health and FP wings of the MOHFW, and by organizing training based on needs identified by observation in the field. An advanced schedule for the dates of the outreach session was developed for the entire calendar year in each of the CHILD-II thanas. Project staff regularly monitored field activities, provided supervisory training (including on the spot training) to MOHFW staff, and developed and implemented the use of a supervisory checklist that also served as a quality assessment checklist for outreach sessions. Supervisory performance was analyzed at monthly staff meetings. A MIS board was established at the thana health complex to monitor thana performance of outreach activities.

In the three CHILD-II thanas MOHFW workers have been trained and motivated to provide improved outreach services, and the district and thana-level managers/supervisors have worked as partners with the project to foster improved planning of outreach services, improved coordination between the two wings of the MOHFW, improved transport and logistics for outreach services, and improved community involvement/mobilization.

Perhaps even more impressive from the standpoint of capacity building is the strong evidence provided that the gains achieved in the five CHILD-I Project thanas between 1991 and 1995 have not only been maintained but they have been further advanced even though the project provided presence and support there between 1995 and 1999. The evidence for this conclusion comes from the EPI coverage surveys carried out in each thana of the District during the Spring of 1999 (including the five Child-I thanas) as well as from information in the HIS and MIS for the CHILD-I thanas.

### 2.2.2 Coordination between Health and Family Planning of the MOHFW

One of the objectives of both the CHILD-I and the CHILD-II Projects was to improve the coordination between health and family planning workers so that the mothers could obtain services from one site and so that supervision and management of outreach services would be simplified. The projects helped to organize "joint" EPI outreach sites sessions (in which an FWA attended along with the HA) and "merged" Satellite Clinic outreach session (in which the Satellite Clinic session and EPI Outreach Session were held at the same place and the same time). The projects also facilitated coordination meetings of outreach staff and their supervisors from both the health and FP wings of MOHFW at the thana and union level.

As a result of these efforts, the percentage of scheduled Satellite Clinic sessions in the CHILD-I Project areas that were actually held increased from approximately 60% to 80% by the end of the CHILD-I Project in 1995. Between 1995 and 1999 the percentage of scheduled sessions held increased even further, to around 90%. The percentage of merged sessions held also increased similarly.

In the CHILD-II thanas between 1995 and 1999, the percentage of planned Satellite Clinic sessions which were held has remained steady at around 85%, the percentage of merged sessions increased from virtually 0% in the first year of the CHILD-I Project to over 70 percent in the second year and then gradually increasing to around 85% by the end of the project (see Figures 16-17).

Figures 16-17

The Final Evaluation Team encountered numerous examples of how the methods used by the CHILD-I and CHILD-II Projects have been adopted in the remaining, non-CHILD thanas in the Sylhet District, and there is strong suggestive evidence that the overall program effectiveness in these non-CHILD thana has improved as a result of this "spillover" effect, providing further support for the effectiveness of the capacity building process of the project and its sustainability.

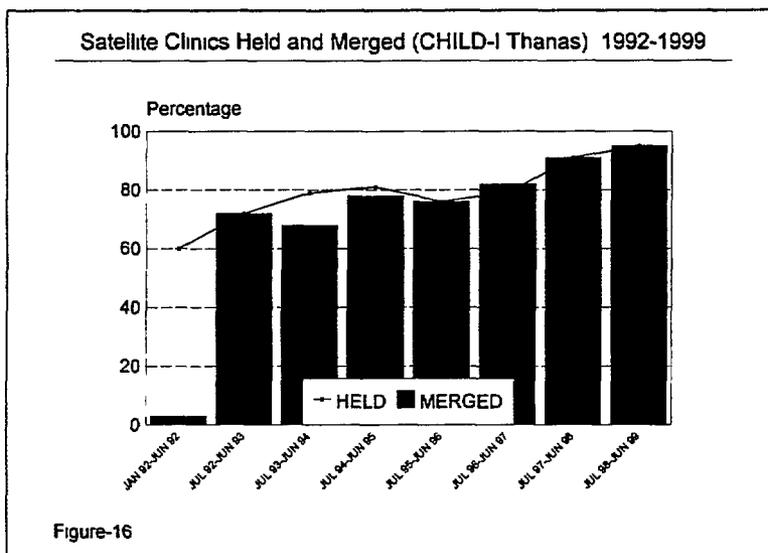
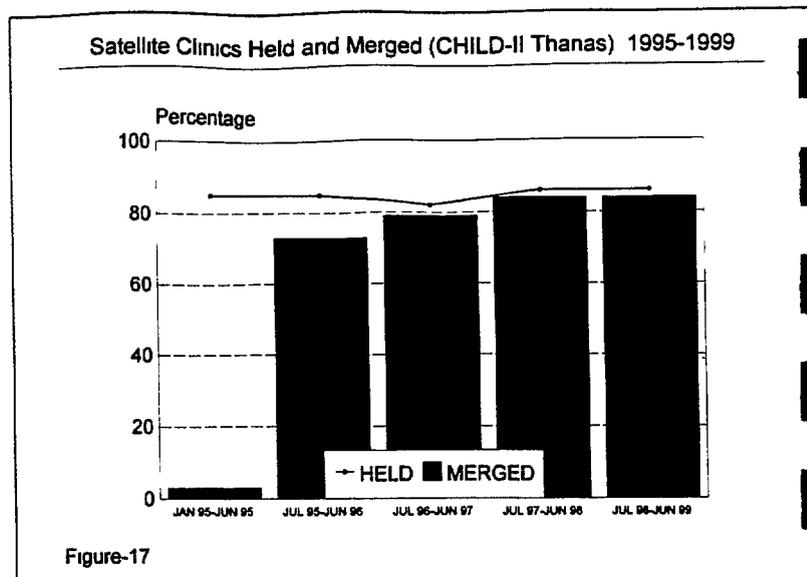


Figure-16

Capacity building within the MOHFW has been made possible by three key elements of the partnership between the MOHFW and the CARE/CHILD-II Project staff. Key elements of this partnership include the following:

- Joint planning of activities at the district and thana level
- The signing of a formal agreement pledging both partners to carry out the plans which had been jointly developed
- Joint supervision and monitoring of field activities
- Responsiveness of the CHILD-II Project to requests from the MOHFW and from the community



- Transparency and mutual trust

## 2 3 Community Mobilization and Involvement

### 2 3 1 Capacity Building in the Community

The project assisted the MOHFW in involving the community in outreach activities by selecting and training 627 "Information Banks," who are community members such as household members who offer their house for EPI outreach site session, TBAs, Local Initiative Project (LIP) volunteers<sup>1</sup>, school teachers and other local leaders. These persons received training each year about the services available to the local population and they assist in mobilizing mothers and children to attend outreach sessions and to participate in special events such as NIDs and Vitamin A week (Section 4 describes the Information Banks further).

The project recruited 210 members of the union *parishad*, 30% of whom were women, and provided them with an orientation about outreach services. The project also made broader efforts in the communities to raise awareness about the importance of outreach services.

The Child-to-Child (CtC) Initiative began in 1996 as a cross-learning experience from other CARE health projects in Bangladesh. Twenty-six groups of children 8-15 years of age were established in geographic areas of the CHILD-II Project that were considered to be diarrhoea-prone, as determined by field reports of the Health Assistants. In each diarrhoea-prone area, 1-3 groups of children were formed. Each group has 10-12 children, and one child was selected to be a group leader. The members of each group were selected and oriented by the HA and/or the FWA for the area in collaboration with the CHILD-II Field Trainer responsible for the area. Information Banks also collaborated in this activity.

The children were taught messages by playing a game called "ludu," which is an adaptation of the well-known children's game, Chutes and Ladders. The messages on the game are written in Bangla and focus on diarrhoea prevention and control, vitamin A, and EPI. The children were encouraged to share these

<sup>1</sup> The Local Initiatives Project is a large scale program that recruits local volunteer women to serve as "link persons" between the FWAs of the national family planning program and women of reproductive age.

messages with their families and neighbors. The children's group met once a week with one of the health staff or volunteers, but they frequently played the game at other times as well.

Through the CtC Initiative, awareness was created about diarrhoea prevention, vitamin A, and EPI. An evaluation of the CtC Initiative was carried out through semi-structured surveys of household heads and mothers in those communities that had CtC groups. Direct observations of activities and behaviors in household were also carried out. These data were collected in 1996 (baseline), 1997 (MTE) and 1999 (Final Evaluation). The findings of the evaluation of the CtC Initiative are shown in Table 7.

**Table 7 Findings from Evaluation of the Child-to-Child Initiative**

Indicator	Baseline (1996)	Mid-term (1998)	Final (1999)
Presence in the household of a functioning tubewell	11%	19%	44%
Presence of a latrine (any kind) in the household	62%	62%	93%
Use of household latrine	not available	not available	100%
Presence of a water seal latrine in the household	5%	23%	64%
Children observed to wash their hands with ash or soap after defecating	34%	80%	68%
Feces observed in the household courtyard	27%	25%	5%
Children's feces disposed in a fixed place	15%	47%	86%
Tubewell water used for washing dishes and bathing	21%	41%	38%
Tubewell water used for drinking	61%	70%	82%
Children 6-12 years of age observed to use latrine	18%	53%	77%
Household members observed to wash hands before eating	72%	95%	99%
Prevalence of diarrhoea in children <5 years during previous 2 weeks	not available	4.2% (March 1998)	2.9% (March 1999)

### 2.3.2 Local Resource Mobilization

The project gave great effort along with the MOHFW to encourage the community to contribute local resources for special events (such as NIDs and Vitamin A Week) and for ongoing routine outreach activities. In the CHILD-II thanas, the communities themselves produced banners, carried out "miking"<sup>2</sup> in hard-to-reach areas, provided boats for transportation, printed leaflets and produced special caps to promote NIDs and Vitamin A Week. In Companigonj Thana (a CHILD-II thana), the community raised Tk

<sup>2</sup> Miking<sup>2</sup> is a common activity in Bangladesh in which a rickshaw driver (or a driver of a motorized rickshaw, also called a baby taxi) is hired to drive through the community announcing a message through a battery powered mobile loudspeaker system.

22,750 (about US\$ 500) for expenses related to promoting the NID in 1998. Altogether, the community members in the Sylhet District raised Tk 88,500 (about US\$1,800) to promote the NID in 1998 and another Tk 32,350 (about US\$ 700) to promote National Vitamin A week in 1998.

## **2.4 Sustainability Elements**

### **2.4.1 Sustainability with the MOHFW**

By working directly with the MOHFW to enhance its own capacity to provide quality services and to work effectively with the community as a partner, the sustainability of project benefits is ensured. The CHILD-II Project is not a provider of services itself, but rather an enhancer of the MOHFW's capacity and a catalyst to strengthen linkages between the community and the MOHFW.

The phase-out strategy of the project for the CHILD-I thanas has been an effective approach to sustaining and even extending the achievements made as of 1995.

By emphasizing training of MOHFW staff, the project has been able to ensure that many benefits will be sustained and even spread to new locations outside of the Sylhet District as the staff members are transferred to new posts. The benefits include the stronger technical knowledge of the staff members that can lead to improved quality of services as well as the awareness they have developed about effective strategies for improving the management capacity of the MOHFW and for involving the community in outreach services.

Between January 1997 and June 1999, the CHILD-II Project leadership working with the MOHFW in the Sunamgonj District also established the BATCHA Project (Building Appropriate Training for Community Health Activities) in cooperation with the Thana Functional Improvement Project, financed by the European Union. This project was essentially a replication of the best practices of the CHILD-II Project, but during a shorter time frame and for a larger population. The shorter time frame did not allow for strong community outreach efforts to emerge, since a 3-4 year period is required to achieve this. Nonetheless, the final evaluation conducted in July 1999 showed strong gains in coverage of services.

### **2.4.2 Sustainability at the Community Level**

The project has served as a facilitator and catalyst to make it possible for the community to experience high-quality outreach services and to help the community realize that their involvement, participation, and support are necessary in order for these services to be available on an ongoing basis. Slowly, the community is coming to realize that they have a right to expect these services and also that they have a responsibility to assist in the mobilization of the community to utilize these services. Effective community mobilization requires local resources. The benefits of building community partnerships are long-lasting and may even become greater over time.

No cost-recovery activities were carried out as part of project activities since all of the services provided by the MOHFW at the outreach level are free (in accordance with the national policy of the MOHFW).

Some additional information about the nature of the capacity and sustainability activities of the project with the MOHFW are outlined in Table 8.

**Table 8 Capacity Building and Sustainability Plans and Outcomes of the CHILD-II Project**

Goal from the DIP	End-of-Project Objectives	Steps Taken to Date	Outcomes
<p>Improve the MOHFW's capacity to implement replicate transfer and conduct child survival and related health services through a phase-over process for sustainability</p>	<p>Collaboration workshops and annual capacity- building training sessions organized for MOHFW staff local NGOs, community representatives and household landowners</p> <p>CARE's participatory training approach is formalized in two locations outside of CHILD-II thanas</p>	<p>CHILD-II staff conducted monthly meetings/ orientation/training for thana and union level staff of MOHFW</p> <p>A total of 200 such training sessions were organized for MOHFW Thana/union level staff</p>	<p>MOHFW staff capable of conducting monthly performance analysis formulating supervision plans using checklists and so forth</p>
<p>MOHFW will adopt CHILD approach to improve field-level capacity to provide quality health care services</p>	<p>MOHFW adopts CARE's CHILD approach as a national model of partnership for NGOs in Bangladesh</p> <p>Disseminate CHILD II experience on GOB NGO collaboration at national and divisional levels</p> <p>Share experience sharing through field visits with MOHFW managers and staff from other PVOs/NGOs</p>	<p>3 lessons-learned workshops organized at district level</p> <p>6 cross visits (for MOHFW supervisors/field worker) were organized from non CHILD to CHILD-II thanas</p> <p>Visits to CHILD Project areas were made by national-level counterparts</p>	<p>CHILD model being replicated in neighboring thana, Sunamgonj through BATCHA Project (a joint partnership between CARE and the MOHFW with funding from the MOHFW)</p>
<p>Selected community based sites become operational as a result of collaboration among MOHFW, CARE and local NGO community representatives</p>	<p>Merging of EPI sites with Satellite Clinic sustained</p>	<p>Planning done with MOHFW staff at the thana and union levels</p> <p>Discussion sessions held with the community representatives and local leaders</p> <p>210 union <i>parshad</i> members trained</p>	<p>More than 80% EPI outreach sites are merged with Satellite Clinics and sustained</p>

### **3. Community Perception of Benefits**

Community members in the CHILD-II thanas expressed to the Evaluation Team on a number of different occasions their appreciation that the MOHFW outreach sessions are now being held regularly (in contrast to the situation at the time the CHILD-II Project began) and that the merging of the EPI Outreach Site sessions with Satellite Clinic sessions was a great benefit to them, making it easier for them to obtain basic services as a "one-stop shopping" activity

The Union *Parishad* members now have a clear understanding of the services that the community can rightfully expect from the MOHFW field workers. Prior to the CHILD-II Project, this understanding did not exist.

One of many benefits perceived by younger community members is the exposure that they have had to a new role model for young women. Being a highly conservative area in which the mobility of women is greatly restricted because of traditional cultural norms, the presence of highly mobile female staff members as Field Trainers, Assistant Project Officers and Project Officers has given the community members new ideas about gender roles. Female CARE staff members are renowned in the Sylhet District for their riding of motorcycles, a practice totally foreign to the area until recently.

### **4 Review of New and Innovative Practices**

The CHILD-II Project recruited 627 volunteers (called "Information Banks") at the community level. These persons are teachers, TBAs, local leaders, and students. Both men and women participate as Information Banks. These Information Banks were provided with basic and refresher training from the project regarding health issues and on the health and family planning outreach services that need to be provided to the population. Information Banks are responsible to assist with the organization of outreach sessions in their areas once in a month and to invite mothers to the sessions. The Information Banks are also involved in other voluntary health activities such as NIDs and National Vitamin A Week. These persons are valued highly by the community and receive local recognition for their work. In addition, outstanding Information Banks receive a special award from the MOHFW. Information Banks have made a positive impact on improving the effectiveness of outreach services.

All the Union *Parishad* members (including the Chairmen) for the three project thanas were given orientation on different health issues and on how they could support different local health and family planning activities. A total of 210 participants took part at the orientation sessions, including 60 female members. As a result of this activity, these persons undertook some responsibilities for community mobilization.

The CHILD-II Project also incorporated some innovative methods for dissemination of health education messages through the Child-to-Child game (described previously) as well as through PAL/Simulation activities. All of these drew considerable attention within the community.

At the time of special events such as NIDs and National Vitamin A Week, the project organized folk songs, drum beating in market places, and even an elephant parading with promotional banners to draw attention to the event.

## **5 Major Constraints Faced**

The CHILD-II Project and its capacity-building approach was hampered by a chronic shortage of MOHFW staff, especially among thana-level managers and union supervisors in the FP wing. Up to one-third of the positions of Health Assistants (HAs) and Family Welfare Assistants (FWAs) have been vacant in most of the thanas throughout the project period.

In 1997, there was a critical national shortage of EPI cards, which are provided by the MOHFW. This shortage hampered immunization activities for the great part of one year. CARE worked with other providers to print EPI cards locally until the national supply could be replenished.

There was also considerable turnover of CHILD-II Project staff, leading to vacancies that were not always quickly filled. The turnover was largely due to other professional opportunities available elsewhere in CARE/Bangladesh for project staff members, so this turnover was to a large degree generated by career advancement opportunities rather than by dissatisfaction with the work or poor performance.

In August and September of 1998, devastating floods affected 75% of the country, causing severe damage to human life, crops, livestock, and housing. Although the Sylhet area was not severely affected (since it is normally flooded anyway at that time of year), CARE played a major role nationally in flood-relief efforts. During the month of September 1998, many project staff participated in relief efforts in the areas of food, health care, and sanitation in other parts of the country and therefore was not able to conduct normal project activities during that time.

The project area does experience flash floods from time-to-time which disrupt project activities for brief periods.

In 1998, Kanaighat thana, which represents almost half of the project area, experienced a disruption of its electricity supply, preventing the maintenance of the vaccine cold chain and severely hampering EPI activities in the area. The CHILD-II Project handled the situation efficiently (by arranging for a temporary source of electricity after the problem was not promptly resolved) and proved itself capable of solving emergency problems of this type.

## **6 Plans for Continuation of Project Activities**

At the present time, the Project has secured a no-cost extension for four months, and then anticipates "bridge" funding from CARE, the Australian High Commission, and several other sources yet to be finalized to provide support until June 2000. In the meantime, longer-term funding will be sought to provide support after June 2000.

## **7 Financial Report of Expenditures**

As shown in Appendix-0, the total cost of the CHILD-II Project was US\$ 1,275 million, or an average of US\$ 318,764 per year. CARE contributed Twenty-eight percent of this amount, and the USAID PVO Child Survival Support Project contributed the other 72% of project costs. Seven percent of total costs were for indirect costs. Fifty-seven percent of project costs were for personnel.

The costs per beneficiary and their methods of calculation are shown in Table 9. The overall annual cost per beneficiary is only \$1.68 per person per year. The EPI component is the most expensive (and also the most cost-effective as well, although we have not calculated here the actual presumed effect on mortality reduction). Even so, the cost is only \$3.50 per beneficiary per year. The annual cost per beneficiary for each of the vitamin A, CDD and family planning components ranges from only US\$ 0.25 to 0.95.

The benefits arising from other activities supported with these same funds, including management strengthening of the MOHFW, training of MOHFW and CARE staff, and community mobilization activities (all of which have benefits far beyond the four interventions shown below), have not been included in these calculations. The benefits which can reasonably be expected to accrue after the ending of the project (which we can assume to be substantial, based on the findings from the CHILD-I thanas) have not been included in these calculations. Nor have we included the benefits of promoting nutritional improvements beyond vitamin A, which are also substantial. If all of these benefits, which have been achieved with the same financial resources attributed to the four child survival intervention, and their associated costs were included in the analysis, the cost per beneficiary for each of the four child survival interventions would be substantially less than that reported in Table 9.

**Table 9 Calculations of Costs per Beneficiary of CHILD-II Project Activities**

Indicator	Method of Calculation	Result
Overall annual cost per beneficiary	This has been determined by dividing US\$318,764 (the total annual cost) by 189,722 total beneficiaries (mothers 15-49 years of age and children 0-72 years of age)	US\$ 1.68
Annual cost per beneficiary for the EPI component	EPI activities were targeted at 35% of project effort. Assuming this represents the actual expenditure of funds as well, this would imply an expenditure of US\$111,567 per year. The number of pregnant women is 18,655 and the number of children 0-11 years of age is 13,194. Thus, the number of beneficiaries for this intervention is 35,616. The annual cost per beneficiary for the EPI component has been determined by dividing US\$111,567 by 31,816.	US\$ 3.50
Annual cost per beneficiary for the vitamin A component	Vitamin A activities were targeted at 15% of project effort. Assuming this represents the actual expenditure of funds as well, this would imply an expenditure of US\$47,815. The beneficiaries in this case are all women of reproductive age and all children 0-59 months of age, or a total of 189,722 beneficiaries. The annual cost per beneficiary for the vitamin A component has been determined by dividing US\$47,815 by 189,722.	US\$ 0.25
Annual cost per beneficiary for the control of diarrhoeal disease component	CDD activities were targeted at 25% of project effort. Assuming this represents the actual expenditure of funds as well, this would imply an expenditure of US\$76,691. The beneficiaries in this case are all children 0-59 months of age, or 84,027 beneficiaries. The annual cost per beneficiary for the CDD component has been determined by dividing US\$76,691 by 84,027.	US\$ 0.95
Annual cost per beneficiary for the family planning component	Family planning activities were targeted at 25% of project effort. Assuming this represents the actual expenditure of funds as well, this would imply an expenditure of US\$76,691. The beneficiaries in this case are all women of reproductive age, or 88,326 beneficiaries. The annual cost per beneficiary for the family planning component has been determined by dividing US\$76,691 by 83,326.	US\$ 0.87

## **8 Issues Identified by the Evaluation Team, Project, or PVO**

The only significant issue which the Evaluation Team felt was worth noting is that the MTE recommended that a separate final KPC survey be carried out at the time of the Final Evaluation in the CHILD-I thanas and in the non-CHILD thanas. This was not done.

Given the importance of this project and the impressive achievements attained, carrying out these surveys would presumably provide additional helpful evidence documenting the continued progress in CHILD-I thanas as well as documenting progress in the non-CHILD thanas as a result of "spill over effects" and "cross fertilization" of ideas within the district.

The final results for the CHILD-II area are based on the KPC survey of 300 mothers who have 0-23-month-old children. Since the survey ended up with information on only 110 children 12-23 months of age, the findings for this age group have a 95% confidence interval of +/- 12% (or a 90% confidence interval of +/- 10%). The project's achievements would be more convincingly documented if a standard EPI cluster sample survey of 210 respondents who are mothers of children 12-23 months of age was carried out in the CHILD-II Project area, so that a 95% confidence interval of only +/- 10% could be assured. However, the additional effort and expense may not be worth the additional precision obtained.

## **9 Lessons Learned**

### **9.1 Project Strategy**

The Evaluation Team was unanimous in its view that the strategy employed by the CHILD-II Project is highly appropriate to the current context of service delivery in Bangladesh. The strategy involves the strengthening of outreach service delivery sites, the integration of services between the Health and FP wings of the MOHFW, and the strengthening of MOHFW management and community participation at the thana level and below.

It was the Evaluation Team's observation that the project strategy, while effective, requires several years before progress at the field level can take hold and be documented. But the strategy will pay off in the longer run if persistence and patience can be maintained. The progress made between the initiation of the CHILD-II Project and the time of the MTE was very modest compared to the impressive gains achieved between the time of the MTE and the time of the final evaluation. The project strategy requires a strong NGO with highly competent staff and the institutional strength to develop a mutually respectful partnership over a long period of time.

### **9.2 Project Staffing**

The Evaluation Team was highly impressed with the professional capacity, the commitment, the enthusiasm, and the dynamism of the CARE-II Project staff members. The relationships of mutual respect and trust, which have emerged between CARE-II Project staff members and MOHFW staff members were a delight to observe.

### **9 3 Ministry of Health and Family Welfare**

The MOHFW, from the district-level officials (Civil Surgeon and Deputy Director for Family Planning) down to thana-level and union-level staff members, all expressed appreciation to the CARE-II Project for the many contributions which the project has made to strengthening outreach services in the district

### **9 4 Community**

The Evaluation Team met with many community members during the course of its field visits. There was great appreciation expressed for the improvements in outreach services that the community has now come to enjoy.

## **10 Conclusions**

The findings of the Evaluation Team indicate that the CHILD-II Project has cooperatively and effectively facilitated increases in the management capacity of the MOHFW at the thana level and below in the three thanas where it has worked from 1995-1999 and in the five thanas where the CHILD-I Project worked from 1991-1995 (where also the CHILD-II Project provided limited support from 1995-1999). This enhanced capacity has been sustained and has even spread "spontaneously" to other thanas in the district where the project has not worked directly.

Even when all of the costs of project activities are attributed to the specific benefits of the four project interventions (EPI, vitamin A, CDD, and FP) and the benefits of capacity building of the MOHFW, training of MOHFW staff and CARE-II Project staff, and community mobilization (all of which appear to extend beyond the time and locale of the CHILD-II Project), the overall costs per beneficiary are sustainable in the long run with resources from Bangladesh if the MOHFW and the community are willing to support them with resources which they have readily available to them.

The MOHFW has cooperated effectively with the CHILD-II Project and deserves strong affirmation for its hard work in achieving the results documented by this evaluation.

The partnership between the MOHFW and the CARE/CHILD-II Project has led to greatly increased community participation in the delivery of MCH-FP outreach services. Such participation has been essential in promoting increased utilization of outreach services and in generating local resources, which are needed in order to provide transportation support to field workers and supervisors.

The high level of acceptance of the CHILD-II Project by the MOHFW in the Sylhet District has been due to the transparency of the relationship between the two partners, the mutual trust and respect which has been developed between the two partners, and the willingness and ability of the CHILD-II Project staff to blend into the MOHFW system. The CHILD-II Project staff members and the MOHFW staff members all deserve commendation for being able to achieve such an effective relationship.

There is still a need for further improvements in the range and quality of outreach services in the CHILD-II thanas, but remarkable progress has been made nonetheless

The CARE/CHILD strategy is effective, and the improvements in services, which the strategy helps to make possible, appear to be sustained. However, continued sustainability of the improvements as well as additional improvements in services within the context of the Government of Bangladesh's health sector reform (the Health and Population Sector Program) will require further long-term collaboration between CARE and the MOHFW in the Sylhet District

In summary, a mutually respectful partnership between the MOHFW and the CARE/CHILD-II Project has been developed which has made possible sustainable improvements in outreach service coverage, in management capacity of the MOHFW at the thana level and below, and in increased community participation

## **11 Recommendations**

The partnership in the Sylhet District between the MOHFW and CARE should continue since the MOHFW is eager for this, since the partnership as it now exists represents the results of eight years of fruitful collaboration, and since there are many challenges still to be overcome in improving outreach MCH-FP services in the Sylhet District

In the future, emphasis should be placed on low-performing, hard-to-reach areas within the district. This may mean focusing on specific unions within thanas rather than on the entire thana. The identification of priority areas will require the maintenance of a strong MIS (of the MOHFW) and a strong HIS (of the Project)

The project should consider expansion beyond EPI, vitamin A, CDD, and FP to include control of acute respiratory infections (ARI) and malaria, surveillance for acute flaccid paralysis (AFP), stronger safe motherhood activities, and activities to ensure that arsenic-contaminated tubewells are not being used for drinking water. The project should look for innovative and sustainable approaches that at the same time enhance the capacity of the MOHFW

The project should consider a broader involvement in strengthening management at the thana level and below in the context of HPSP reorganization. As health sector reform progresses, as the two wings of the MOHFW become merged at the thana level, and as local-level accountability and local-level decision-making become stronger, there will need to be ongoing efforts to assist the MOHFW in enhancing its management capacity. CARE is uniquely equipped to do this in the Sylhet District

The CHILD strategy should be replicated in other low-performing areas of the country. In light of the fact that CARE has a long institutional history for more than a decade now in applying this strategy in two areas of the country (in Khulna/Barisal and in Sylhet), CARE should consider developing a new project site in another low-performing area. The MOHFW should consider prioritizing other low-performing areas of the country and encourage the involvement of other NGOs in addition to CARE to work in partnership with the MOHFW to improve performance using the strategy that CARE has developed. However, any other NGOs that work as partners with the MOHFW in implementing the CARE strategy should have the strength to

attract highly capable staff, provide them with high-quality training, and to develop a mutually respectful long-term partnership with the MOHFW

## References

Perry, H , M Siddiqi, P Roy 1999 *Technical Guidelines for Child Survival Interventions in Bangladesh* Dhaka, Ministry of Health and Family Welfare, National Integrated Population and Health Program, and BASICS/Bangladesh

**APPENDIX**

## Appendix A

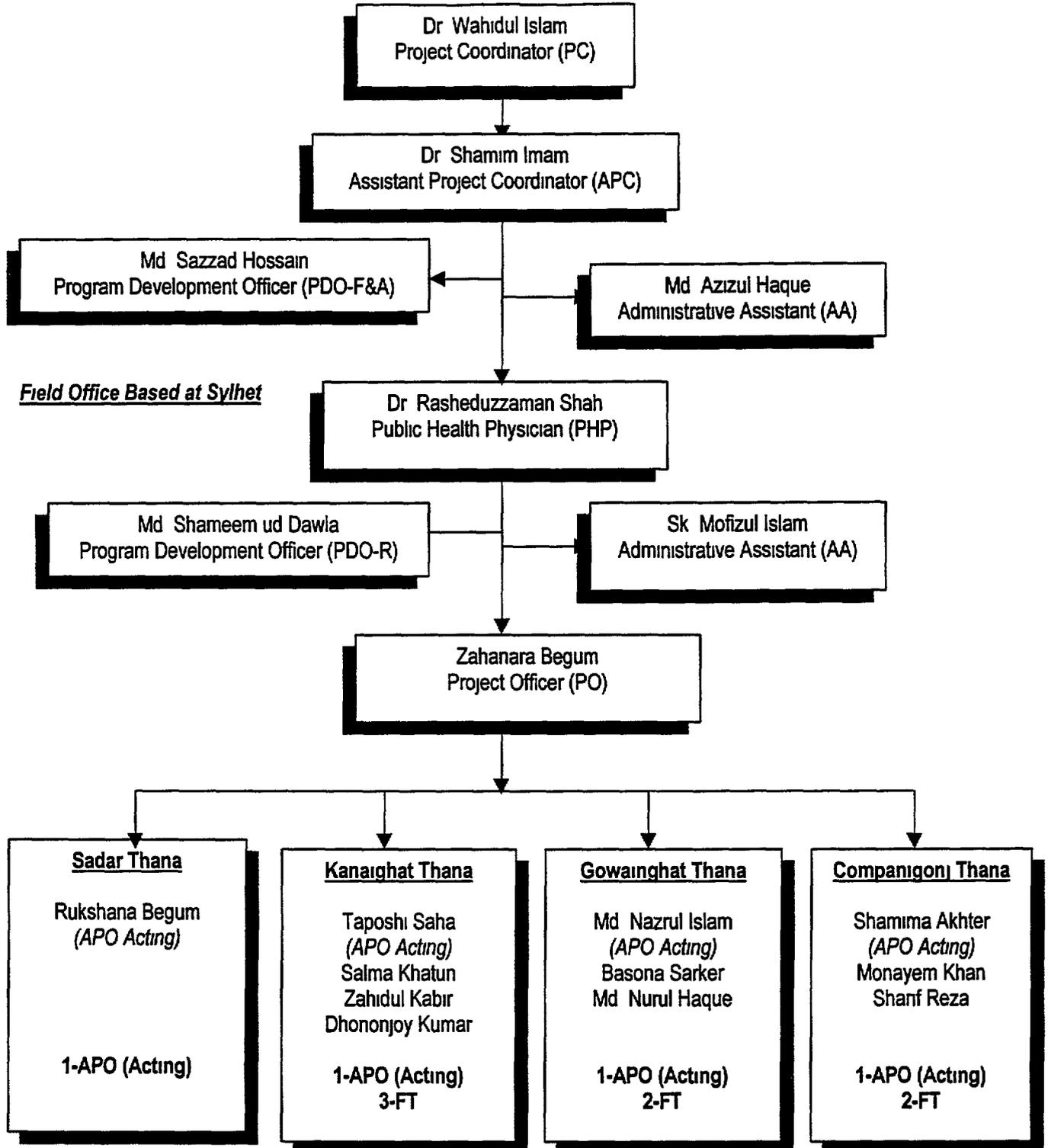
### Beneficiaries of the CHILD-I and CHILD-II Thanas

#### Populations of the Beneficiaries of the CHILD-I and CHILD-II Thanas in the Sylhet District

<b>Thana</b>	<b>Total Beneficiaries</b>	<b>Children 0-11- months of age</b>	<b>Women 15-49 years of age</b>	<b>Children 0-72 months of age</b>
CHILD-I Thanas (five thanas)	488,024	39,709	245,114	242,910
CHILD-II Thanas (three thanas)	189,722	13,194	89,326	100,396
<b>Total</b>	<b>677,746</b>	<b>52,903</b>	<b>334,440</b>	<b>343,306</b>

## Appendix B

### Organizational Chart for CHILD-II Project



**Total Staff of CHILD Project =19 (CBHQ=4) PC 1, APC-1, PDO-1, AA 1, (FO=15) PHP 1, PDO-1, PO-1, AA-1, APO (Acting)-4, FT-7**

## Appendix C

### Objectives and Methodology of the Evaluation

The final evaluation encompasses the four years of activity of CHILD-II Project in Sylhet District from October 1995 until September 1999

#### Overall Purpose

To assess, document, and disseminate the achievements of the CHILD-II Project since its beginning in October 1995

#### Specific Objectives

- To assess the Project achievements in terms of the Project's outputs and outcomes and also to explore reasons for not meeting the objectives (if any)
- To assess improvements in the capacity of the MOHFW partners to plan and implement child survival activities effectively
- To assess the sustainability of Project activities and benefits with particular attention given to assess the phase-out strategy followed in the thanas where the CHILD-I Project worked from 1991 to 1995 and where the CHILD-II Project maintained a minimal presence between 1995 and 1999
- To carry out an assessment of the changes in skill development and improved management practices of MOHFW field staff, supervisors, and managers
- To assess the rationale and effectiveness of new and innovative initiatives undertaken by the Project in order to achieve Project objectives
- To assess progress in the implementation of the Mid-Term Evaluation Response Plan
- To review issues identified by the Evaluation Team, by the Project, or by partners
- To identify and discuss lessons learned
- To highlight achievements of the Project and major constraints that affected Project activities
- To make recommendations regarding the future direction for the CHILD-II Project, particularly in light of the emerging needs for child survival programming within the context of the new Health and Population Sector Program of the Ministry of Health and Family Welfare

#### Methodology

##### Team

The Evaluation Team members are listed in Appendix F. Dr. Henry Perry served as Team Leader. All of the members of the Evaluation Team were present during the Team's activities in Sylhet and also were present for the dissemination of Team findings to MOHFW officials in Sylhet.

### **Process**

Prior to beginning of the evaluation, the Evaluation Team reviewed the basic documents describing the Project and its progress. The Team held its first meeting in Sylhet on August 16. At that time, the Project staff presented the Project goals, objectives, and achievements (as documented in the final KPC survey). The Team developed a plan for field visits, interviews with key informants (including CHILd-II Project staff members, MOHFW staff at the district, thana, and field levels, local NGO workers, and beneficiaries), discussions, and document review leading to the final debriefing session in Sylhet on August 20 (see Appendix E).

After completion of the Evaluation Team's activities in Sylhet, Dr. Perry worked on the Final Evaluation Report with the CHILd-II Project staff based in Dhaka, along with Dr. Rasheduzzaman, Public Health Physician, and Mr. Shameem-ud-Dawla, Program Development Officer. Prior to the finalization of the report, comments were incorporated from other members of the Evaluation Team and from CHILd-II Project staff members. The final version of the report was completed after Dr. Perry returned to the United States.

The Evaluation Team was well balanced, representing a rich diversity of expertise and experience. The Team functioned smoothly and was able to achieve consensus on all of its conclusions.

### **Dissemination**

The findings of the Evaluation Team were shared in a two-hour seminar with MOHFW managers and supervisors and NGO representatives from throughout the Sylhet District on August 20 in Sylhet Municipality. Another dissemination seminar was held in Dhaka on August 24 which was attended by senior MOHFW managers, representatives from different donors (USAID, DFID), international organizations (WHO, FPMD, MSH, UFHP, World Vision, and PLAN International), and senior CARE staff. Findings of the evaluation were also shared in a meeting with representatives of the Department for International Development of the British High Commission in Dhaka. The meeting scheduled with USAID representatives had to be canceled.

### **Constraints**

The field visits and time spent by the Evaluation Team in Sylhet were reduced by one day because of a national holiday on August 15 and because of difficulties in coordinating the schedules of the Evaluation Team members. Therefore, the thoroughness of the field activities was less than optimal, although nonetheless still quite adequate. Meetings with the Director General for the Directorate of Health Services and with USAID had to be canceled because of a national strike on August 22.

## Appendix D

### Training Provided to MOHFW Staff by CHILD-II Staff and Training Provided to CHILD-II Staff

Training course	Number of staff members trained	Category of staff member trained
Supervisor training	79	HI, AHI, FPI, FWV, Sr FWV
Refresher training on EPI and FP	167	HA, FWA
Training on CtC and PAL/Simulation	52	HA, FWA
FWA register	85	FWA
Supervisory checklist	79	HI, AHI, FPI, FWV, Sr FWV
Orientation on special events	246	HA FWA Supervisor
HA register	82	HA
30 cluster sample survey	246	HA, FWA and Supervisor
AFP surveillance	20	HI, AHI

### Training Courses Attended by CARE-II Staff, July 1998 - July 1999

Training Program/Workshop and Place	Person Attending the Conference (and Number of Days Attended)													Total person days
	Rashed	Shameem	Maksuda	Zahanara	Rukhsana	Mofiz	Taposhi	Shamima	Nazrul	Sharif	Munayem	Basona		
Performance Management at CBHQ (2) and Sylhet (1)	2	1	1	2	1	1	1	1	1	1	1	1	1	14
Computer Training - National computer Ltd						10								10
Project Support Operation - CBHQ	4													4
Epidemiology & Biostatistics ICCDR B		28												28
Basic PHC - VHSS			6						6		6			18
LRSP Regional Workshop - BARD Comilla	2		2				2							6
Motorcycle Maintenance - Sylhet MPFO				1	1		1	1	1	1	1	1	1	8
AFP Surveillance - Sylhet MPFO			1		1		1	1	1	1	1	1	1	8
Partnership Workshop - CBHQ			3											3
Gender Training BRDTI Sylhet	4	4		4		4								16
National Partnership Workshop BARD Comilla			4											4
Initiative Inquiry - BRWC			1											1
Monitoring & Evaluation Sylhet MPFO				1	1		1	1	1	1	1	1	1	8
FP Integration Workshop - CDM Gazipur	7													7
TOT on Integration of FP - CDM Gazipur	7													7
Pre-disaster Planning Workshop - Chittagong	3													3
TOT on Supervisor Training - Sylhet MPFO	1			1	1		1	1	1					6
TOT on Gender Development - CBHQ			5											5
Health Sector Retreat Sundarban	4	4					4							12
Project Proposal Writing - H&P Sector CBHQ	1													1
Financial Management - NRT Dhaka	5													5
National LRSP Workshop - Cox s Bazaar	3													3
NGO Mapping & Management Needs														0
Assessment Workshop - ADAB BRDTI Sylhet														0
Finance and Administration Workshop - CBHQ						3								3
Child Survival Workshop CDM Gazipur	6		6											12
Partnership Policy Workshop CDM Gazipur			2											2
Materials Development BARD Comilla				6										6
Team Building - CBHQ		4			1		1	1	1	1	1	1	1	11
Foundation Management Workshop - CBHQ					5									5
<b>Total Person-days</b>	<b>49</b>	<b>41</b>	<b>31</b>	<b>15</b>	<b>11</b>	<b>18</b>	<b>12</b>	<b>6</b>	<b>6</b>	<b>11</b>	<b>11</b>	<b>5</b>	<b>216</b>	

Training Program/Workshop and Place	Person Attending the Conference (and Number of Days Attended)											Total Person-days
	Nurul	Zahid	Dhanajay	Salma	Ataur	Dwijen	Dalim	Zaman	Bulbul	Sushanta	Selina	
Performance Management at CBHQ(2) or Sylhet (1)	1	1	1	1	1	1	1	1	1	1	1	11
Computer Training - National Computer Ltd												0
Project Support Operation - CBHQ												0
Epidemiology & Biostatistics - ICCDR,B												0
Basic PHC - VHSS	6	6	6					6	6	6	6	42
LRSP Regional Workshop - BARD Comilla				2								2
Motorcycle Maintenance - Sylhet MPFO	1	1	1	1	1	1	1	1	1	1	1	11
AFP Surveillance Sylhet MPFO	1	1	1	1	1	1	1	1	1	1	1	11
Partnership Workshop - CBHQ												0
Gender Training - BRDTI Sylhet	4				4	4		4				16
National Partnership Workshop BARD Comilla												0
Initiative Inquiry - BRWC												0
Monitoring & Evaluation Sylhet MPFO	1	1	1	1	1	1	1	1	1	1	1	11
FP Integration Workshop - CDM Gazipur						7						7
TOT on Integration of FP - CDM Gazipur												0
Pre-disaster Planning Workshop Chittagong							4					4
TOT on Supervisor Training Sylhet MPFO	1			1	1	1	1					5
TOT on Gender Development CBHQ												0
Health Sector Retreat - Sundarban	4											4
Project Proposal Writing H&P Sector CBHQ												0
Financial Management NRT Dhaka												0
National LRSP workshop Cox's Bazaar												0
NGO Mapping & Management Needs								3				3
Assessment Workshop ADAB BRDTI Sylhet												0
Finance and Administration Workshop - CBHQ												0
Child Survival Workshop CDM Gazipur												0
Partnership Policy Workshop CDM, Gazipur												0
Materials Development Workshop - BARD Comilla												0
Team Building Workshop - CBHQ	1	1	1	1	1	1	1	1				8
Foundation Management Workshop - CBHQ						5	5					10
<b>Total Person-days</b>	<b>20</b>	<b>11</b>	<b>11</b>	<b>8</b>	<b>22</b>	<b>19</b>	<b>6</b>	<b>18</b>	<b>10</b>	<b>10</b>	<b>10</b>	<b>115</b>

## Appendix E.

### Response of the Project to Mid-Term Evaluation Recommendations

The Mid-Term Evaluation (MTE) contained 13 recommendations, each with a number of specific sub-recommendations. The Knowledge, Practice and Coverage (KPC) survey that was carried out at the time of the MTE showed minimal progress in improving coverage rates. The main thrust of the MTE was to shift Project activities more forcefully to the community level.

This Project leadership managed this change in emphasis by assigning each of three Assistant Project Officers (APOs) specifically to one thana and by limiting his/her responsibilities to that thana. Previously, each APO had other responsibilities in addition. Once this shift had occurred, a massive four-month effort was undertaken with the MOHFW field staff to update the household registers. This effort involved visiting 60,000 households.

A stronger focus on the community level was possible after the MTE because the Project completely withdrew the lower-level staff from two CHILD-I thanas at that time. The Information Banks were selected and trained after the MTE.

**Recommendation 1 Increase the awareness between MOHFW and CHILD-II staff members regarding the Project's achievements and importance of the partnership**

As a result of increasing experience with the Project and continued joint meetings, the staff members from the MOHFW and from CARE/CHILD-II are gaining a better appreciation of the Project's achievements and the importance of the partnership.

**Recommendation 2 The Project's indicators do not demonstrate progress in improving quality and capacity strengthening. Therefore, 4-6 new indicators should be developed and monitored**

It was not possible to change the Project's key goals and objectives nor the indicators to measure these. The Project's health information system (HIS) contains a number of indicators regarding quality and capacity strengthening which are being routinely monitored as process indicators even though they are not outcome indicators for the Project. A quality checklist for outreach sessions was simplified after the MTE.

**Recommendation 3 Review staffing pattern in order to strengthen CHILD-II staff support at the thana level and below**

As mentioned above, this was carried out and Project staffing was strengthened within the three CHILD-II thanas.

**Recommendation 4 Review performance standards for Field Trainers in the Project and current needs for further training. Provide additional training and support to narrow the gap between standards and performance**

This was carried out. In addition, a training manual for Field Trainers was developed.

**Recommendation 5 Update the quality checklist for outreach activities and share the findings arising from quality monitoring with local-level staff**

The quality checklist for outreach activities was reduced to one page in length. At the end of the outreach session, the findings from the checklist are now reviewed with all parties. The monitoring findings are also now reviewed in monthly union meetings of field staff (usually attended by 7-8 HAs/FWAs along with their supervisors). The findings are also shared at the thana-level meetings as well.

**Recommendation 6 Assess the feasibility for including ARI and malaria detection and treatment as part of Project activities since ARI is the leading cause of death among children in Bangladesh and since malaria is endemic in selected parts of the Project area**

Given the fact that the Project was behind on its schedule in achieving its goals and objectives when the MTE was carried out, the Project leadership did not feel it would be wise to add major new interventions during the last two years of the Project. There were several geographic areas in the CHILD-I thanas where the Project did assist in strengthening malaria treatment activities. The MOHFW National ARI Project was also working in four thanas of the district, thereby diminishing the need for the Project to invest in ARI activities. Finally, neither CARE as an organization nor the Project's leadership felt comfortable in changing course in "mid-stream" by adding new goals and objectives that had not been previously agreed to with USAID in Washington.

**Recommendation 7 Shift the focus of monitoring to the union and ward levels, and consider three KPC surveys at the completion of the Project - in the CHILD-II thanas, in the CHILD-I thanas, and in the non-CHILD thanas**

The focus of monitoring did shift to the union and ward levels, and this was one of the factors that led to markedly improved program performance. The Project staff did not feel that the other two KPC surveys (in the CHILD-I and non-CHILD thanas) were essential, so this recommendation was not followed through.

**Recommendation 8 Search for continuation of funding for Project activities**

The Project is in the process of securing "bridge" funding to allow it to continue in a limited form until June 2000. The search for longer-term funding is actively underway.

**Recommendation 9 Develop applied research capability**

The Project upgraded the status of the HIS Officer for the Project, Mr. Md. Shameem-ud-Dawla, to Project Development Officer (Research). Mr. Dawla assisted the Sylhet District MOHFW in 1998 and 1999 to carry out an EPI coverage survey in each of the thanas of the district. Mr. Dawla led the evaluation of the Child-to-Child participatory learning activity. Mr. Dawla also supervised two students in social work from Sylhet University who carried out research projects for their master's thesis in collaboration with the Project.

**Recommendation 10 Assess options to decrease the cost and improve the quality of curative services**

This recommendation was not carried because it was not considered a priority.

**Recommendation 11 Recognize good performance among MOHFW workers**

Prizes, awards, and certificates were given to MOHFW field workers for outstanding performance. This activity helped to improve morale among the MOHFW staff.

**Recommendation 12 Address EPI logistics problems**

CARE did begin to work with the national EPI headquarters office in Dhaka regarding supply problems. Several times CARE vehicles carried supplies directly from Dhaka to Sylhet when the MOHFW transport system was not functioning. CARE provided money to print EPI cards when a national shortage of EPI cards developed. CARE also provided assistance in obtaining a new supply of syringes and needles since those in use had worn out. In one thana (Kanaighat), electricity was unavailable for three months, making it impossible to store vaccines there and therefore temporarily halting the entire EPI program in the thana. CARE provided assistance making temporary electricity possible until the regular system was repaired.

**Recommendation 13 Resolve discrepancies between tally and survey estimates of EPI coverage**

CARE was not able to address this issue because of priority given to other activities.

## Appendix F.

### Final Evaluation Schedule and Activities

#### Monday August 16

Evaluation Team members traveled to Sylhet and met with CARE-II Project staff to review Project objectives and findings from the KPC. The Team met to make plans for field visits, including establishing a strategy for conducting field visits. The guidelines for each field visit are shown below. The Team divided into three sub-teams for field visits (see table below). Several CHILD-II Project staff members accompanied each Sub-team.

#### Tuesday August 17

The Team visited Beanibazar Thana (a non-CHILD thana), Balanganj Thana (a CHILD-I thana), and Gowainghat Thana (a CHILD-II thana). The Team met at the end of the day to discuss observations from field visits.

#### Wednesday August 18

The Team visited Jamalganj Thana (a BATCHA thana in Sunamgonj District, adjacent to Sylhet District), Zakiganj Thana (a non-CHILD thana), and Companigonj Thana (a CHILD-II thana).

#### Thursday August 19

The Team visited Jointapur Thana (a CHILD I thana), Sadar Thana (a CHILD I thana), and Kanaighat Thana (a CHILD-II thana). Sub-team I also met with the Deputy Director for Family Planning, the Civil Surgeon, and local NGO representatives.

The Team met at the end of the day to discuss observations from field visits on Tuesday and Wednesday. The Team met to consolidate the observations of the field visits.

#### Friday August 20

The Team reviewed again the findings from the KPC survey as well as the original goals and objectives of the Project. The Team developed its summary conclusions and recommendations. The Team finalized its plans for the debriefing session. The debriefing session was held with representatives of the MOHFW and NGOs. Dr. Rasheduzzamam Shah served as Announcer for the occasion. Dr. Wahidul Islam, Project Coordinator, presented the Project Goals, Objectives and Methodology. Dr. Shamim Imam, Assistant Project Coordinator, presented the Evaluation Objectives and Methodology. Dr. Khairul Islam, Evaluation Team member, made a presentation on the Project's achievements in building MOHFW capacity. Dr. Saqui Khandoker, Evaluation Team member, made a presentation of the Project's achievements in mobilizing community participation and community resources. Dr. Henry Perry, Evaluation Team leader, presented the Findings of the KPC Survey, Summary Conclusions, and Recommendations. Dr. S. M. Asib Nasim, Evaluation Team member, led the Question and Answer session. Mr. James Setzer, Evaluation Team member and representative of the CARE-USA Office in Atlanta, gave the Vote of Thanks.

Field Visitation Schedule of Evaluation Team			
Date	Sub Team Composition		
	Sub Team 1 Dr Asib Nasim, Team Leader Dr Henry Perry Dr Shamim Imam Dr Rasheduzzaman Shah	Sub Team 2 Dr Khairul Islam, Team Leader Mr Jim Setzer Mr Subrata Kumar Dey Ms Jahanara Begum	Sub-Team 3 Dr Saqui Khandokar, Team Leader Dr Wahidul Islam Mr Shameem ud-Dawla
17 August 1999	Beanibazar (non-CHILD thana)	Balanganj (CHILD-I thana)	Gowainghat (CHILD II thana)
18 August 1999	Companigonj (CHILD-II thana)	Jamalganj (BATCHA thana in Sunamgonj District)	Zakiganj (non-CHILD thana)
19 August 1999	Sadar (CHILD-I thana), meet with Deputy Director of Family Planning and Civil Surgeon	Kanaighat (CHILD-II thana)	Jointapur (CHILD I thana)
20 August 1999	Preparation of summary findings Debriefing and presentation of findings to local partners		

Guidelines for Information to Be Collected by Evaluation Team Members at the Time of Site Visits to Thana Health Complexes and Outreach Sites				
Activity to Be Carried Out	Site of Activity			
	EPI Outreach Session	Satellite Clinic Session	Merged EPI Outreach/Satellite Clinic Session	Thana Health Complex
Observe quality	Complete quality checklist Observe counseling about side effects, card retention, and next visit date	Complete quality checklist	Same	Not applicable
Talk with providers	Ask about knowledge of childhood and maternal immunization schedule Ask about inputs which CHILD II Project has made Ask about satisfaction with training	Ask about the plan for locating injectable clients who did not come for the session (but who were scheduled to come) Ask about knowledge of side effects of birth control pills and contraindications to recommending birth control pills	Same	Not applicable
Talk with and observe supervisors	Ask about inputs from the CHILD II Project Observe nature of supervision	Same	Same	Not applicable
Talk with community volunteers and community partners	Ask what they are doing and why Ask what training has been provided	Same	Same	Not applicable
Talk with members of the Union <i>Panshad</i>	What do they do to promote MCH FP outreach services and why? What has been their role in promoting special events (Vitamin A Week, NIDs, etc )? What has been their role in generating local resources to promote MCH FP	Same	Same	Not applicable

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**Guidelines for Information to Be Collected by Evaluation Team Members at the Time of Site Visits to Thana Health Complexes and Outreach Sites**

Activity to Be Carried Out	Site of Activity			
	EPI Outreach Session activities?	Satellite Clinic Session	Merged EPI Outreach/Satellite Clinic Session	Thana Health Complex
Talk with clients	Ask who told them to come to the session Did they bring their EPI card? What is their opinion about the behavior of the service providers? Are they satisfied with the services? What other services do they need at the outreach site? When are they supposed to return to the outreach site? Ask if they participated in Vitamin A Week and if not why not Ask if their child had diarrhea during the previous two weeks and, if so, what did they give to the child Ask if the mother had ever received any orientation about the prevention and treatment of diarrhea	Same	Same Ask about satisfaction with merging	Not applicable
Review MIS forms for the session	Determine if forms being filled out correctly	Same	Same	Not applicable
Talk with CARE/CHILD II Project field staff based in the thana				How has the CHILD II Project been effective? What is your job description? What kind of training have you received and what is your opinion about it? What kind of support a vision have you received?

**Guidelines for Information to Be Collected by Evaluation Team Members at the Time of Site Visits to Thana Health Complexes and Outreach Sites**

Activity to Be Carried Out	Site of Activity			
	EPI Outreach Session	Satellite Clinic Session	Merged EPI Outreach/Satellite Clinic Session	Thana Health Complex
Meeting with thana level staff at the Thana Health Complex Thana Health and Family Planning Officer, Thana Family Planning Officer, Medical Officer for Disease Control, Medical Officer (MCH), EPI Technician, Health Inspector and Senior FWV				What has the CHILD II Project been doing in your thana? What is your planning process? Did CHILD II making a contribution to this? What support has the CHILD II Project provided to strengthen supervision? Is there an MIS control room? (observe) Is there a demographic profile for the thana? Who made this?

## Appendix G

### Members of the Final Evaluation Team

- Ms Zahanara Begum, Project Officer  
CHILD-II Project, CARE-Bangladesh  
Sylhet, Bangladesh
- Mr A B M Shameem-ud-Dawla, Project Development Officer (Research)  
CHILD-II Project, CARE-Bangladesh  
Sylhet, Bangladesh
- Mr Subrata Kumar Dey, Technical Officer  
BATCHA Project, CARE-Bangladesh  
Sylhet, Bangladesh
- Dr Shamim Imam, Assistant Project Coordinator  
CHILD-II Project, CARE-Bangladesh  
Dhaka, Bangladesh
- Dr Khairul Islam, Director  
Program Development Support  
PLAN International-Bangladesh
- Dr Wahidul Islam, Project Coordinator  
CHILD-II Project, CARE-Bangladesh  
Dhaka, Bangladesh
- Dr Saqui Khandoker, Essential Services Package and Quality Assurance Officer  
Bangladesh Population and Health Consortium
- Dr S M Asib Nasim, Program Coordination Cell  
Ministry of Health and Family Welfare  
Dhaka, Bangladesh
- Dr Henry Perry, International Public Health Specialist (Team Leader)  
Clyde, North Carolina, USA
- Mr James Setzer, Senior Health Advisor, CARE International  
Atlanta, Georgia, USA
- Dr Rasheduzzaman Shah, Public Health Physician  
CHILD-II Project, CARE-Bangladesh, Sylhet, Bangladesh

## Appendix H

### Summary Conclusions Arising from Field Visits of the Evaluation Team

After the three Sub-Teams had completed their visits to the three CHILD-II thanas, three CHILD-I thanas, two non-CHILD thanas, and one BATCHA thana (in neighboring Sunamgonj thana), the following observations were made

#### Observations of the CHILD-II thanas

#### **1 The management capacity of the MOHFW at the thana level and below has been improved**

This has occurred through the following activities

- a Improvements have been made in the planning of coordination meetings and field activities, including increasing collaboration between the Health and FP wings for field activities
- b Regular monthly staff/coordination meetings are now held at the thana and union levels
- c Improvements have taken place in the training of supervisors and in staff development
- d Improvements have taken place in the management information system (MIS) of the MOHFW
- e Improvements have taken place in the monitoring of field activities
- f Improvements have taken place in the supervision of field activities, including joint supervision by Assistant Health Inspectors (who supervise Health Assistants in the Health wing) and Family Health Inspectors (who supervise Family Welfare Assistants in the FP wing)

#### **2 Community participation in MCH-FP activities has increased**

This has occurred through the following activities

- a "Information Banks" (community volunteers such as school teachers, LIP volunteers, TBAs, household heads who offer their houses for EPI Outreach Session, and local opinion leaders who serve to mobilize the local community to attend EPI Outreach Site sessions and Satellite Clinic sessions) have been recruited and incorporated in field activities
- b Members of the Union *Parishad* (elected local officials for a population of approximately 25,000 persons), *Imams* (local Muslim religious leaders), and women have become involved in promoting the utilization of outreach MCH-FP services
- c Awards and prizes have been presented for outstanding contributions made by volunteers
- d Local resources have been generated to support outreach MCH-FP services, especially for transport of MOHFW staff to attend EPI Outreach Site sessions and Satellite Clinic sessions
- e A Child-to-Child Program has been established to involve village children in learning and transmitting basic MCH educational messages throughout the community

**3 The CHILD strategy is an effective one, and the CARE staff has been effective in implementing the strategy**

These conclusions are based on the following observations

- a A strong and mutually respectful partnership between the MOHFW and CARE has emerged
- b The CARE/CHILD Project staff is motivated, dynamic, and well-trained
- c The MOHFW at various levels has made multiple requests for continuation and expansion of CHILD activities in the Sylhet District

**4 The provision of basic MCH-FP services at outreach sites has been strengthened**

This conclusion is based on the following observations

- a The knowledge and motivation of MOHFW field staff have improved as a result of increased training and supervisory support
- b The ability of field staff and supplies to reach outreach sites has improved as a result of improved logistical support, including transportation
- c The utilization of outreach services has improved as a result of the increased availability of services and increased community awareness and involvement
- d The percentage of Satellite Clinic sessions (of the FP wing) which have been merged with EPI Outreach Site sessions (of the Health wing), and the percentage of EPI Outreach Site sessions attended by an FWA (from the FP wing) has increased as a result of collaboration between field staff from the Health and FP wings of the MOHFW and also as a result of improved coordination and planning of managers/supervisors from the two wings at the thana level
- e Client satisfaction has increased as a result of improvements in the availability and quality of outreach services

**5 There are still needs for improvements in field-level services**

This conclusion is based on the following observations

- a Outreach services are still dependent (although to a limited degree) on CARE/CHILD staff to maintain their current effectiveness
- b EPI activities have been emphasized by the Project and are approaching optimal levels. However, there is still considerable room for improvements in the coverage and quality of vitamin A supplementation, CDD activities, and family planning activities. There is also a need for expansion of Project activities to include the other child health components of the new Essential Services Package of the MOHFW and other special initiatives such as polio eradication
- c Inadequacies in the completion of MIS field reports were observed
- d There has been a high turnover of CARE/CHILD-II Project staff that has affected the quality of inputs provided to the Project
- e There has been little innovation with community-based health education during the Project period
- f Establishing stronger linkages between the CARE/CHILD-II Project Office in Dhaka and the MOHFW at the national level would be helpful in resolving problems in service delivery that cannot be resolved at lower levels, such as vacancies in staff positions and lack of essential supplies

## Observations of the CHILD-I Thanas

- 1 **The management capacity and the level of performance achieved at the end of the CHILD-I Project (in 1995) has been sustained**

This conclusion is based on the following observations

- a The planning schedule has been maintained
- b The MIS still functions well
- c A high coverage of EPI and FP services has been maintained
- d The management tools developed during the CHILD-I Project have been applied to other MCH-FP services in the thanas

- 2 **There is an openness of the MOHFW to other partners and to strong community involvement**

This conclusion is based on the following observations

- a The MOHFW appears less resistant now to work with other NGO partners and increasingly recognizes the contributions that NGO partners can make in helping to strengthen MOHFW services
- b The MOHFW now has a strong appreciation for the contributions that the community can make in helping to strengthen outreach MCH-FP services

- 3 **The CARE/CHILD-II Project has effectively maintained a limited presence in the CHILD-I thanas, and the gradual phase-out strategy for the CHILD-I thanas implemented from 1995 – 1999 has been important in sustaining what had been achieved there by 1995**

This conclusion is based on the following observations

- a The CARE/CHILD-II has provided continued (but limited) training, management and logistic support in the CHILD-I thanas
- b CARE/CHILD-II staff members have continued to make occasional visits to the CHILD-I thanas and to the outreach activities there
- c The CARE/CHILD-II Project has assisted the CHILD-I thanas in maintaining community participation

## General Observations

The number of vacancies among field staff and supervisors of field staff has hampered field work. In many thanas of the district, one-third of the positions are vacant.

There is a widespread concern and confusion among the MOHFW staff at the thana level about the reorganization of services currently underway in the context of HPSP.

In the non-CHILD thanas, there is still a marked lack of coordination between the Health and Family Planning wings, a lack of merging of EPI Outreach Site sessions and Satellite Clinic sessions, a lack of attendance of FWAs at EPI Outreach Site sessions, and a lack of effective supervision of field activities.

### Observations Regarding CDD Activities of the Project

The CHILD-II Project did not give as much attention to CDD activities as it did to EPI activities. However, it should be noted that the Project Detailed Implementation Plan assigned 25% of Project activities to CDD activities compared to 35% for EPI activities.

The CHILD-II Project staff members did receive training in CDD, and the Project did facilitate the use of CDD materials at EPI Outreach Site sessions, at Satellite Clinic sessions, and at merged sessions. The Project also promoted the dissemination of CDD messages through its Child-to-Child activities. The training for volunteers (Information Banks) did include CDD, but it did not include guidance in the communication of this information.

The CHILD-II Project staff did work with the local government officials in promoting activities to prevent diarrhoeal diseases.

However, there were no CDD activities included at the thana or district level in the planning process for outreach services. The monitoring indicator for CDD activities (ORT communication meetings) was not included in the MIS nor was it appropriately recorded at outreach sessions.

## Appendix I

### Key Persons Interviewed by the Evaluation Team

Name	Designation	Place of Meeting
Dr Raj Gopal Basak	Civil Surgeon	CS Office
Dr Joyanta Dutta	MO (CS)	"
Dr Jalil	DCS	"
Mr Abul Kasem	EPI Supervisor	"
Mr Abdus Salam	DD FP	FP District Office
Mr Amir Hossain	TFPO Sadar	THC-Sadar
Dr Shammi	MO-Sadar	"
Dr Afroz	MO (Clinic) MCWC	"
Dr Nasreen	MO-Golapgonj	"
Dr Sayeed	MO-Sadar	"
Dr Zia-ur-Rahman	MO-Gowainghat	THC Gowainghat
Dr Gopal	MO (DC), Companigonj	THC Companigonj
Dr Salma	MO (MCH), Companigonj	"
Dr Fayez Ahmed	THFPO Beanibazar	THC-Beanibazar
Mr Jasim Uddin Bhuiyan	TFPO, Beanibazar	TFPO Office Beanibazar
Mr Hamid	EPI-Technician, Gowainghat	THC Gowainghat
Mr Ilias	Health Inspector, Gowainghat	"
Dr Abul Hashem	THFPO, Kanaighat	THC-Kanaighat
Dr Shahrear	MO (DC) Kanaighat	THC-Kanaighat
Dr Shamsul Islam	THFPO, Zakigonj	THC-Zakigonj
Dr Md Ali	MO Beanibazar	THC Beanibazar
Dr Ratna	MO (MCH), Beanibazar	"
Dr Akbar	MO (DC) Beanibazar	"
Mr Shaunik Shaheed	Associate Director FIVDB	CARE-Sylhet Office
Mr Mustafizur Rahman	APO FPAB	"
Mr Sharif Reza	FT CHILD, Companigonj	CARE Office, Companigonj
Mr Munayem Khan	FT-CHILD Companigonj	"
Ms Shamima Akhter	APO-CHILD Companigonj	"
Mr Nazrul Islam	APO-CHILD Gowainghat	CARE Office Gowainghat
Mr Nurul Haque	FT CHILD, Gowainghat	"
Ms Basona	FT-CHILD Gowainghat	"
Ms Taposhi	APO-CHILD, Kanaighat	CARE Office, Kanaighat
Ms Salma	FT-CHILD, Kanaighat	"
Mr Zahid	FT-CHILD Kanaighat	"
Mr Dhanonjoy	FT-CHILD, Kanaighat	"
Ms Ruksana	APO-CHILD, Sylhet	CARE-Sylhet Office
Mr Steve Wallace	Country Director CARE Bangladesh	CARE Staff House
Dr Pierre CLAQUIN	Team Leader, IOCH Project, MSH	BASICS Office Gulshan
Mr Frank Atherton	Health & Population Advisor, DFID	DFID Office British High Commission
Alec Mercer	Program Manager (NGOs) DFID	"
Dr E G P Haran	Sr Health Advisor, IOCH Project, MSH	BASICS Office, Gulshan

## Appendix J.

### Methodology for Final KPC Survey

The methodology for this KPC rapid survey follows the outlines for the cluster survey recommended by Child Survival Support Program (CSSP) of Johns Hopkins University

#### THE QUESTIONNAIRE

The questionnaire contains 46 questions, some with multiple sub-sections. The questions are derived from the matrix of the Knowledge, Practices and Coverage (KPC) Questionnaire recommended by the Child Survival Support Program of the Johns Hopkins University to be used for the PVO Child Survival Program. Based on the experience gained during the three different surveys in the CHILD-I Project, we adjusted and refined the questionnaire in order to better reflect the particularities of the area and of the Project interventions.

The questionnaire is made up of four main sections related to the specific interventions of the CHILD-II Project, including questions on breastfeeding and nutrition, on diarrhoeal diseases, on immunization and on maternal care. The revised questionnaire, initially written in English, was translated into Bangla and pre-tested. The final version is attached in the Appendix K.

- Questions 1-5 demographic data
- Questions 6-15 breastfeeding, weaning knowledge and practice
- Questions 16-25 knowledge and practice of diarrhoeal disease case management
- Questions 26-35 vaccination knowledge and treatment
- Questions 36-45 maternal care
- Question 46 mother's education

#### SAMPLE SIZE AND CLUSTER SELECTION

The method for determining the sample size for the Rapid KPC survey is based on the following random sampling formula

$$n = z^2(pq)/d^2 = 96$$

where n = sample size (to be determined)  
z = statistical certainty (95%) = 1.96  
p = estimated prevalence = 0.5  
q = 1 - p = 0.5  
d = precision desired = 0.1 (this is adequate for management purpose)

The value of "z" corresponds to the confidence limits of the survey result. It was decided that for EPI coverage, the confidence limits of 95% would be adequate. This means that a 95% probability that the results obtained from the survey would lie within  $\pm 10\%$  of the true population value means that if 100 separate surveys were carried out, in 95 of these surveys, the coverage findings would lie within 10 percentage points of the true value. Consulting standard statistical tables for values for "z" for the normal deviate, a value of 1.96 for "z" corresponds to a level of accuracy of 95%. The values for "p" and "q"

correspond to the proportion of persons in the population who are immunized (p) and not immunized (q). The addition of "p" and "q" must equal 1.0. Of course, if these proportions were actually known beforehand, there would be no need to take a sample. The survey planner, therefore, is faced with making a best guess. As "n" in the formula is maximized when a value of 0.5 is assigned to both "p" and "q", this value was adopted.

Solving the formula

$$n = (1.96)^2(0.5)(0.5)/(0.01)^2 \\ = (3.84)(0.25)/(0.01) = 96$$

To compare the 1995 baseline data for the CHILD-II Project area and the mid-term 1997 data with the final evaluation data, we have kept the same method and rationale for calculating the sample size. Taking the diarrhoea prevalence during the last two weeks of 20% (WHO estimation) as the determinant indicator, we calculated a sample size of 300 interviews to get valid results within a 95% confidence limit of  $\pm 10\%$ .

The sample included 300 mothers 15 to 49 years old with a child under the age of two years. The standardized WHO 30-cluster sampling method was used and the population figures of the 1991 Census were updated (based on GOB population growth estimates for Sylhet) to provide an estimate for the population in 1995. The ward was taken as the sampling frame to calculate the cumulative population and randomly select the clusters. Within the selected wards, one village was then randomly selected. The method for visiting households in each cluster followed the usual steps for random selection (as per WHO guidelines for the 30-cluster EPI coverage survey).

To avoid potential bias during data collection, the CHILD-II Project hired external surveyors. The survey team included 15 interviewers and 12 supervisors. The survey was conducted on two days in July 1999 following two days of training for the survey team. Following the data collection activity, there was a one-day feedback session with interviewers and surveyors. The data was entered using EPI-INFO software. Mr. Shameem-ud-Dawla, Program Development Officer (Research) carried out a preliminary analysis of the findings.

## DATA MANAGEMENT

The questionnaires were reviewed to ensure that all items had been corrected/completed, that the correct respondents had been interviewed and that items of information recorded was consistent with one another. The interviewers, with the help of the CHILD-II Project staff, carried out the editing.

## METHOD FOR DATA ANALYSIS

Computerization of data included a number of activities:

- data entry in the computer files,
- checking accuracy of data in the files,
- validation of data on the file by conducting consistency checks between interrelated variables,
- construction of working computer files to produce tables for preparation of the report.

Data were entered using the EPI-INFO computer software. Analyses with EPI-INFO included frequency distributions of all variables, cross-tabulation with specific variables (such as the age of the child), and comparison with previous survey results.

The data entry into EPI-Info version 6.0 was done by two teams of two persons, with each team composed of one survey member and one person skilled in data entry process. The frequency distribution of all variables, cross-tabulation with specific variables such as age and sex, and comparison with the baseline and MTE KPC surveys were completed later.

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## Appendix K

### KPC Survey Findings

#### Promotion of Immunizations

At the time of the baseline survey, 60% of mothers reported that they had never had an immunization card for their child. At the time of the final evaluation survey, only 10% of mothers reported that they had never had one. The percentage of mothers who were able to show the interviewer their child's immunization card increased from 26% to 80%. At the time of the final evaluation, the percentage of children 12-23 months of age with card-documented receipt of specific antigens was as follows:

BCG	77%
OPV1	77%
OPV2	77%
OPV3	72%
OPV4	61%
DPT1	77%
DPT2	77%
DPT3	73%
measles	75%

As reported earlier, the percentage of 12-23-month-old children who had completed all their immunizations (as determined by information on the immunization card as well as by reports of the mother) increased from 22% to 91%, and card-documented coverage increased from 16% to 72%.

Drop out rates among children 12-23 months of age declined between the baseline and final evaluation surveys as shown below:

Changes in Drop out Rates		
Drop out Indicator	1995 Baseline Survey results	1999 Final Evaluation Survey results
BCG to measles	43%	2%
DPT1 to measles	data not readily available	2%
DPT1 to DPT3	35%	5%
DPT3 to measles	data not readily available	data not readily available

The percentage of mothers who knew that her child should receive its measles immunization at 9-11 months of age increased from 32% to 71%, and the percentage who did not know the proper age of measles immunization declined from 50% to 22%.

The percentage of mothers who never had a maternal immunization card decreased from 71% to 28%, and the percentage able to show their maternal immunization card to the interviewer increased from 13% to 49%. Card-documented coverage of maternal TT immunization improved as shown below

Changes in Maternal Tetanus Toxoid Immunization Coverage		
TT indicator	1995 Baseline Survey results	1999 Final Evaluation Survey results
Never received a TT immunization (according to information on the maternal immunization card)	1%	0%
Received at least one TT immunization dose during the most recent pregnancy (according to information provided by the mother)	41%	86%
Received two or more TT immunization doses during the most recent pregnancy (according to information provided by the mother)	31%	73%
Received two or more TT immunization doses during the most recent pregnancy (according to information on the maternal immunization card)	8%	46%

The percentage of mothers who knew that TT immunization protects both the mother and the child increased from 12% to 72%. The percentage of mothers who know that two or more doses of TT immunization are needed to provide protection was already 93% at the time of the Baseline Survey and showed no further improvement at the time of the Final Evaluation Survey.

### Promotion of Vitamin A Consumption<sup>1</sup>

The percentage of children 12-23 months of age who received a vitamin A capsule during the previous six months increased from 52% to 74%. Infants under 12 months of age only receive vitamin A at the time of immunization, and mothers may not have been aware that their child was receiving vitamin A, so we have not included the findings here for 12-23-month-old children.

The percentage of mothers who know that vitamin A prevents night blindness increased from 13% to 79%, and the percentage of mothers who know that green leafy vegetables prevent night blindness increased from 10% to 68%. Similarly, the percentage of mothers who knew that yellow fruits prevent night blindness increased from 4% to 54%, and for meat, 3% to 36%. The percentage of mothers who know to add vitamin-A rich foods when complementary foods are being introduced increased from 32% to 79%.

<sup>1</sup>We should point out here that the policy of the MOHFW regarding the distribution of vitamin A capsules in order to prevent vitamin A deficiency is currently as follows: Mothers should receive a single dose of 200,000 international units of vitamin A during the post-partum period (preferably during the first two weeks, but not later than 4-6 weeks after giving birth). During the first year of life, an infant should receive a single dose of 100,000 international units of vitamin A at the time of receiving the measles immunization (at or as soon as possible after 39 weeks of age has been attained). After reaching 12 months of age until reaching 59 months of age, the child should receive 200,000 international units every six months (at the time of the National Immunization Day, usually in December or January, and at the time of National Vitamin A Week, usually in May or June). Formerly, children up to 72 months of age were included in the vitamin A distribution program, and hence children 0-72 months of age were chosen as the age group of childhood beneficiaries when the Detailed Implementation Plan was prepared in 1995 (Perry et al., 1999).

## Control of Diarrhoeal Diseases

The percentage of children with diarrhoea during the previous two weeks did not appear to change any during the course of the project 23% in 1995, 29% in 1997, and 18% in 1999 (The baseline survey was carried out in April 1995, a time of high-diarrhoeal incidence The MTE was carried out in August 1997, and the final evaluation in July, 1999, both times of high diarrhoeal incidence) As reported earlier, there are marked improvements in the percentage of mothers who gave the same amount or more breast milk, fluid, and solid food during episodes of diarrhoea The increases were, respectively, 47% to 75%, 49% to 86%, and 13% to 77%

The percentage of mothers who sought advice when their child developed diarrhoea showed no change over the course of the Project At the time of each of the three surveys, approximately two-thirds of the mothers sought some type of advice At the time of the final evaluation, the most frequently sought sources of advice were the village health worker and the TBA

The knowledge of mothers about warning signs of diarrhea for which advice or treatment should be sought was found to be still limited at the time of the final evaluation Only 26% mentioned dry mouth/sunken eyes, only 5% mentioned blood in the stool, and 38% mentioned weakness/tiredness Eighty-eight percent of mothers know to give some type of ORS if her child develops diarrhea, but only 17% of mothers mentioned that they should give more fluids of other types The percentage of mothers who knew to increase food intake when her child is recovering from diarrhea improved substantially The percentage of mothers who knew to increase the number of feedings increased from 9% to 46%, the percentage of mothers who knew to give more food than usual increased from 5% to 39%, and the percentage who knew to give foods with high-caloric intake increased from 39% to 46%

The fact that the percentage of children developing diarrhea did not decline during the period of Project activities is not surprising since the environment in which these children live has not changed in any significant way However, the improvements in knowledge and practice related to treatment of diarrhoea disease that these surveys demonstrate lead to strong presumptive evidence that the mortality from diarrhoeal disease may have declined during the course of the CHILD-II Project

## **Promotion of Family Planning**

The percentage of women of reproductive age who are pregnant did not change over the course of the Project Seven percent of mothers in the Baseline Survey were pregnant compared to 9% in the Final Evaluation Survey The percentage of mothers who reported that they did not want to have another child during the next two years increased from 13% to 38% The percentage of non-pregnant mothers who are currently using contraception increased from 8% to 38% At the time of the Baseline Survey, 76% of those using a method of contraception were using a modern method compared to 67% of those using contraception at the time of the Final Evaluation Survey There were no major changes in the "method mix" among contraceptive users at the time of the Baseline Survey compared to the time of the Final Evaluation Survey

## **Promotion of Breastfeeding, Appropriate Infant Feeding, and Maternal Nutrition**

The percentage of mothers who breast fed during the first hour following delivery increased from 24% in 1995 to 57% in 1999, and the percentage of mothers who gave colostrum to their newborn increased from 54% to 77%

Appropriate infant feeding is still a major challenge as demonstrated by the fact that 86% of infants under three months of age are receiving water and 29% are receiving semi-solid foods. Only a quarter or fewer of mothers are aware that exclusive breastfeeding, avoidance of bottle feeding, and frequent suckling will lead to increased milk production. There is an increased understanding of when complementary foods should be introduced. 21% of mothers in 1995 said 4-6 months compared to 46% in 1999. There is also a greatly increased level of understanding of what food should be introduced. The percentage of mothers who know to add oil to foods increased from 11% in 1995 to 50% in 1999. Similar marked increases were noted for vitamin-A rich foods (32% to 79%) and for iron-rich foods (20% to 78%).

Seventy-seven percent of mothers knew at the time of the final evaluation that eating eggs, fish and meat and eating green leafy vegetables (which are rich in iron) is useful for preventing iron-deficiency anemia during pregnancy. The percentage of mothers who ate less than usual during their previous pregnancy declined from 67% to 28%, and the percentage who ate more than usual increased from 6% to 34%.

The findings related to improvements in knowledge and practice related to infant feeding and nutritional intake during pregnancy are remarkable, especially since these activities were not even part of the Project's objectives as outlined in its Detailed Implementation Plan.

### **Conclusions**

The findings reported from the KPC surveys are remarkable, and perhaps could even be considered extraordinary. One can hardly imagine more impressive results given the environment in which the Project was working and the multiple constraints produced by it.

Although we have not presented the data from the MTE survey, in virtually every case the MTE findings document steady improvement over the baseline rates. But the final evaluation survey results show marked improvement over the MTE survey results. Thus, the findings from the MTE survey serve to confirm the fact that steady progress was being made during the first half of the Project period and that the findings of the baseline and final evaluation surveys are reasonable and accurate.

**Appendix L**

**Samples of Monitoring Forms Used by CHILD-II Project**

**Outreach Session Monitoring Checklist CHILD HIS Form # 3**

Thana \_\_\_\_\_  
 Data Record \_\_\_\_\_  
 Phase Out = 1

Month \_\_\_\_\_  
 Entry Date \_\_\_\_\_  
 Phase In = 2

		1	2	3	4	5	6	Total (Y + N)		
		Y	N							
A	Outreach Site	Union								
		Ward								
		Site								
		Merged = /								
		Non Merged = x								
B	Outreach Site Date									
	Starting time of Session									
	Ending time of Session									
C	Presence of Staff	1 Family Welfare Assistant (FWA)								
		2 Health Assistant (HA)								
		3 TBA/IB/LIP								
D	Logistics	1 FP Methods								
		2 ORS Packet								
		3 Vitamin A Capsule								
		4 Vaccination Card								
		5 Health Education Materials								
		6 Moni Flag								
		7 Vaccine Supply								
E	Counseling									
F	1 Vaccination Sterilization	1 1 Sterilization done in the center								
		1 2 Non-Touch Methods Followed								
2	Vaccine preserver correctly	2 1 Inside vaccine carrier								
		2 2 Outside vaccine carrier								
3	Method of vaccination	3 1 Amount of Dosage								
		3 2 Route								
4	Registration	4 1 Registration Book								
		4 2 Vaccination Card								
		4 3 Tally Form								
G	Counseling on vaccination done									
H	Vitamin A Capsule has given									
I	Session organized									
	Target of the session									
	Achievement of the Session									

Remarks \_\_\_\_\_

Name \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Designation \_\_\_\_\_

**CHILD HIS Form # 3 CHILD Project Satellite Clinic Monitoring Checklist**

Thana \_\_\_\_\_ Month \_\_\_\_\_  
 Data Record \_\_\_\_\_ Entry Date \_\_\_\_\_ Phase Out = 1 Phase In = 2

		1	2	3	4	5	6	Total (Y + N)	
		Y	N						
A	Satellite Clinic Site								
	Union								
	Ward								
	Unit								
	With OR (Merged)								
B	Date of Satellite Clinic								
	Starting time of session								
	Ending time of session								
C	Presence of Staff								
	1 Family Welfare Assistant (FWA)								
	2 Family Welfare Visitor (FWV)								
	3 Health Assistant (HA)								
	4 Family Planning Inspector FPI								
	5 Aya								
	6 TBA/ IB /LIP								
D	Logistics								
	1 Contraceptive Pills								
	2 Injection								
	3 Condom								
	4 IUD								
	5 IUD Kit								
E	MCH								
	1 Iron + Folic Acid								
	2 Vitamin A Capsule								
	3 ORS								
	4 Essential Medicine								
	5 Health & Education materials								
F	Motivation for Health Education Session								
G	Conduction of Clinic								
	1 Privacy maintained								
	2 Sterlization done								
	3 Necessary FP Methods was distributed								
	4 Counseling to the clients								
	5 Updating of the Registration Book								

Remarks

1

Signature \_\_\_\_\_

2

Name of Visitor \_\_\_\_\_

3

Designation \_\_\_\_\_

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## Appendix M

### Summary of Activities Carried Out in CHILD-II and CHILD-I Thanas

#### Activities in CHILD - I Thanas

Output	1998						1999						Total
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	
HA meeting	3	3	3	3	3	3	3	3	3	3	3	3	36
FWA meeting	3	2	2	3	3	3	3	3	2	3	2	3	32
EPI performance monitoring session	3	1	0	3	3	3	1	3	2	3	2	2	26
FP performance monitoring session	2	1	0	3	3	3	1	3	3	3	2	1	25
Findings sharing session with Thana managers	6	5	0	6	6	6	6	6	6	4	6	6	63
FWC review meeting attended by FT	5	3	1	0	3	3	0	3	0	2	2	1	23
Joint community visit of FT with MOHFW staff	12	17	0	6	9	13	10	11	5	9	10	9	111
Individual community visit of FT	0	5	0	0	2	0	1	3	1	10	3	1	26
Visit to OR session jointly with MOHFW managers by FT	4	10	2	0	10	8	9	8	10	6	9	8	84
Visit to MSC session jointly with MOHFW managers by FT	5	5	1	0	8	5	6	6	3	4	11	6	60
Individual visit of FT to OR session	2	0	0	0	10	0	1	0	1	2	1	0	17
Individual visit of FT to MSC session	0	0	0	0	6	0	1	1	1	0	1	1	11
PAL session organized by FT	17	23	0	7	12	9	10	12	9	8	15	9	131
Simulation session organized by FT	2	2	0	0	1	4	1	1	2	2	2	0	17
Other health education session organized by FT	4	0	0	0	2	8	3	9	5	4	7	7	49
Male group counseling on FP by FT	9	9	0	2	10	10	10	9	5	4	8	7	83
ORT group meeting	15	16	0	15	21	17	17	16	17	5	43	13	195
Supervisory visit by PHP and PO	3	7	0	2	1	0	1	2	2	3	3	3	27
Monitoring visit by PDO	3	2	0	4	8	7	6	4	2	2	9	3	50
HIS received	13	13	0	12	19	10	16	14	15	13	14	15	154
OR session planned	889	870	924	802	928	907	811	814	826	800	957	901	10429
OR session held	609	634	838	684	897	837	750	524	720	731	847	826	8897
SC planned	188	0	188	149	188	187	183	182	115	188	188	180	1936
SC held	175	0	164	141	177	171	178	171	115	178	178	180	1828
Merged SC held	174	0	178	141	177	171	178	171	113	177	177	178	1835
Male participation during health education session	132	211	297	50	103	73	42	55	56	32	46	86	1183

## Activities in CHILD-II Thanas

Output	1998						1999						Total
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	
HA meeting	3	4	4	4	4	4	4	4	4	3	3	3	44
FWA meeting	3	3	3	3	4	4	4	4	4	3	3	3	41
EPI performance monitoring session	4	4	4	4	4	4	4	4	4	3	3	3	45
FP performance monitoring session	4	4	4	4	4	4	4	4	4	3	3	3	45
Findings sharing session with Thana managers	8	8	6	8	8	8	8	8	8	6	5	6	87
FWC review meeting attended by FT	10	5	12	2	5	13	13	8	4	9	10	4	95
Joint community visit of FT with MOHFW staff	64	76	31	22	49	63	66	59	44	36	43	41	594
Individual community visit of FT	15	6	4	1	3	1	2	0	7	3	3	1	46
Visit to OR session jointly with MOHFW managers by FT	42	59	69	111	92	42	26	45	50	36	60	55	687
Visit to MSC session jointly with MOHFW managers by FT	27	18	16	23	36	18	24	12	12	8	13	8	215
Individual visit of FT to OR session	21	24	17	37	27	16	20	23	26	23	24	28	286
Individual visit of FT to MSC session	11	7	19	4	14	9	10	16	12	11	15	18	146
PAL session organized by FT	26	52	38	86	38	9	68	53	46	27	52	41	536
Simulation session organized by FT	18	20	5	4	31	4	11	13	13	11	8	17	155
Other health education session organized by FT	34	78	30	60	100	8	42	36	25	44	53	48	558
Male group counseling on FP by FT	22	20	5	31	39	10	31	25	19	16	14	16	248
ORT group meeting	66	94	32	0	55	75	74	65	40	38	85	46	670
Supervisory visit by PHP and PO	17	9	6	0	15	10	8	11	19	15	13	8	131
Monitoring visit by PDO	1	0	0	0	0	0	0	1	0	1	1	2	6
HIS received	86	117	102	0	171	97	81	120	119	83	125	126	1227
OR session planned	555	579	642	0	553	632	578	569	459	417	488	459	6031
OR session held	351	528	605	0	591	440	353	472	427	398	464	372	5001
SC planned	152	152	172	0	176	176	104	164	130	125	132	132	1615
SC held	155	133	154	0	161	163	102	82	108	112	110	108	1388
Merged SC held	127	123	131	0	134	136	82	78	114	96	94	93	1208
Male participation during health education session	235	318	297	637	521	73	96	429	357	263	418	400	4344
Thana coordination meeting	2	2	2	4	4	3	4	3	3	3	3	2	35
Team meeting	4	4	1	4	4	3	4	4	4	3	3	3	41
CiC organized by FT	23	22	18	17	18	0	27	28	32	20	24	20	248
APOs community visit with FT	5	5	1	0	7	8	4	6	3	6	7	7	59
APOs community visit with MOHFW managers	3	5	0	3	5	3	3	2	2	4	2	2	34
APOs merged session visit with FT	9	6	5	6	9	6	7	7	9	9	14	11	98
APOs merged session visit with MOHFW managers	4	7	9	23	13	10	10	9	9	11	15	18	138
FWC review meeting attended by APO	3	3	2	0	1	2	1	2	0	4	2	1	21
Supervisory visit by APOs	24	26	17	0	35	34	27	27	23	34	40	40	327

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## Appendix N

### List of Key Project Documents

Project Proposal of CHILD-CS XI  
Detailed Implementation Plan (DIP)-CS XI  
Annual Report of the of 1995, 1996, 1997, 1999  
Project Implementation Report from FY-1995 to FY-1999  
Evaluation Report Final Evaluation (CHILD-I) and Mid-Term Evaluation (CHILD-II)  
Annual Implementation Plan (AIP) for 1995, 1996, 1997, 1998 and 1999  
KPC Survey Reports (Baseline, Mid-term and Final) and Questionnaire (CHILD-II)  
MIS and HIS Reports from 1991 to 1999  
Training Reports Information Bank Training (Basic and Refresher), Union Parishad Training Report,  
Supervisors' Training Report  
Work Plans for CHILD staff at all levels  
Reports on Special Events NIDs, National Vitamin A Week and other special events  
Monthly Activities Report from 1996- May 1999  
EPI Outreach Session and Satellite Clinic Advance Schedule from 1996-May 1999  
30-Cluster Survey Report 1998 and Questionnaire (English Version) – for Sylhet District  
Training Module on Supervision  
EPI Coverage Survey Report (for Sylhet District – both 1998 and 1999)  
Child-to-Child Survey Reports Baseline (1996), Mid-term (1998), and Final (1999)  
Report on Local Resource Mobilization  
Final Evaluation Report of BATCHA Project  
Field Trainers' Guide  
Diary for Supervisors (provided to the supervisors during their training)

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## Appendix O

### Pipeline Analysis of Country Budget

FINANCIAL PIPELINE REPORT OF THE CARE/BANGLADESH CHILD-II PROJECT (CS XI) (as of June 1999)									
	Expenditures from October 1995 to June 1999			Remaining Obligated Funds			Total Agreement Budget 9/30/95 - 9/29/99		
	AID	CARE	TOTAL	AID	CARE	TOTAL	AID	CARE	TOTAL
<b>I DIRECT COSTS</b>									
A Personnel	452,280	155,006	607,286	127,925	(6,791)	121,134	580,205	148,215	728,420
B Travel/Per Diem	54,432	34,528	88,960	6,468	(19,677)	(13,209)	60,900	14,851	75,751
C Consultants/Services	2,809	7,670	10,479	42,497	656	43,153	45,306	8,326	53,632
D Procurement	31,808	73,880	105,688	9,489	8,126	17,615	41,297	82,006	123,303
E Other Direct Costs	115,958	83,579	199,537	8,239	(2,312)	5,927	124,197	81,267	205,464
<b>TOTAL DIRECT COSTS</b>	<b>657,287</b>	<b>354,663</b>	<b>1,011,950</b>	<b>194,618</b>	<b>(19,998)</b>	<b>174,620</b>	<b>851,905</b>	<b>334,665</b>	<b>1,186,570</b>
<b>II INDIRECT COSTS</b>									
A Indirect Cost Recovery	59,287	31,991	91,278	7,076	(9,870)	(2,794)	66,363	22,121	88,484
<b>TOTAL COSTS</b>	<b>716,574</b>	<b>386,654</b>	<b>1,103,228</b>	<b>201,694</b>	<b>(29,868)</b>	<b>171,826</b>	<b>918,268</b>	<b>356,786</b>	<b>1,275,054</b>

**BURN RATES**

Actual Expenses	78%	108%	87%	22%	-8%	13%
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