

CSSP
1/25/95

**FINAL EVALUATION & SUSTAINABILITY ASSESSMENT CHILD SURVIVAL
PROJECT OF CHRISTIAN SERVICE SOCIETY AND
WORLD RELIEF CORPORATION**

KHULNA, BANGLADESH AND WHEATON, IL, USA

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L PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. PROJECT ACCOMPLISHMENTS

A1. Objectives of the project, as outlined in the DIP.

1. 90% of children aged 12-23 months in the old-CSP and 85% of children in the new-CSP will have complete immunization coverage.
2. 85% of women aged 15-45 yrs. in the old- and **new-CSP** will have received two doses of TT.
3. 60% of mothers of children 0-23 months old in the old- and new-CSP will administer **ORS/ORT** when their children have diarrhea.
4. 60% of mothers of children 0-23 months old in the old- and new-CSP will know to give greater amounts of fluids to a child with diarrhea.
5. 60% of mothers of children 0-23 months old in the old- and new-CSP will know to seek help when the child has signs of dehydration.
6. 65% of mothers in old- and new-CSP area will exclusively breastfeed through the 4th month.
7. 80% of mothers in the old-CSP and 50% of mothers in the new-CSP will know to introduce weaning foods at five months.
8. 70% of children 0-23 months old in the old-CSP and 60% of 0-23 months old in the new-CSP will be weighed bimonthly.
9. 80% of families in the old-CSP and 50% of families in new-CSP will grow kitchen gardens.
10. 90% of children 12-71 months in the old- and new-CSP will have had two 200,000 **IU** vitamin A within the last twelve months.
11. 90% of mothers in the old-CSP and 80% of mothers in the new-CSP will receive 200,000 **IU** vitamin A in the first two months post-par-turn.
12. 60% of couples in the old-CSP and new-CSP will use a modern contraceptive method.
13. 60% of women 15-45 in the old-CSP and 50% of women 15-45 in the new-CSP will know to consult a TBA during the first trimester of pregnancy.

14. 50% of pregnant women in the old-CSP and **40%** of pregnant women in the new-CSP will eat more than usual during pregnancy.
15. 78 **CHWs** in the old-CSP and 87 **CHWs** in the new-CSP will be trained.
16. 85 TBA in the old-CSP and 97 TBA in the new-CSP will be trained.
17. 172 Women's cooperatives in the old-CSP and 220 women's cooperatives in the new-CSP will be established.
18. 78 CHCs in the old-CSP and 87 CHCs in the new-DSP will be functioning.

A2. Accomplishments related to each objective.

Accomplishments by objective are most easily seen in the Final Evaluation KPC survey, (**Appendix A**); particularly so since that table gives not only the percent of achievement but also the numbers of persons involved.

1. Children completely immunized

	Old CSP	New CSP
Objective:	90%	85%
Achievement:	86%	88%

2. Women immunized against tetanus

	Old CSP	New CSP
Objective:	85%	85%
Achievement:	67%	57%

3. Use of ORT

	Old CSP	New CSP
Objective:	60%	60%
Achievement :	79%	88%

4. Knows to give greater amounts of fluid during diarrhea

	Old CSP	New CSP
Objective:	60%	60%
Achievement:	10%	12%

5. Seek help for signs of dehydration

	Old CSP	New CSP
Objective:	60%	60%
Achievement:	68%	70%

6. Exclusive breastfeeding for four months

	Old CSP	New CSP
Objective:	65%	65%
Achievement:	62%	47%

7. Knows to introduce weaning foods at 5 months

	Old CSP	New CSP
Objective:	80%	50%
Achievement :	86%	88%

8. Children weighed bi-monthly

	Old CSP	New CSP
Objective:	70%	60%
Achievement:	81%	75%

9. Women growing kitchen gardens

	Old CSP	New CSP
Objective:	80%	50%
Achievement:	72%	64%

10. O-4 yr. olds who received 2 vitamin A capsules during past 12 months

	Old CSP	New CSP
Objective:	90%	90%
Achievement:	92%	90%

11. Post-Par-turn vitamin A capsule

	Old CSP	New CSP
Objective:	90%	80%
Achievement:	33%	23%

12. Modern contraceptive prevalence

	Old CSP	New CSP
Objective:	60%	60%
Achievement:	47%	33%

13. Consult TBA during first trimester of pregnancy

	Old CSP	New CSP
Objective:	60%	50%
Achievement :	37%	32%

14. Eating more during pregnancy	Old CSP	New CSP
Objective:	50%	40%
Achievement:	51%	38%
15. Community Health Workers trained	Old CSP	New CSP
Objective:	78	87
Achievement:	81	91
16. Traditional Birth Attendants trained	Old CSP	New CSP
Objective:	85	97
Achievement :	88	99
17. Women's cooperatives formed	Old CSP	New CSP
Objective:	172	220
Achievement :	157	141
18. Community Health Committees formed	Old CSP	New CSP
Objective:	78	87
Achievement:	80	89

A3. Comparison of accomplishments to objectives

Objective #1: Achieved: children's immunization coverage rates, according to survey, are between **80%** and 92% in the old CSP area and between 83% and 94% in the new CSP area; these confidence intervals include the stated objectives of 90% and 85%.

Objective #2: The survey findings indicate that the Project did not achieve its 85% coverage objective for women's tetanus immunization. This does not necessarily mean that women's tetanus toxoid coverage levels are lower than 85%.

The survey accepted only card-documented immunizations. The MOHFW, however, lacked women's health cards throughout most of the Project's duration. The MOHFW accepted the Project's repeated offer to print and provide women's health cards only three months ahead of survey date. Consequent to this delay, eight percent of women in the old CSP and sixteen percent of women in the new CSP never had a card on which to record their immunizations. Furthermore, lost cards had not yet been replaced for 16% of women in the old CSP and 21% in the new CSP.

Coverage rates among mothers with cards was 88% in the old CSP and 92% in the new. If the same rates prevail among women who lost their cards or didn't receive them in the first place, then the Project has achieved its objective.

The card-loss rate indicates that mothers' education was inadequate. The **MOHFW's** inadvertent policy of vaccinating women without giving them cards, however, probably implied a strong message that runs counter to the Project's urging to take good care of cards and to bring them to every immunization session!

Objective #3. According to the survey, ORT use objectives are surpassed. The numbers of women whose children suffered from diarrhea during the previous two weeks were small, but the result's confidence intervals (63%-94% in the old CSP area and 77%-99% in the new CSP areas) are high enough to exclude the probability that the objective was not achieved.

Objective #4. The Project's objective for-mother's knowledge concerning use of greater amounts of fluid during diarrhea is grossly underachieved, in spite of its ten-fold improvement over the baseline findings.

This apparent failure is not consonant with the excellent ORT use rates which the survey found. Among the women who had actually practiced ORT during the previous two weeks 18% in the Old and 6% in the New CSP area said they had given more fluids than usual. Further study might discover if these odd findings resulted from the manner in which the question was posed or, alternatively, if the population maintains a prejudice against home-available fluids during diarrhea despite their ready acceptance of ORT.

The interviewees may have thought their response was complete when they **affirmed** that they treat diarrhea with ORS. If interviewers do not probe more deeply, the response "more fluids" is not elicited. Alternatively, the findings could have resulted from inadequate health education: for example, if the advice to "continue fluids" did not recommend "greater quantities of fluids" with sufficient emphasis.

Objective #5. Knowledge to seek help when signs of dehydration manifest themselves is now more prevalent than foreseen by the Project's objective.

Objective #6. Achieved in old CSP but not in new CSP. According to the baseline survey, 48% of mothers in the old CSP and 52% of mothers in the new CSP breastfed their children exclusively during the first four months of life. Unfortunately, the two baselines used different definitions of "exclusive breast-feeding". In the **new** CSP, the definition included sugar-water feeding; consequently, the result was spuriously high. Comparison of this spuriously high baseline result to the final survey results makes it appear that exclusive breast feeding rates declined.

The definition of exclusive breastfeeding used in final surveys of both areas excluded sugar-water feeding, as they should have. At final survey, the old CSP rate was 62%, with a confidence interval

that includes the Project's objective of 65%. The New CSP area's, exclusive breast-feeding rate at final survey was 47%. Its confidence interval, **30%-64%**, excludes the objective of 65%.

Objective #7. Knowledge to give weaning foods at five months is clearly more prevalent than the Project's objective foresaw.

Objective #8. The Project's bi-monthly weighing objective was clearly exceeded in both CSP areas. Weighing results informed growth promotion activities: severely malnourished children were referred to government-operated health centers for rehabilitation and the parents of most malnourished children were counseled in child feeding and trained by Mother's Committee members to prepare and feed kitchuri.

Weighing records from the Project's Information System show a higher prevalence rate of malnutrition in the New CSP area than **in the** old CSP area. **This** observation is consonant with finding that the New CSP area has lower growth-monitoring and lower breast feeding rates than the Old CSP area. For example, among 0-11 month infants, severe malnutrition prevalence rates were 2% in the Old and 5% in the New CSP area. The differences in rates should be an important consideration in setting priorities for breast-feeding promotion and home-based nutritional rehabilitation during succeeding child survival activities.

Objective #9. Kitchen garden prevalence was not included in the survey questionnaire, so achievement status was assessed from the Project's information system. Prevalence of kitchen gardens improved from **60%** to **72%** in the old CSP, but failed to reach the objective of 80%. In the new CSP, kitchen garden prevalence reached **64%**, very near the objective of 65%. Promotion of kitchen gardens will continue over the next few years. It would be **useful** to inform future promotive activities by a rapid assessment of kitchen garden prevalence and of reasons why some families make gardens and others don't.

Objective #10. Vitamin A coverage rates were equal to the objective among children 12-23 months old, but children aged 24-71 months were excluded from the survey. Including the older children was nearly impossible for two reasons: they would have doubled the number of children to find, and most of them did not have cards.

Vitamin A's impact on children's survival has been most clearly documented among younger children. Measuring vitamin A capsule coverage rates among one-year-old children, therefore, logically takes priority in competition for survey time and effort.

It is unclear in what ways the statistical model on which cluster-sampling is based may be constrained if older children were to be chosen from the same clusters as the younger children. As other Child Survival Projects may have this same question, its discussion in future editions of the Guidelines may be very helpful.

Objective #11. Post-partum administration of vitamin A capsules fell short of its objective for two reasons. Mothers traditionally remain confined at home with their newborns for forty days and do not attend post-natal consultations until they bring their baby for their first DPT vaccination at age 2 months or more. Furthermore, many mothers had no health card at all on which to record the vitamin A doses, and most of them had received their health cards within the last three months (see Objective #2, above).

The Project attempted to circumvent the mother's confinement period by requiring **TBA**s to administer vitamin A capsules immediately after delivery. The MOHFW, however, lacked sufficient vitamin A capsules to share with the **TBA** throughout much of the Project's duration. Furthermore, many of the Project-area residents traditionally leave the area and go to their mother's residence to deliver their baby and pass their confinement period. By the time they finish their confinement and return to the Project area, it is too late to give them post-partum vitamin A capsules without risk to the next pregnancy.

Objective #12. Contraceptive Prevalence increased during the Project from 32% to 47% in the old CSP area; and declined, in the new CSP area, from 36% to 33%. These results are greater than the national rate of 31%. The Project staff recognized during the mid-term evaluation that their objective of 60% was over-optimistic.

Objective #13. First trimester prenatal consultation rates at final survey were 37% and 31% in the old and new areas respectively: well below the objectives of 50% and 40%. Although the objectives were over-optimistic, some **staff members** suggested that the challenge of high objectives was partly responsible for the admirable improvement in prenatal consultation rates during the Project. Baseline rates of prenatal consultation, at any stage of pregnancy, were doubled to 64% and 53% in the old and new CSP areas respectively.

Objective #14. Eating more during pregnancy. Achieved.

Objective #15. CHWs trained. Achieved.

Objective #16. TBAs trained. Achieved.

Objective #17. Women's cooperatives established. 91% of the objective was achieved in the old CSP area but only 64% of the new CSP area's objective was attained. Cooperatives' membership size, educational needs and level of demand for loans were all higher than anticipated and the **staff** assert that time and loan funds were too meager for the establishment of as many cooperatives in the new CSP area as were planned initially.

Objective #18. Functioning Community Health Committees. CHCs were replaced by Mother's Health Committees (**MHCs**) which took a greater interest than the CHCs in the health problems of children and women. Objectives of both CSP areas were fully achieved with **MHCs**. 169 MHCs have been formed and have all met at least twice in the past six months.

A4. Unintended benefits of project activities.

Water and Sanitation were not included in the Child Survival Project plan but were among the population's most acutely felt needs. Accordingly, the CSS provided loans and private funds which permitted local MHCs to install tube wells and 1,693 latrines through Unicef's water and sanitation program.

A5. A copy of the Project's Final Evaluation Survey has been enclosed with this evaluation. Results for each relevant USAID indicator is attached (see Appendix B).

B. PROJECT EXPENDITURES

B1. A pipeline analysis of project expenditures is attached (see Appendix C)

B2. Comparison of the budget contained in the approved DIP with the Project's actual expenditures.

At the Project's close, its DIP "country" budget of \$456,583 appears to be underspent by approximately 2%. Two decisions account for most of the underexpenditure: the MOHFW decided to assume its personnel's transport and travel expenses much sooner than the budget predicted, and the Project decided to hire certain administrative and technical **staff** later than the budget predicted. The Midterm Evaluation mentioned the delay in hiring, the matter was corrected and some months of salary remained unspent.

Both **staff-training** and income-generating activities were under-funded by the original budget and were later supplemented with monies from underspent items. Even more money could have been well used in these two categories and the experience constitutes a lesson to be applied in future projects.

B3. Management of Project finances

It is possible that the two line items mentioned in B2 (above) might have been budgeted better and spent in a more timely manner but their handling does not, by any means, constitute a mismanagement of finances. The Project managed all finances properly.

Given the many commitments and excellent achievements of this three-year-eighteen-objective-Project, its modest field budget of \$456,583, and its service population of 210,882, it is difficult to see how the money could have been allocated for greater beneficial effect.

B4. Lessons learned regarding project expenditures

It is better to engage all technical **staff at** the beginning of a project than later on, when training has been done and established methods become difficult to change.

It is indeed possible to implement a successful health promotion project that has 18 objectives and to do it on a budget of only \$0.72 per capita per year! Good complementarity of services provided by each partner and excellent communication and coordination with the communities and with the MOHFW explains some of the Project's success; modest salaries, **staff's** and volunteer's dedication and the population's readiness to participate kept costs low and performance high.

Spending for methods development, training and supervision could all have been more efficient if all technical staff had been hired at the beginning of the Project rather than later on. Furthermore, the **MOHFW's** tardy acceptance of the Project's offer to provide health cards when the supply was exhausted may be related to the tardiness with which professional level technical staff was hired.

Proceeds from income-generating activities are modest and do not produce a level of revenue sufficient to sustain so many activities for such a large population unless greater amounts of money are invested than was the case in this Project.

C. LESSONS LEARNED

C1. Collaboration with government

(CSS learned this lesson long ago but the Project illustrates it too well to allow the omission of comment)

Government-community collaboration is worth the time and patience to establish it. Such collaboration is essential to successful government-financed primary health care. **Useful** collaboration depends more upon persons than upon bureaucratic mandates. A PVO can facilitate the personal links that make primary health care work but communities must soon learn to continually renew and maintain them. Key persons are likely to be promoted or transferred or otherwise replaced by persons with whom new personal links must be established. More must be learned and written about how communities learn to establish and maintain the essential links.

C2. Supervision

Training and support of supervisors is a necessary investment in program quality. Technical staff are needed early and throughout a Project to guide the development of methods, manage training courses and maintain an information system. Good information gathering and prompt processing are needed to manage personnel, measure progress and improve project quality. Communities must begin to play an important role in the supervision of their services. The present Project's involvement of the community in supervision of their own services is still minimal.

C3. Health Information System (HIS)

A detailed HIS can assure communication with every community and every family in the Project's service area. In this Project good information about children's nutritional status and health-card prevalence was not only gathered but acted upon to improve children's health.

Personal health cards and Health Worker's rosters of their clients are the essential first elements of a HIS. Information is difficult to obtain from women and children who lack health cards. The activity of health workers is difficult to evaluate if they keep no records of the clients they serve.

Personal health records, such as immunization cards or road to health cards are essential to beneficiaries' education and documentation and for precise and accurate evaluation of coverage rates. Rosters of their clients help health workers to define their tasks precisely and to report their activities in relation to specific clients.

H. PROJECT SUSTAINABILITY

A. COMMUNITY PARTICIPATION

A1. The following community leaders and members were interviewed

Ladies Savings Societies' members interviewed

Peara Begum
Sonali Biswas
Laily **Begum**
Shanaz **Parveen**
Firoza Begum
Fatema Begum
Bepali Biswas
Zainiti Biswas

Rama Rani Biswas
Lakhi Rani Biswas
Durga **Rani** Biswas
Mina **Rani** Biswas
Monika Biswas
Kalpone Biswas
Zamuna Biswas
Lalita Biswas

Mothers interviewed

Vanu **Bibi**
Shimul
Maduri **Rani** Adikari
Laki **Rani**
Mamo Tu
Bitan Mondul
Lipika Molik

Shamoli **Rani** Biswas
Lakshmi **Rani** Biswas
Hasina **Begum**
Sorbita Chackrabortti
Monika Biswas
Kalpone Biswas

Mothers' Health Committee members interviewed

Shanti Lata Tikadar
Lakhi Golder
Anjali Gaiu
Kamala Tikadar
Arathi Mandal

Numala Dali Nath
Aleala Bala Mandal
Namita **Rani** Dalal
Kamala **Rani** Dalal
Kalpana **Rani** Mandal

Health Officials interviewed

Dr. Abdul Hafiz Khan' Civil Surgeon' Khulna District
Dr. Mahbubul Haque, Medical Officer, Khulna City Corp.
Dr. S.K. **Anam**, Health Officer, Batiaghata **Thana**
Dr. **Kazi** Shahadat Hossain, 'Family Planning Officer, Batiaghata **Thana**

A2. Perceptions of community members and leaders concerning the effectiveness of child survival activities in meeting current health needs.

Community members and leaders were especially appreciative of **EPI's** effectiveness but considered all Project activities to be effective and currently needed. The evaluators questioned this position' asking why promotional activities are still necessary, given the present high coverage rates with almost all child survival services. The questions were met with firm predictions that the current rates will fall to lower levels in the future if current promotional activities are not maintained.

A3. PVO activities that enable communities to better meet their basic needs and increase their ability to sustain effective child survival project activities.

CSS promoted MOHFW child survival services at the family and neighborhood level through personal prompting, the formation and education of mothers health committees (MHC), monthly mother's meetings, bimonthly growth-monitoring sessions, and home-visiting. The MOHFW extended their CS services monthly to each of the Project communities and is committed to continuing this practice.

For several years, the Project provided transport of MOHFW personnel to the satellite posts for EPI and Family Planning services. This is no longer done as the MOHFW assumed this function and intends to continue it.

Family and MHC knowledge of health services and their motivation to use them was developed by the Project. The high utilization rates achieved are likely to be sustained as parents and committee members contemplate the dramatic improvements in child health that are associated with the services.

CSS organized and trained ladies' savings societies (LSS) and provided them with loan funds. The loans are used by the society members to launch individual enterprises such as shrimp-raising, egg and poultry production, fish-net making and sewing. The income that these enterprises add to the households permits increased expenditure for food and care of children. CSS will continue to "recycle" its loan funds, turning over the capital at least once per year for several years: and to extract a surcharge of 4% on the repayment of each loan to support the Project's continuation. The revenue from this source is still small and is expected to improve when pay-back rates reach 98% or greater and when the amounts of money loaned exceed the current level of approximately \$75,000.

The project acts through a network of 172 volunteer community health workers (**CHWs**) chosen by their neighbors to each serve a neighborhood of 200-250 families. CSS identified, trained, equipped and supervises 187 traditional birth attendants (**TBAs**) to serve the same population as the CHW. Both categories of volunteer will continue to serve their communities after the AID **funding** for the Project terminates. Their supervisors will be reduced in number and supported from private **funds**.

CSS brokered, partially **funded** and coordinated Unicef's self-help activities in safe water and sanitation. In this way 1,693 families obtained materials and help to install tube wells and latrines which will help protect them from disease for several years to come.

Population Crisis Control, (PCC), a PVO with funding from the UK, provides child survival, family planning and micro-enterprise loan services in some of the villages served by the Project. This organization recently notified CSS that it has engaged 18 **TBAs** and 10 **CHWs** who were formerly supervised by the Project. This means of sustaining both the services and the volunteers through the interventions of other **PVOs** was not foreseen when the Project began seven years ago but is likely to be an increasingly frequent outcome among villages located very close to Khulna City.

Finally, the network of volunteers trained by CSS: CHW, TBA, MIX and LSS maintain their places and their health promotion activities and will help their communities access new development and health projects as opportunities arise.

A4. Participation of the communities in the design, implementation and/or evaluation of child survival activities.

Communities selected or participated in the selection of their own local agents of child survival: the **CHWs** and members of their MI-K. **CHWs**, members of MHCs and randomly selected community members were interviewed for both the mid-term and final evaluations.

Communities participated, through interviews and focus groups, in the design of Project strategies during the development of the detailed implementation plan. It was on the recommendation of these focus groups that mothers-in-law were specifically targeted for education by the Project. Many health messages and the means to overcome certain constraints identified through focus groups. A 30-cluster baseline survey of the Project communities helped select and **quantify** the Project's

objectives. The Project's TBA training component is a specific example of an action taken in direct response to a need identified by baseline survey.

Communities participate in implementation of Project activities **by** providing sites for EPI and Growth-Monitoring sessions, providing food for kitchuri demonstrations, and through the MIX's active follow-up of mothers who fail to get their children immunized or to attend monthly mother's meetings. **CHWs** educate mothers, conduct growth-monitoring sessions, visit homes, keep a census-based health register, and report bimonthly to the project supervisors.

A5. A number of functioning health committees in the project area, frequency of meeting during the past six months and extent to which committee members are representative of their communities.

169 Mother's Health Committees (**MHC**) met at least twice in the past 6 months. All **MHC** members are mothers and can adequately represent all the adult project beneficiaries as they are also mothers.

A6. Issues currently being addressed by these health committees

MHC minutes of their meetings or letters written by them to Project staff during the past two months show that the topics discussed were EPI defaulters and how to contact them, provision of nutritional demonstrations and training mothers in the preparation of kitchuri, and emergency transport for women in complicated labor who must go to the District Hospital for care.

A7. MHC methods and role

MHC teach nutrition by demonstrating the preparation and use of kitchuri; a mixture of rice, lentils, oil and vegetables. Fed often and in appropriate amounts, kitchuri can hasten the recuperation of malnourished children.

Mothers who fail to get their children vaccinated or to attend women's meetings or to bring their children to growth-monitoring sessions in spite of urging by the **CHW** are called upon by members of the MHC. This sort of peer pressure may be partially responsible for some of the high coverage rates found by survey.

MHCs hold mother's meetings, give kitchuri demonstrations and visit homes of non-compliant families. In this way they help formulate health activities such as child immunization, vitamin A capsule distribution, kitchuri feeding and treatment of diarrhea with ORT into norms of behavior expected of the entire community. This role of the MHC is key to assuring the long-term sustainability of the Project's health achievements.

AS. Community contributions that will encourage continuation of project activities after donor funding ends

Community members lend their houses as sites in which the child survival services of EPI, Family Planning, Growth Monitoring and kitchuri demonstrations are provided at regular intervals. Interest and surcharges totaling **16%** are levied on LSS loans and provide revenue which is used to support Project activities. Community members contribute both money and labor to the installation of wells and latrines. 172 **CHWs** 184 **TBAs** and more than 500 members of MHCs all volunteer their time to plan and promote health activities.

A9. Reasons for the success of the communities to contribute resources for the continuation of effective project activities

All contributions sought from the communities are well within the means of this economically depressed population. The services to which they contribute result in immediate benefits that are easily perceived by the contributors. The interest and surcharge on LSS loans is within the limits of national regulations and small enough not to raise serious objections.

B. ABILITY AND WILLINGNESS OF COUNTERPART INSTITUTIONS TO SUSTAIN ACTIVITIES

B1. Persons interviewed

Dr. Abdul Hafiz Khan, Civil Surgeon, Kbulna District
(Chief Medical Officer of the MOHFW in the Khulna District)

Dr. Mahbubul Haque, Medical Officer for Khulna City Corporation
(Medical Officer responsible for the health of Khulna City's population, including Ward 15 where CSS works)

Dr. S.K. **Anam**, Health Officer, Batiaghata **Thana**

Dr. **Kazi** Shahadat **Hossain**, Family Planning Officer, Batiaghata **Thana**

Mohammed Mujibur **Rahman**, District Project Officer in Charge, Bangladesh Family Planning Association (affiliated with **IPPF**) BFPA provides direct family planning services in part of **CSS's** Child-Survival area and has engaged 4 **TBAs** that were previously trained and employed by CSS. Is committed to **further** expansion in areas presently served by CSS.

Mrs. Zakia Akhtar, Project Coordinator, Banophul Family Welfare Project. The Project provides family planning services in seven small geographic areas served by CSS and is highly appreciative of CSS' promotional activities, which apparently coordinate well with services provided by Banophul.

Mr. M. Amanulla, Divisional Coordinator of Under-privileged Children's Educational Program. Mr. Amanulla is an active participant in the PVO Coordinating group of which CSS is a founding member.

Mr. **Mazoor** ul Islam, District Coordinator, UNICEF; Mr. AY.M. **Fazul** Hoque, Deputy Chief of Divisional Office, UNICEF. UNICEF has assisted CSS to improve sanitation and access to clean water for the population served by the Child Survival Project.

Mr. Mirza Taslim Hossain, Executive Director, Population Crisis Control and Mass Education Committee (**PCC/MEC**). This organization has recently engaged twenty-eight TBA and CHW previously trained and employed by CSS and is now occupying the geographic areas, close to Khulna City, served by these persons.

B2. Linkages between the child survival project and the activities of key health development agencies

The Child Survival Project (CSP) promotes and monitors, at the community level, child survival services that are provided by the Ministry of Health: Expanded Program of Immunization (EPI), distribution of vitamin A capsules, provision of Oral Rehydration Salts (ORS) for the care of persons with diarrhea, training and supervision of traditional birth attendants, provision of contraceptive services and supplies and referral care for illness. The Project implements its promotional and monitoring activities through a network of Community Health Workers (CHW), Traditional Birth Attendants (TBA), and Mother's Health Committees (**MHC**) who are volunteers, led and supervised by paid supervisors and coordinated at the union or ward level by paid Union Officers.

Planning of the MOHFW activities with the Project coordinators takes place at monthly planning and coordinating meetings held in the office of the Chief Health and Family-Planning Officer for the **Thana**.

The Project implements and promotes a series of development projects in order to enable communities to sustain the health gains achieved through child survival services. It enables villages to access, implement and pay for **Unicef's** safe water and sanitation program. It monitors child growth and trains mothers in practical nutrition and supports the planting of several thousand kitchen gardens. It links the communities to current government programs such as fruit-tree planting which it facilitates. Furthermore, it organizes and trains ladies savings societies (LSS) which provide the savings and credit services that enable women to launch sewing, egg production, fishponds, shrimp raising, fish-net making and other small-scale remunerative enterprises. The LSS are linked to the local branches of the Sonali bank.

B3. Local institutions that will sustain Project activities

The key local institutions which Christian Service Society (CSS) expects to take part in sustaining project activities are families, MHC, LSS and the MOHFW.

B4. Child survival project activities that MOHFW personnel and other staff in key local institutions perceive as being effective

The Civil Surgeon for Kulna District, the Chief Medical Officers of Kulna City Corporation, Bhatiagata **Thana** and Tala **Thana** as well as the Unicef District Coordinator and the Banophul Family Welfare Project Coordinator all indicated that, in their opinion, CSS promotion of EPI, vitamin A distribution, family planning, safe water, sanitation and savings societies has been very effective.

B5. CSS activities that built skills of local MOHFW personnel or staff of key counterpart NGOs

The MOHFW provides Child Survival services in the Project area: the Project's function is to promote the services and monitor their utilization at the village and household level. MOHFW staff were invited to all training sessions implemented by the Project and sometimes participated in them either as trainers or learners.

Future promotion of health services remains the function of volunteer agents who reside in their communities and continue to serve **after** AID funding terminates: CHW, TBA, MIX and the families themselves. All these categories of volunteer have received repeated trainings for the promotion of health activities.

B6. Current ability of the MOHFW, CSS and WRC to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends

MOHFW resources are committed to sustain the provision of health and child survival services in the various delivery sites that it has developed with the Project. The Project will receive some continued funding from WRC for one to two years after AID funding terminates, and the burden of promotion of, and collaboration with, the health services will continue to be born by volunteers at the village level (CHW, MHC, TBA and families) . They have been adequately trained in promotion and collaboration and will be able to sustain those activities. They will be working with less intensive supervision, so may be able to sustain the very well developed reporting system at only half its current level of function. This reduction in reporting is expected to have a minimal impact on the Project's productivity.

B7. Project activities that counterpart organizations perceive as effective

CSS's counterpart organizations are the MHC and LSS in each village: their perceptions of the Project effectiveness has already been mentioned. They regard all the Project activities as effective and necessary. They intend to maintain the health habits the Project has taught, continue to use CS services provided by the MOHFW and teach their children to do the same.

B8. Phase-over of to local institutions of major project responsibilities and control

The village-level volunteers, CHW, TBA, MHC, and LSS are trained and competent to continue promoting the CS services and the MOHFW **staff maintains** regularly scheduled visits to the EPI-Family Planning sites provided by the MHC. The schedule of these visits is regularly communicated to the volunteers and the participating families by the MOHFW **staff**. The intensity of supervision will now be reduced to half its previous frequency and village-level reporting will be simplified to a level that can be processed by the reduced supervisory **staff**. A useful level of supervision and reporting will be maintained, however. This will permit the local volunteers to demonstrate how they maintain effective CS activities despite termination of AID **funding** and thus assure potential donors that they are competent to implement complementary health objectives not included in the present Child Survival Project.

B9. Financial commitments to sustain project benefits

WRC has assured CSS of its continued collaboration and some technical and financial support of the Project's initiatives for at least one to two years after AID funding ends (see DIP, Section C., DIP SUSTAINABILITY STRATEGY). WRC considers its provision of the match for **CSS's** new Child Survival grant (about to begin in October, 1994) to be a partial fulfillment of this commitment. The same section of the DIP indicates that CSS is able to seek new funding **from** other sources than AID to support Child Survival activities. Originally, the CS expansion proposal included both the old CSP area and the newly proposed area. However, **USAID** funds for the total proposed area were insufficient and the original CSP area had to be cut from the grant. In response, WRC assessed CSS to find \$8 1,180 in alternative **funding** to **fund** CS initiatives through December 1996. This will allow CSS to consolidate gains made in CS initiatives and strengthen the sustainability of these initiatives.

Malnutrition, micronutrient deficiencies, intestinal parasites, and tuberculosis have been mentioned as current health problems which are not addressed by any strong preventive program in the Project area. Given their success with the CS Project, the **CHW, TBA, MHC** and LSS can now expend less effort to sustain CS health achievements. Thus, the services of this excellent village-level volunteer network, developed through the CS Project, can be made available to address health problems which are still neglected, relative to the present status of EPI-preventable diseases and vitamin A deficiency, for examples.

B10. Reasons for the success or failure of WRC to keep their commitment

WRC's commitment to provide further technical support awaits start-up of the new AID-funded CS Project in October, 1994.

B11. In-country agencies which worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

UNICEF and the District and **Thana** levels of the MOHFW helped with the design and implementation of the Project's midterm and final evaluations.

C. ATTEMPTS TO INCREASE EFFICIENCY

CI. Strategies implemented by WRC/CSS to reduce the costs, increase productivity, or otherwise make the project efficient

Efficiency was improved by changing the type of village committee with which the Project worked. The original community health committees (CHC) were composed almost entirely of men. They found it **difficult** to meet regularly and to participate actively in the Project's personal prompting and educational activities. When the Project switched to mother's health committees (**MHC**), meetings were regular and the members participated actively in visiting non-compliant families and in preparing demonstrations and training in the preparation and feeding of kitchuri.

The Project's low costs are primarily related to the fact that **CHWs, TBAs**, and MHCs are volunteers; and salaries for Supervisors and Union Officers are modest.

c2. Reasons for the success of attempts to increase efficiency of this project

Members of the MHC , and most **CHWs**, being mothers, relate well to the adult beneficiaries of the Project, all of whom are mothers. Furthermore the Project is perceived as successful and their association with it is regarded as prestigious.

c3. Lessons learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to USAID's support of these projects

In this particular case, committee members who are mothers have taken a more active and effective role in promoting CS activities than committee members who were men. This uncontrolled and non-quantified observation supports the intuitive assertion that mothers, who must constantly deal with their children's health and nutritional needs in the home, are likely to be more highly motivated than men to participate in the detailed problem-solving and prompt action required of health-committee members.

Again, in this particular case, high coverage rates were achieved at low cost. The result appears to be associated with the engagement of local residents who voluntarily participated in planning the activities, loaned their own homes as service-delivery sites, prompted their neighbors to utilize the services and reported their activities and achievements to the enabling PVO.

In brief the lesson to be learned from these many communities, inhabited by 205,000 Bangladeshis, is that communities can be enabled, at reasonable cost, to make appropriate use of health services and health education. If this enablement proves to be self-sustaining over succeeding years, and

there are many indications that it will be, the expenditures that brought it about can be viewed as an excellent investment in health and development.

D. COST RECOVERY ATTEMPTS

D1. Cost-recovery mechanisms (i.e., revenue-generating measures) implemented by WRCKSS to offset project expenditures

Loans provided to the LSS returned 12% in interest and 4% in surcharges per year. The Overseer of the loan program implemented the collection of this revenue.

D2. Dollar amount of costs recovered during the project and percent of project costs recovered

\$5,007 was collected in interest and surcharges during the past three years as loan repayments are made. More capital has recently been added to the loan funds and the loans “recycle” once per year. Recent increases in volume of money loaned should increase revenue for the operation of the Project over the next several years.

Once a loan payment is collected, the additional work to collect the surcharge is trivial, so even modest amounts of revenue can easily **justify** that effort. The loan program could well consider the advantages of simultaneously increasing the loan collection rate, the volume of money loaned, and the rate at which the capital is turned over each year. Such actions can markedly improve household economies and raise the revenue collected by the surcharge to very substantial levels.

D3. Effect of cost recovery activity on CSS's reputation and on the equitable delivery of services

CSS's reputation is very secure in the community. No objections to the surcharge have been raised. No inequities in service delivery have resulted from the surcharge.

D4. Reasons for the successes and failures of the household income generating activities of this project.

Two LSS, interviewed as focus groups, declared they had not made sufficient money with their first enterprises: egg and poultry production. They were pleased, however, with their switch to shrimp raising or net-making. The shrimp-raisers live on the banks of a tidal river, so have an abundant supply of brackish water for their shrimp-ponds. The net-makers' husbands use the nets to catch fish in the Bay of Bengal. In these cases, success was clearly linked to the appropriate choice of enterprises.

The members of a third WSS interviewed by the evaluators live in different circumstances, and are relatively satisfied with their chicken-raising or sewing enterprises. Many women in that group,

however, have not yet taken a loan and are simply accumulating savings while they consider what enterprises might be sufficiently profitable to them to merit launching by means of a loan.

D5. Lessons regarding cost recovery that might be applicable to other PVO child survival projects or to USAID's support strategy

This project demonstrates a rather obvious lesson: recovering portions of health-care costs from loan-driven micro-enterprises is possible, but very modest amounts were recovered in the present Project. Specially trained staff and professional consultation may improve the matter greatly. Quite probably, the improvement will be well worth the increase in operating costs which added **staff** and consultation will engender.

E. HOUSEHOLD INCOME GENERATION

E1. Household income-generating activities implemented by the Project

The Project organizes Ladies Savings Societies (LSS) to which it provides loan funds. Members may take a loan in order to launch household income-generation projects which other members of the Society agree are likely to make an adequate return on the money invested. The projects themselves are implemented by the LSS members, not by the Project. Examples of implemented projects are given in section D (above).

E2. Estimated dollar amount of income added to a family or household's annual income, as a result of income-generating activity promoted by the Project.

In the three LSS interviewed, the additional family income provided by the loan-driven income-generation activity was described variously as 100 to 300 taka per month (\$2.50 - \$7.50).

E3. Contribution of the revenues to meeting the cost of health activities and percentage of Project costs covered by income generation

Contributions of the loan program to meeting the cost of health activities is discussed in section "D" (above). Briefly, interest and surcharges totaling 16% produced \$5,007 in revenue during three years. It is expected that this amount will increase, as more money has recently been added to the loan capital. Revenue generated from the loan interest and surcharges has not been used as yet to cover annual Project costs: it has been saved to help sustain the Project when AID funding ceases. Project costs will be much lower in the future and loan capital will be increased in amount and will be recycled at least annually. These circumstances can increase the percentage of Project annual costs covered by loan surcharge revenue.

E4. Lessons learned regarding household income generation that might be applicable to other PVO child Survival projects or to USAID's support strategy

The lesson learned is described in D-S (above).

F. OTHER

F1. Sustainability-promoting activities carried out by CSS over the lifetime of the project

Mothers were educated to get themselves and their children immunized and dosed with vitamin A when appropriate, care for episodes of diarrhea with ORT, use a latrine, wash hands after defecation, use safe water, plant kitchen gardens, nourish their children appropriately, attend antenatal care sessions, secure the services of trained TBA and seek family planning services when appropriate. Furthermore, mothers questioned by the evaluators responded that they were able to teach these health-maintaining behaviors to their children.

The Project promoted MOHFW services, facilitated MOHFW communication with communities and organized mother's health committees (MIX) to maintain that communication and to prompt families to utilize the services.

The Project thus improved family capacity to maintain their members health in sustainable ways, increased community demand for health services and formalized community-level organizations which can communicate with the MOHFW and community members in ways that achieve effective responses to health service demands.

The Project furthermore provided modest loans to women and is able to recover some health-care costs **from** a surcharge on these loans. Finally, the Project encouraged household income-generating activities which enable many families to practice the above-mentioned health behaviors and to pay for the health services that their families require.

F2. Aspects of CSS's sustainability plan that were implemented or not implemented; and activities which were unplanned, but formed an important aspect of the Project's sustainability effort.

The Project's sustainability plan included changing maternal health knowledge and practices, improving the capacity of CSS to seek funding for important new health projects, acquiring short-term technical and financial support from WRC at the end of AID funding, staying in close communication with the MOHFW planners, remaining ready to collaborate with new national initiatives, advocating with the MOHFW for more comprehensive care for the service population, increasing community sense of ownership of their health care, enabling families and voluntary health workers to provide ORT, appropriate nutrition and other home health care procedures, developing means to recover health care costs and, finally, improving families' capacity to pay for health care and to feed their children better.

Every aspect of the sustainability plan was addressed by the Project; most were implemented and had a satisfactory result. The exceptions are important: **WRC/CSS** identified neither new health projects nor the funding to support them. The MOHFW has not implemented new initiatives in health or more comprehensive care at the community level. Partial recovery of costs has been achieved but the amounts recovered are not commensurate with the costs. Finally, many families have increased their income but a great many more still need to do so.

Collaboration with UNICEF in their **safe** water and sanitation program was facilitated by the Project's Health Educator and improved CSS's capacity to seek new projects and **funds** at the same time that it helped many communities to sustainable improvements in sanitation and access to **safe** water. This result was not planned from the Project's beginning but has been very satisfactory **to** UNICEF, CSS, and the numerous families that benefitted **from** it. Additionally, WRC is committed to support CSS's new Child Survival Project, scheduled to begin in October, 1994. Finally, WRC has assisted CSS in finding sufficient alternative funds to permit the present Project to maintain supervision of **CHWs** and TBA during the next year or two. This further WRC contribution to Project sustainability will assure documentation that the activities are sustained by the service population.

F3. Qualitative data indicating a change in the sustainability potential of Project benefits.

At its beginning, the Project paid MOHFW employee transportation costs to and from the Project EPI and FP service sites: these costs are now born by the MOHFW.

The change from CHC to **MHC**, engages mothers in decisions concerning their own and their children's health and has increased the likelihood that community participation in health care will be sustainable.

In many communities Population Crisis Control has incorporated a number of **TBA**s and **CHWs** trained by the Project into their program of family planning and child survival, thus strengthening the probability that these volunteer personnel will continue to serve their communities.

III. EVALUATION TEAM

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See Appendix D for Final Evaluation Scope of Work

APPENDICES

Bangladesh 12/94

WORLD RELIEF/CSS CHILD SURVIVAL OBJECTIVES
Percent of Target Population Covered by CSP Interventions

	OBJECTIVES	End-of-Project (Actual)		Target Beneficiary Exp		% Target Pop. Covered	
		OLD	NEW	OLD	NEW	OLD	NEW
1.	Children 12-23 months completely immunized	1,587	1,999	1,845	2,272	86.0%	88.0%
2.	Women 1545 immunized with two doses Tetanus Toxoid • *	14,549	13,774	21,748	24,039	66.9%	57.3%
3.	Mothers of children 0-23 months who administer ORS/ORT when their children have diarrhea	3,038	4,028	3,865	4,583	78.6%	87.9%
4.	Mothers of children 0-23 months who know to give greater amounts of fluids to a child with diarrhea	383	550	3,865	4,583	9.9%	12.0%
5.	Mothers of children 0-23 months who know to seek help when a child has signs of dehydration	2,640	3,194	3,865	4,583	68.3%	69.7%
6.	Mothers who exclusively breastfeed their children through the fourth month	1,256	1,088	2,020	2,311	62.2%	47.1%
7.	Mothers who know to introduce weaning foods at five months	3,324	4,019	3,865	4,583	86.0%	87.7%
8.	Children 0-23 months weighed bimonthly	3,111	3,424	3,865	4,583	80.5%	74.7%
9.	Women 15-45 who have a kitchen garden in their homes	15,659	15,385	21,748	24,039	72.0%	64.0%
10.	Children 12-71 months who had two 200,000 IU doses of Vit A within last 12 months **	8,100	9,531	8,786	10,649	92.2%	89.5%
11.	Mothers who received 200,000 IU Vit A in first month postpartum	669	532	2,020	2,311	33.1%	23.0%
12.	Able couples using a modern contraceptive method	8,048	6,559	17,160	19,757	46.9%	33.2%
13.	Pregnant women who consult a TBA during first trimester of pregnancy	745	740	2,020	2,311	36.9%	32.0%
14.	Pregnant women who eat more than usual during pregnancy	1,020	871	2,020	2,311	50.5%	37.7%

• The figures calculated for women 15-45 were extrapolated from final evaluation survey percentages based on mothers of children 0-23 months.

• * The figures calculated for children 12-71 months were extrapolated from final evaluation survey percentages based on children 12-23 months.

Final Evaluation Results for USAID INDICATORS

INDICATORS	End-line Project		Potential beneficiaries/Pop.		Percentage of POP. covered	
	OLD	NEW	OLD	NEW	OLD	NEW
1 Initiation of breastfeeding in first 8 hrs. after delivery	2,829	3,171	3,865	4,583	73.2%	69.0%
2 Exclusive breastfeeding until 4 months	1,256	1,088	2,020	2,311	62.2%	47.1%
3 Introduction of solid/semisolid foods between 5 and 9 months	1,669	2,064	2,020	2,311	82.6%	89.3%
4 Persistence of breastfeeding between 20 and 24 months	1,793	2,138	1,845	2,272	97.2%	94.1%
5 Continuation of breastfeeding during diarrhea	2,624	2,502	3,865	4,583	67.9%	54.6%
6 Continuation of fluids during diarrhea	1,797	1,668	3,865	4,583	46.5%	36.4%
7 Continuation of foods during diarrhea	1,102	1,668	3,865	4,583	28.5%	36.4%
8 ORT use	NA	NA	3,865	4,583	82.0%	82.0%
9 Pneumonia Control	NA	NA	NA	NA	NA	NA
10 EPI Access: Children 12-23 months who received DPT 1	1,716	2,152	1,845	2,272	93.0%	94.7%
11 EPI Coverage: Children 12-23 months who received OPV3	1,701	2,102	1,845	2,272	92.2%	92.5%
12 EPI: Measles coverage of children 12-23 months	1,587	2,015	1,845	2,272	86.0%	88.7%
13 EPI: Drop out rate	29	34	1,716	2,152	1.7%	1.6%
14 Mothers with a maternal card	2,930	2,874	3,865	4,583	75.8%	62.7%
15 Tetanus Toxoid Coverage of mothers of children 0-23 months	2,586	2,626	3,865	4,583	66.9%	57.3%
16 Antenatal visits (not a card, response of mother)	2,454	2,415	3,865	4,583	63.5%	52.7%
17 Modern contraceptive usage	1,813	1,522	3,865	4,583	46.9%	33.2%

WRC/CSS Final Evaluation

December, 1994

APPENDIX B