SAVE THE CHILDREN

BANGLADESH FIELD OFFICE

CHILD SURVIVAL 8 FINAL EVALUATION

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Acronyms

ASA	Association for Social Advancement
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ATFPO	Assistant Thana Family Planning Officer
BFO	Bangladesh Field Office
CDC	Community Development Coordinators
CDD	Control of Diarrheal Diseases
CDO	Community Development Organizers
CPR	Contraceptive Prevalence Rate
CS Coord	Child Survival Coordinator
CSP	Child Survival Project
DD-FP	Deputy Director-Family Planning (MOHFW)
DIP	Detailed Implementation Plan
EPI	Expanded Program for Immunization
FHP	Family Health Promoters (SC)
FWA	Family Welfare Assistant (MOHFW)
FWC	Family Welfare Center (MOHFW)
FWV	Family Welfare Visitor (MOHFW)
GP	Group Promoters (SC)
HA	Health Assistant (MOHFW)
HIS	Health Information System
IAC	Impact Area Coordinator
IAM	Impact Area Manager
IEC	Information, Education, Communication
KPC	Knowledge, Practice and Coverage
LBW	Low Birth Weight
MOHFW	Ministry of Health and Family Welfare
NGO	Non Governmental Organization
NMW	Nurse Midwife
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
PROMIS	Program Management Information System
PNC	Pre-Natal Care
SC	Save the Children (USA)
SES	Socio Economic Status
TBA	Traditional Birth Attendant
THFPO	Thana Health and Family Planning Officer (MOHFW)
TFPO	Thana Family Planning Officer (MOHFW)
THC	Thana Health Complex
TOT	Training of Trainers
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VAC	Vitamin A Capsules
VHP	Village Health Practitioners
WPC	Women's Program Coordinator
WSG	Women's Savings Group

Other Information

Dhaka:	Capital of Bangladesh
Chittagong:	One of six Divisions in Bangladesh (The others are Dhaka, Sylhet, Khulna, Rajshahi, Barisal). Nasirnagar Thana is located in Chittagong.
Brahmanbaria	One of fifteen administrative districts in the Chittagong division Nasirnagar Thana is located in this district.

Administrative Units:

Thana	Administrative unit serving an estimated population of 200,000; 7 Thanas in Brahmanbaria district.
Union	Administrative unit serving an estimated population of 20,000; 13 unions in Nasirnagar Thana; 97 Unions in Brahmanbaria District.
Ward	Subdivision of a union (3 wards per union); 39 wards in Nasirnagar thana.

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SAVE THE CHILDREN/BANGLADESH
CHILD SURVIVAL 8 FINAL EVALUATION

EXECUTIVE SUMMARY

Save the Children's Child Survival 8 project in Bangladesh, operational in parts of Brahmanbaria and Chittagong divisions, was evaluated in two parts, in July and November of 1995. The findings of the comparative Knowledge, Practices and Coverage surveys (from 1992 and 1995) suggested significant changes in child survival program indicators in a short amount of time. These findings were particularly impressive given that a great area of the project was new to Save the Children work, not having been covered under the previous CS 4 project which was operational in a subset of the communities covered.

The project approach, utilizing women's savings groups as an organizational foundation for community level mobilization and motivation, helped reach the poorest women in the communities and served to bond women together in their efforts to improve the health of themselves and their children, and to improve their economic situation. These groups also identified other needs which women had, including recourse to legal advice, and helped create other organizations and processes to address these concerns. The survey results show the relatively rapid increases in knowledge and protective health behaviors of these women over the life of the project.

The women's savings groups in the Rangunia area, where Save the Children discontinued activities in July of 1995, were recently found to be meeting more than 3 months after the end of the project activities. This is hopeful for the continuation of support groups which have better knowledge and practices to protect child health. However, the evaluation team could not well assess the sustainability of the behaviors and practices which had been adopted by community members through the intensive community level work of this project. Certain elements of the strategy seemed to be sustainable, such as providing training to traditional birth attendants and village health practitioners who pre-existed the project, and are compensated by their "patients" and thus, are likely to continue to serve their communities.

However, despite suggestions in the midterm evaluation, not enough attention was given by Save the Children/Bangladesh to testing the feasibility of cost-recovery or other mechanisms which might have helped ensure the continuation of the improved government services which were delivered by the project. The concerns about the sustainability voiced by the evaluation team ought to be answered by Save the Children, perhaps through a follow-up survey after health motivation activities by SC staff are discontinued, and/or continued work with their Ministry counterparts on evaluating the potential for some cost recovery within the project's service delivery component.

1. Introduction and Background

The Save the Children (USA)/Bangladesh Field Office (BFO) Child Survival 8 (CS-8) project was an ambitious attempt to expand upon a successful model utilized for reduction of maternal, infant and child mortality under the previous Child Survival 4 (CS-4) project. The project strategy was to promote improved health behaviors and an increase in the use of modern contraception through intensive education and motivation delivered in an individual and group setting by project funded Family Health Promoters (FHP)s. In addition training was conducted for existing community based private providers such as traditional birth attendants (TBAs) and Village Health Practitioners (VHPs). The project also created and provided training for Women's Savings Groups (WSGs). WSGs were seen as a vehicle to promote and sustain better practices among the poorest women in the communities and to provide access to credit for women to engage in small income generating activities. This was a women's empowerment strategy that the project hypothesized would result in improved maternal-child health behaviors among participants within a sustainable local institution - the women's savings group.

The CS-8 project began in October 1992 and has been in operation for just over three years. In Nasirnagar the project continued its work in two "old" unions in which they were working during the CS-4 project and expanded into five "new" unions. Project staff had also worked in four "old" villages in Rangunia during the first two years of the project but had phased out when SC closed out their work in the District a few months after the midterm evaluation. Although the evaluation team did speak with the evaluator of the CS-8 Rangunia Project, they did not actually visit the district during this evaluation. A separate report detailing the Rangunia findings is attached to this report.

The CS-8 project focused on the following key intervention activities:

- Community mobilization and registration/enrollment of the entire population;
- Formation, strengthening and utilization of the WSGs;
- WSG participation in promotion of child survival and women's/adolescent girl's health;
- Partnership with the public sector for the delivery of health services and supplies;
- Partnership with the community level private sector for the delivery of health services.

Through this approach, the project activities focused on the promotion of improved health behaviors and increased utilization of services in the following health areas recognized for their importance in improving child survival and reducing maternal mortality:

- Immunization for both women and children;
- Case management of diarrhea;
- Maternal nutrition during pregnancy;
- Family planning and child spacing;
- Case management of acute respiratory infections (ARI);
- Vitamin A Capsule (VAC) distribution;
- Maternal health, antenatal care (including iron tablets to reduce anemia) and safe deliveries;
- Exclusive breastfeeding for up to 4-6 months.

Save the Children utilizes an extensive information system based upon the registration of all the families in the project area. This system which is maintained by the FHPs (each FHP is responsible for approximately 350 families which he/she visits once a month), allows them to identify trends and specific health problems among community members. During each visit, FHPs record new vital information regarding births, deaths, immunizations received, family planning practices, and other health practices. The FHPs then utilize their rosters to manage their work by providing those persons identified as "at risk" (i.e., those with children who have not been properly immunized) with appropriate education and motivational messages to direct them to services. As part of SC's commitment to women-focused, child-centered programming developed as part of the WCI program, FHPs are "connected" to WSGs, a potentially sustainable community institution which seeks to provide economic resources and vital information to its membership. The FHPs often provide educational and motivational messages at the WSG weekly meetings. Information regarding upcoming MOHFW outreach services is also provided at WSG meetings and through home visits by FHPs. These efforts comprise the demand-raising strategy of the project.

Virtually all services are delivered by public facilities or private practitioners in the area. The project targeted these service providers in order to improve their availability, skills

and the quality of their health advice. Thus, SC has made limited, but important contributions to the supply side of the service provision equation. Lessons learned from the CS-4 project about the need to concentrate on local providers as the most sustainable source of services dictated this investment strategy.

The SC information system allows BFO staff to monitor the effects of the project interventions on indices such as contraceptive prevalence rates (CPR), immunization coverage, maternal mortality, and infant and child mortality. The presence of this computerized Program Management Information System (PROMIS) should allow the BFO to conduct operations research activities within the framework of project activities and presents a unique resource for evaluating the effectiveness of preventive health services in Bangladesh.

2. Evaluation Methodology

The final evaluation of the Save the Children (USA)/ Bangladesh Field Office's Child Survival-8 Project occurred between November 3 - 13 1995. Sandra A. Wilcox, M.P.H., consultant, was designated team leader for the evaluation and principal author for the evaluation report. Members of the BFO participating in the evaluation were: Afzal Hossain, MD, M.P.H., Senior Program Officer and Najma Khatum, MD, Senior Medical Officer. Chanda D. Rai, RN, SC Health Program Director, Nepal and Mary Beth Powers, Reproductive Health Advisor, SC Westport also participated on the team. Other people who participated in the evaluation in a more limited capacity were Kabir U. Ahmed, MD M.P.H., FPMD/MSH and Abul Barkat, Ph.D., University of Dhaka.

Process

The team followed the USAID BHR/PVC CS guidelines for the final evaluation. These key points are addressed in the outline and body of the report.

During the evaluation, Wilcox, Rai and Powers worked closely with the BFO in Dhaka to review project activities to date. A thorough review of project documentation, including the detailed implementation plan and preliminary and final KPC results, was conducted. The team (Wilcox, Rai and Powers plus the BFO members) also conducted a three day field visit to several of the project sites located in Nasirnagar Thana. The team developed a field questionnaire and local SC staff made the arrangements and schedules for the visits once the team criteria for selection were agreed upon. The methodology developed provided qualitative information from communities in both "old" and "new" unions. A total of six project areas and 15 communities were visited by two field teams. Team members were accompanied by a Government Representative, the Thana Health and Family Planning Officer (THFPO) during some site visits. Team

members met with community leaders, Women's Savings Groups, Traditional Birth Attendants, Village Health Practitioners, family health promoters, group promoters and key health and family planning officers at the Thana level. A list of persons contacted and places visited during the final evaluation is attached. From November 5 - 7 the team was in Nasirnagar (see annex 1 for final evaluation schedule).

After the return to Dhaka, team members continued to work together and arranged interviews with other NGOs, USAID, SC senior staff in Bangladesh, and other individuals involved in the project as appropriate. The team used the information from the field, from interviews in Dhaka and from review of project documents to answer the questions posed in the final evaluation guidelines, so that it would be able to provide Save the Children with a report that documented the progress that has been made during the three years of CS-8 operation and some suggestions that would build on the experience for future health activities in the region.

3. Project Accomplishments and Lessons Learned

3.A. Project Accomplishments

The documented levels of success and positive impact (i.e. significant reductions in both maternal and infant mortality) in the "old" project areas at the time of the CS-4 and midterm evaluations gave the project staff confidence that the model chosen by the project to promote better health behaviors and practices is valid and capable of bringing about measurable reductions in mortality indicators.

A Knowledge, Practice and Coverage (KPC) study was conducted as a baseline in 1992 and as a final in 1995. Data from this study in comparison with the objectives outlined in the DIP are discussed below. However it is useful to point out that SC's use of the community registration and periodic update on individuals information system allowed them to closely monitor the effectiveness and impact of their interventions on a regular basis. In fact this methodology is undoubtedly the major factor that allowed them to reach such high target rates. Regular data collected by the FHPs which was input into the PROMIS information system has allowed the project staff to closely monitor progress toward achievement of project objectives and to establish work plans to address areas where performance was weak. The major purpose of having field workers collect community registration data and include them in the project data base was so they could use specific information concerning maternal child health to identify people in need of services. This system allows the FHP to more carefully target his/her monthly visit with the families they visit (about 350). The project information system is very complete and in addition to providing information for targeting of project activities and management of the program, the information also allows staff to document important changes in program impact. It also permits calculation of maternal, infant and

child mortality rates for the population in the project areas which may be unique among non-research directed projects in Bangladesh.

The FHPs keep the following manual registers so that they can target community members who are in need of particular services:

* children under the age of two for EPI targeting;
* children under the age of six for VAC distribution targeting;
* fertile couples for family planning counseling and methods targeting;
* women between the ages of 15 and 45 for tetanus immunization targeting;
* pregnant women for antenatal services, counseling and possible referral;
* training activities targeted at community members and
* training targeted to WSGs.

This accomplishment of having a very effective community census system though not specifically mentioned in the DIP objectives is noted here as it had a tremendous impact on the level of achievement of project objectives although it may not be a sustainable activity.

The total population covered by the project is estimated to be 157,038, of these 13,022 resided in the Rangunia area. The CS-8 project area included 27,859 households, this represents a total of 25,407 fertile couples for family planning purposes. There are an estimated 28,417 women between the ages of 15 - 45 years of age of whom 9,015 are mothers with children under the age of 5 years. There are an estimated 10,500 children between 0 and 24 months (targeted for immunization, ORT, appropriate breastfeeding and weaning activities).

3.A 1. Objectives Outlined in DIP

A complete presentation of the objectives, the targets set for each, the baseline and final rates achieved are presented in the adjoining pages. Here, I would like to make some comments about the accomplishments and some issues which arose in implementation and evaluation in four areas: immunizations; diarrheal disease; family planning and vitamin A capsule (VAC) distribution.

immunizations

* Out of the nine interventions, one of the most successful has been the immunization levels achieved by the project. Among the target group of children 12 to 23 months, 34% were fully immunized at baseline and by the end of the project, the total had climbed to 81%. Among women of fertile age who were appropriately immunized with at least two doses of TT, the baseline reported 79% and the final 96%.

The MOHFW directors were especially pleased by this as they received commendations from their superiors for being the thana that achieved the highest immunization rates in the country.

* In the final survey the retention of child immunization cards was 87% whereas in the baseline it was only 27% suggesting the new importance accorded to the household immunization records. Likewise in the final survey 86% of mothers had maternal health cards and only 13% had them at the time of the baseline, a significant improvement.

• The BCG to measles drop out rate was reduced to 26.9%, from 58% in the 1992 baseline survey. National data indicates a 46% drop out rate (DHS 1993-4). This again points to the value of the information system and the unparalleled capacity for follow-up in a system which tracks each individual.

Diarrhea1 Disease Treatment

* Use of oral rehydration therapy (ORT) for children under 2 with diarrhea, that occurred in the last two weeks preceding the survey, increased from 14% in the baseline survey to 44% in the final. The difficulty in achieving the targets in objectives related to ORT suggests the complicated nature of the message, the difficulty which mothers have in actually "seeing the results" and ingrained behaviors to reduce fluids and feeding during diarrhea. Other achievements in DD control were similarly below SC's expectation:

* 45% of the diarrhea cases, in the final survey were given the same amount of breastmilk and 28% were given more.

* 28% of the diarrhea cases, in the final survey were given more fluids and 31% were given the same amount of fluids.

* 22% of the diarrhea cases, in the final survey were given more solid food and 30% were given the same amount.

These results, while leaving room for improvement, suggest the value of using a group which will continue to meet to promote and sustain behavioral change. Women inside the savings groups act as resources for each other when questions arise regarding how to treat a child's diarrhea episode.

Family Planning

Family planning is another area where CS-8 was able to make significant progress

over the life of the project in spite of initial constraints. Nasirnagar is still a religiously conservative area although now, due to project efforts, particularly the training of religious leaders, some of the attitudes are changing.

* During the period of CS-8 the contraceptive prevalence rate increased from 9% to 38%.

* In the final survey 50% of the women stated that they wanted to wait three or more years before having another child. 30% stated that they wanted no more children. In the baseline 29% said they wanted to wait three or more years and 27% said that they did not want any more children.

Distribution of Vitamin A Capsules

This is another area where the CS-8 project has made significant progress suggesting that particularly where something concrete is provided to community members, motivation to receive services is high - even higher than the understanding of the benefits sometimes.

* In the final survey 92% of children 6 months to 6 years have received vitamin A. This indicator has progressed far beyond the original DIP objective of 60% and the baseline of 25%. It is interesting to observe here that while the practice of using VAC capsules is high, knowledge about the reason for using it was only 81% or 11 percentage points lower.

SUMMARY OF CHILD SURVIVAL 8 OBJECTIVES

	Target %	Baseline %	Final %
Immunization			
• Children 12-23 mos. completely immunized at project end	80	34	81
• Women 15-45 yrs. appropriately immunized with TT (at least 2 TT)	80	79	96
• Mothers will know the correct age for measles immunization	80	8	82
• Mothers will know the purpose and number of TT immunizations	80	38 72	79 89
ORT			
• Mothers will use ORT when their child has diarrhea	50	14	44
• Mothers will administer more fluid during diarrhea	90	7	28
Breastfeeding Practices			
• Infants <5 months will be exclusively breastfed	30		42
ARI			
• Mothers will recognize danger signs of ARI	70	38	72
• Mothers recognizing ARI danger signs will seek treatment (i.e., clinical care from GOB, SC, VHPs	80	60	84
Weaning Practices			
• Mothers will know and practice appropriate age for weaning	50	23	81
Family Planning		9	38
• Contraceptive practice will be higher than baseline	10% more than baseline		
Vitamin A			
• Children 6mos-6yrs will be covered with high potency Vit A capsule	60	25	92
Maternal Nutrition and Care			
• Mothers will know that food consumption should be increased during pregnancy	30	10	65
• Mothers will attend at least 2 prenatal sessions	60	20	78
• TBAs will be trained as per GOB & SC training module	80	17	94
WSG			
• Women from Target HH will be members of WSG	70	9	48

3.A2. Unintended Positive and Negative Effects of Project Activities

Through a brainstorming exercise, the evaluation team identified and classified (as + or -) the following unintended effects of the CS-8 Project in Nasirnagar:

* (+) Due to the presence of the project in the region there is now a more regular functioning of the government outreach services. Since this was primarily a demand-raising project, one might consider this as a by-product of communities voicing effective demand.

* (+) As a result of the training given by the project to the Village Health Practitioners (VHPs), they formed their own association and have thus incorporated themselves in a more formal way. This should lead to more formalized training, skills exchange and improved practices as SC and others attempt to continue to improve this local resource.

* (+) The development of a Women's legal aid organization (The "Oppression Against Women and Legal Aid Society") came about as a result of the self esteem efforts and research being conducted with groups of women in the WSGs. This organization, now seeking legal registration, was formed with members from Women's Savings Groups and will serve as a resource for women who need legal advice or have domestic problems for which they may need outside assistance.

* (-) There was a feeling on the part of the SC BFO that the project raised expectations among communities that can not be met. Once the members of the communities were convinced of the benefits of the health activities and the income generation activities conducted by the WSGs, there were demands for more activities and resources.

* (+) The partnership between SC and ASA was revised in order to allow the joint WSGs to reach the poorest of the poor. When SC formed the partnership with ASA and had ASA take over the credit system for the WSGs (in order to make them more sustainable), there were certain requirements that the WSGs had to go along with that were not in the original SC savings and credit program that they participated in. The requirements included a weekly required savings amount and the fact that all members had to take out loans. The poorest members could not meet these requirements and therefore had to drop out. As a result, SC negotiated a new agreement with ASA to allow the SC formed WSGs to have a longer time period to pay back loans (15 - 20 months instead of 9 months), also only half of the WSG members have to take out loans. In addition the weekly savings amount from members was reduced from 5 taka to 2 taka.

* (-) The ambitious target indicators discouraged constructive efforts towards the achievement of long term project sustainability. This point is further discussed in the lessons learned and in the recommendations sections of this report.

* (-) Despite several years of SC activity in some of the communities, there still appears to be a high level of dependency on SC by the community leaders. At the present time there is no plan for community takeover of these functions.

3.A3 Final Evaluation Survey

A copy of the Final KPC study results is located in appendix 4 of this report. It was conducted during August 1995 from 300 respondents who were women of fertile ages (15 - 45) who had children between 0 - 23 months.

3.6. Project Expenditures

3.B1. Pipeline Expenditure Report

The pipeline analysis of expenditures is included as Appendix 8.

3.82. Expenditure Comparison/Budgeted vs. Actuais

The only area where the SC budget was grossly overspent was in the area of consultants, in part due to the recommendation of the Mid-term Evaluation that the BFO conduct an analysis of cost-recovery options for the project. The consultant chosen was expensive and this caused the consultant expenses to be twice those projected. Since the final evaluation costs were not yet quantified at the point of the evaluation, the evaluation line item was largely underspent, but this is likely to change when bills for the evaluation exercise are entered into the financial system. Finally, travel funds were somewhat underspent by the project as in-country travel expenses remained low during the life of the project, and fewer than estimated international trips were taken by project staff to attend CS trainings and workshops.

3.C. Lessons Learned

Three years is too short a time period to improve knowledge, establish practices, and expect sustainability.

The project began with two unions which SC had worked in during the CS 4 project. However, SC expanded activities into 5 additional unions and achieved outstanding

results in terms of changes in knowledge, practices and coverage. However, it is unclear to what extent these changes can be maintained at the community level. SC might have sought additional central AID funding to continue working with the five newer unions as well as extending to new areas, but the new Child Survival project guidelines for CS 12 make SC-Bangladesh ineligible since they have received two consecutive grants. Efforts to continue motivation with the WSGs and to turn over leadership of health motivation to the community level could be better achieved if SC had additional funds to continue health activities.

The WSG approach is a good way to motivate the population to change behaviors. SC's overall focus on the empowerment of women provides them with the capacity to solve life problems, including health problems, and thus becomes a longer term economic and social support system.

Not only were WSG members knowledgeable about the health practices which would protect their children, they solved community conflicts, initiated a legal aid organization to protect women, and improved their own and their community's financial situation. WSGs also had access to emergency health funds to cover transport to higher level facilities in cases of critical need.

SC's alliance with ASA, a local NGO working to expand credit to women had positive and negative effects.

The partnership with a large local NGO will allow SC to grow in the area of development of WSGs in a larger area and with additional capital and support services provided by ASA. Since ASA is a local organization which predates SC's activities in the credit sector, the sustainability of the WSG approach is enhanced by the partnership. Many low income women were aided by the access to credit and the forced savings approach promoted by the ASA/SC alliance. However, SC and ASA had different objectives and interests: SC wanted to target the poorest community members while ASA had more of a business orientation and wanted to continue to collect interest to pay for its field workers and to spread its capital further. At the initiation of the partnership, some WSGs were dissolved and reorganized because ASA had strict criteria for membership which included a higher weekly savings requirement (5 taka per week) and insisted that all members had to take at least a 1000 taka loan from the beginning and then had to begin repaying with interest. These two prerequisites discouraged some of the poorest women from joining savings groups Since SC had always tried to target the poorest elements of the community, through negotiation with ASA, they were able to come to an agreement to reduce the weekly savings requirement to 2 taka, and to allow some members into the savings group as long as there were already ten women in the group who were taking the compulsory loan. Thus, the partnership with ASA is in the long run likely to strengthen WSGs in the area and will continue with SC to reach the poorest

community members.

Complete community registration and monthly home visits can achieve significantly higher /eve/s of effectiveness indicators and mortality information.

When comparing the KPC results after 3 years of activities in Nasirnagar with the results achieved by CARE in a similarly deprived area, SC's accomplishments were significantly better. By having monthly home visits with mothers and having a roster of which community members needed services, FHPs could target their work for greater efficiency and effectiveness.

Community mobilization through a staff-intensive approach and high /eve/s of community level inputs can create dependency by the government and communities.

Placing community development staff and FHPs throughout the communities with whom SC is working has had a positive effect in terms of impact. However, community leaders and government health officials seemed to dread the day when Save the Children would phase out of activities in their area. Thana-level health officials felt that communities would not be motivated for immunization and family planning if SC staff were not present. Community leaders in an area where SC has worked for over 20 years felt they could not take on the motivation and other activities which SC staff had accomplished. They actually suggested that SC could leave after another 10 years of assistance! While we could expect that community members and even government officials would fear the removal of external resources which an organization like SC brings to their area, it seemed that perhaps more direct linkages between the government and the community members themselves should have been forged by now so that both would not be dependent upon SC as a bridge to the other. SC needs to have serious plans about how long they should be working in any community, and to withdraw as scheduled, rather than allowing new funding to continually undermine their discussions with community members about phase-over of activities and responsibilities.

Training in improved practices for locally established private health providers such as the TBAs and VHPs, is sustainable, cost effective and beneficial to the health of the community.

TBAs and VHPs predate SC's activities in these communities. The TBAs collect gifts-in-kind for each delivery they attend; VHPs provide services for fees and sell appropriate treatments or give a prescription for free drugs from the government services. SC did an excellent job training these groups in improved practices and those interviewed could well document how they used to treat problems and their current approaches. For example, TBAs used to put dung on the stump of the umbilical cord;

one TBA mentioned how she realized after her training that they may have been the cause of tetanus deaths among infants in her community. VHPs recounted their previous prescriptions of a barrage of antibiotics to treat diarrhea, often coupled with IV fluids; now they were recommending ORS, unless there was a case of severe dehydration, a condition which they previously did not differentiate from mild dehydration. These two groups will continue their work and have developed not only better positive practices, but also have reduced harmful practices.

The DEMAND generation approach to expand utilization of government health services in order to achieve high maternal-child health targets creates tension over sustainability strategies and objectives.

While the SC project had developed sustainability strategies, significant attention was placed upon achieving targets to the neglect of addressing sustainability issues. While cost recovery mechanisms were originally used by the project, they were abandoned due to the belief that poor people would not pay for these basic preventive services. Government officials and policies also are not supportive of cost recovery efforts and thus SC faced little pressure to re-introduce their attempts to generate some of the recurrent costs of the project. To achieve high levels of coverage, SC developed a costly field worker system, and did not design any potential incentives so that health workers might continue their activities after the end of the project. Despite the recommendations of the Midterm Evaluation to explore the sustainability issues, a study was done late in the project which surveyed what others were doing in Bangladesh, but did not provide an analysis of the ability of Nasirnagar community members to share the costs of the project. Rather, the SC staff concentrated efforts on achieving the targeted changes in behavior and knowledge, believing this to be the more important program goal to the community members, government counterparts and the donor.

4. Project Sustainability

The mid-term evaluation had some clear recommendations about the need to further explore the issue of recurrent costs and cost recovery mechanisms. It notes that cost recovery mechanisms needed to be implemented in order to maintain existing recurrent costs of the project (mainly stipends for FHPs and materials in support of public sector delivery of services such as immunization). The authors also noted that the prevailing "conventional wisdom" stated (with little evidence to support this assertion) that it is not possible to ask beneficiaries to contribute directly to the cost of preventive services. However the authors also note that in the SC/Mothercare project, 90% of the community women participated and none of them objected to paying a 2 taka registration fee.

Despite this recommendation, the only effort made on the part of the project to further investigate the cost recovery issue was to commission a study (by Priti Dave Sen) which did not occur until June 1995 and by the time of the final evaluation no action had been taken regarding the recommendations. The author compared experiences with other agencies regarding cost recovery and the potential of WSGs to play an expanded role in community financing and insurance schemes. She found that there was potential to recover some costs (though not all costs) and that there was some interest in prepayment for services that community members might directly benefit from. In conclusion however, the author recommended more studies to further explore both these issues.

It was discovered by the evaluation team during field visits that WSG members and community members both thought that they would be willing to pay "something" for good quality service whether preventive or curative. There was some doubt regarding whether they would pay for the education and motivation activities provided by the FHPs but some thought that they could pay for part of the expense. Another obstacle mentioned in both the mid-term evaluation and the Sen study is the GOB's prohibition against charging for contraceptives and services. However when the evaluation team questioned thana health officials about this they indicated that they were personally in favor of charging for services and medicines but they would need someone like Save the Children to intercede on their behalf with their superiors in Dhaka to allow them to pilot test this type of model. They felt that they would not be able to get this permission on their own and any studies or data to back up the feasibility of this option would be useful.

What is needed here is a directed market study aimed at discovering what services people are willing to pay for and how much they are willing to pay if offered "quality" services. Once this can be determined then services can be structured accordingly and estimates made regarding amount of recoverable recurrent costs. There did not appear to be any outlets for low cost - revolving fund medications and this could be further explored in the market study.

Other issues pertaining to project Sustainability are discussed below.

4.A. Community Participation

Save the Children typically involves community members in the process of problem identification and solution design. Thus, the time and energy of community members is contributed at the beginning of SC's work in any area. In addition, in Nasirnagar, the participating communities contributed the following resources:

- Outreach EPI sites/satellite clinics and furniture,

- Trained community service providers and members will continue with improved skills. These include TBAs, VHPs and WSG members.

- Land for the SC center and offices in villages and regional areas was donated by the communities and will continue to be used for community purposes.

- The meeting space for the WSGs (400+) will continue to be used for this purpose.

- Community volunteer services for health campaigns (sterilizations, immunizations etc.) will continue.

- Community members have paid for services from the VHPs and TBAs and will continue to do so.

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

The main sustainability strategy of the SC project, was to utilize WSGs as the vehicle for message delivery, and as the arbiters of new behavioral norms which might protect the health of this and the next generation of women and children. Due to funding which SC has raised, the value which community members place upon access to credit, and importantly, SC's partnership with ASA, a large local NGO which works in the credit sector in much of the country, it is likely that the WSGs will continue their activities. What is not clear is which woman among the WSG membership will take on the role of giving the educational reminders about the new health behaviors engendered by the project. Still WSGs visited were knowledgeable about the health behaviors promoted by the project and valued the contribution of SC's work in the community.

Secondarily, SC sought to improve the practices and knowledge of service providers. Specifically:

- The MOHFW will sustain the EPI++ (FP,VAC) programs. It is possible that these will continue at a lower rate without SC's extensive mobilization efforts, but the MOHFW has the staff, supplies and enhanced equipment (from the CS-8 project) to continue these services.

- The Village Health Practitioner Association will continue and the VHPs' practices are self sustaining, i.e., already financially sound. SC will provide refresher courses for the VHPs either from SC funds or by charging registration fees.

- The TBAs will continue providing services in their communities. There are between 800-900 in the project area. SC will provide refresher training for them from their

own resources.

Finally, a third group whose support was sought by the project were religious leaders. SC's success in motivating this group to support family planning and other behaviors which protect the health of women and children was recognized and supported by a partnership grant with Pathfinder to take the training to the larger community of religious leaders throughout Brahmanbaria District. In addition, religious leaders who were already trained by the project will also continue. It is anticipated that they will continue to support project objectives in their communities encouraging members to seek improved preventive care.

4.C. Sustainability Plan, Objectives, Steps Taken, and Outcomes

The following pages provide a table which examines the goals of the project, the sustainability steps taken to ensure that behavior change will be sustained, and the outcomes of the project related to the objectives.

GOAL	END OF PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
Improved health status and protective health behavior will be continued by higher proportion of families.	Promote health activities during home visits.	Monthly visits by FHPs to households of women of reproductive age and children under 6 Home visit roster developed WSGs formed	100% of homes visited by FHPs.
	Reinforce protective health behaviors among WSG members.	Protective health messages provided to WSG members.	-455 WSGs formed -Members of all WSGs received health education in EPI, VAC, FP
	Community workers with improved skill in case management.	Training of TBAs Training of VHPs Training of nurse midwives Training of CHOs	- 863 TBAs trained - 210 VHPs trained -3 nurse midwives trained -8 CHOs trained
	FHPs will remain in the community	FHPs trained and utilized by the project	-118 FHPs trained and utilized for project duration

Same	-Social marketing of iron folic acid/contraceptives will be explored for the continuation of FHPs -Information about Sustainability will be shared with other PVOs - Emergency fund will be developed for emergency cases	- Project initiated fees for ANC service (2 taka for registration) - Some sustainability information was shared with other NGOs during PVO, CS conference in Oct. 1993. -Emergency loan/fund established without interest	- strategy abandoned - Annual and semi-annual reports were sent to other PVOs. - All WSG members have access to emergency loans.

5. Recommendations

These recommendations should be considered by SC as they evaluate plans to continue assistance to these same communities for health promotive behaviors, and additional women's empowerment, education and health interventions.

A. There is a need for more internal technical assistance for the new version of the PROMIS information system used by the BFO. Although all the field data was input into the system on a regular basis, the staff was not able to perform some of the more complicated analysis of it by the time of the evaluation.

B. It was also recommended by the team that a certain portion of Save the Children's private funds be set aside to maintain the existing data system. It is anticipated that there will be additional activity conducted in these communities by SC, and USAID/Washington has expressed interest in the SC community enrollment data collection method, so it is possible that in the future efforts will be made to make use of the data. So it is recommended that an attempt be made to keep up the data collection in the project areas even if it is a scaled back effort. Quarterly updates of the data should be adequate until SC determines if there will be additional health activities in the area. This should also be used to advantage to uncover more of the linkages between women's empowerment and health outcomes.

C. Save the Children/Bangladesh should be encouraged to seek additional funding from other donors in order to continue some of the project activities that still need attention because either targets weren't met, such as ORT or there simply needs to be a continued if not expanded effort such as in reproductive health. Project staff are currently analyzing the results of a reproductive tract infection study conducted this year

and will approach donors with interventions which could improve women's reproductive health in the area.

D. During the remainder of the project, SC staff needs to strengthen the abilities of MOHFW personnel particularly in the areas of counseling, community mobilization, and management so that they can continue these efforts once SC scales back. Some system of alerting communities for upcoming health sessions (EPI++ and surgical contraceptive methods campaigns, for example) needs to be established, either utilizing SC or ASA staff with the WSGs, or some other mechanism to motivate community members to attend the health sessions.

E. SC staff need to concentrate on helping community leaders bridge the gap that currently exists between themselves and the health services. The communities need to feel sufficiently empowered to be able to access appropriate health services for themselves (without depending on SC to do it for them). They need to know who to talk to in order to get the services they need, and they need to know what the government expects them to do in order to move this process along.

F. Given that there are so many national and international agencies working in Bangladesh and given that many of them are substantially larger than Save the Children, it would be useful for SC/B to carefully analyze its niche. Its unique programming methods using population based data systems could be one example. However this is something that needs to be carefully studied by both SC/B and SC/US and in consultation with donors.

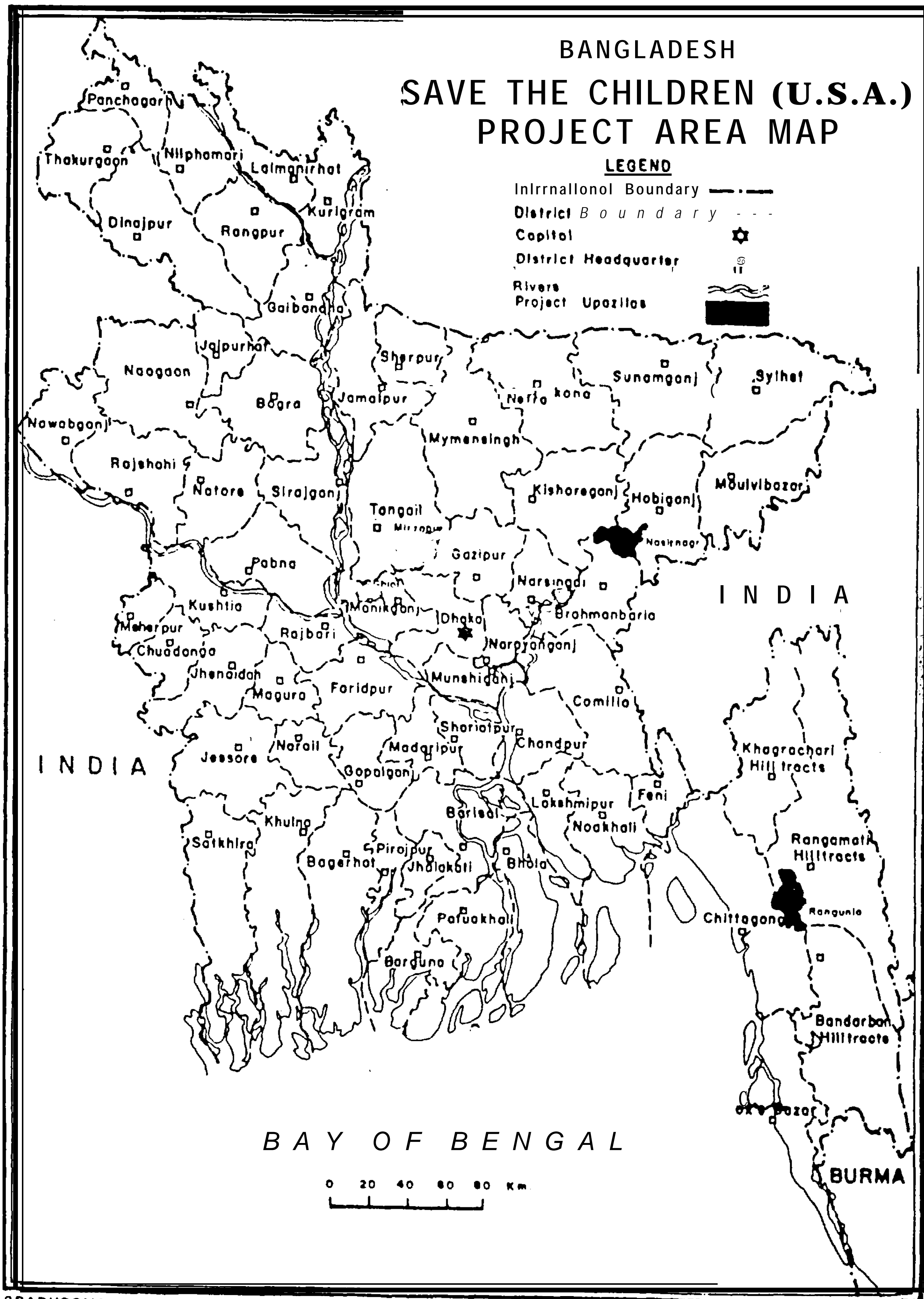
G. One area that needs to be further explored with the MOHFW is that of cost recovery. As mentioned in other sections of this report, the government officials at the thana level of Nasirnagar stated that they would be interested in implementing a cost recovery effort in the current project area. This would require technical assistance including marketing, costing and pricing studies to be done in the region and interventions appropriately designed. It would also require that SC make this request of a "pilot study" to the central government so that the thana be allowed to implement the pilot activity. SC/Nepal has had some success in marketing and pricing studies with regard to the Safe Birth Kit in Nepal. The same consultant might be available for SC/Bangladesh's use which would work to SC's advantage since he is very familiar with the organization, and with health service delivery in South Asia.

H. There needs to be more promotion and marketing of Save the Children/Bangladesh's health program among donors. When the evaluation team visited the USAID/B officials they found that they (USAID) did not know much about the SC program. It would be useful for BFO staff to brief USAID and other donors about the results of the current project and planned follow-on activities. Some project

activities that might interest them include: the population based management information system, the project's successful work with religious leaders, the success of the combined women's credit program and health activities, the results of the Reproductive Tract Infection study completed this year.

I. Abul Barkat who did the final review of project activities in Rangunia had a recommendation concerning phase out operations. He suggested that when SC phases out of an area, they need to do so with a lot of community preparation and they need to have a detailed plan of action. From the beginning they need to be preparing the communities for their eventual withdrawal, asking each community to take on more and more responsibilities so that at the time of the phase out, it is less of a shock. He also stated that the phase out should not be delayed, i.e., that once the date is set that it not be changed.

J. Finally, it is worth noting that SC was able to achieve remarkable results in only three years of activities in a number of the sites under the current project. The sustainability of the behavior changes might be more likely if SC could have applied for additional CS funds to continue in those areas with only three years of action, and take on some new areas. Unfortunately, USAID BHR/PVC Office's CS 12 proposal guidelines disallowed applications from PVOs who had received two consecutive cycles of funding in a country -- even if a change in venue was part of the new project design. The greater time invested in the follow-on funding could help sustainability efforts to be established. As pointed out in the lessons learned section, three years is simply too short a time period to get a program up and running, educate communities about prevention, achieve high target rates of compliance, and make all these services sustainable.



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APPENDIX 6

Target Population for SC Project

1. <u>Population:</u>

Area	# of Vill	Population	# HHs	Tg. HHs
Nasimagar	65	144,016	25,822	19,946
Rangunia	4	13,022	2,037	1,391
Total	69	157,038	27,859	21,337

APPENDIX 7

Final Evaluation Report: Rangunia Impact Area

SUSTAINABILITY AND PHASE-OVER ISSUES: RANGUNIA IMPACT AREA (CS-8 RANGUNIA: FINAL EVALUATION REPORT)

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Prepared for
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I. OBJECTIVE

The main objective of the current evaluation was to assess the critical issues pertaining to the phase-over and **sustainability** of CS-8 Project of the Save the Children (USA) in Rangunia Impact area, The specific objectives of this evaluation were to: assess Government officials perceptions regarding SC activities in **the** project area and Possible problems due to the phasing-over; analyze the training activities provided to the village health practitioners; assess various aspects of womens' savings groups and the recently constituted womens' development committees; analyze the extent of community involvement; provide an analysis of the phasing-over experience; and finally based on the problems identified and lessons learned recommend feasible suggestions for the future.

II. METHOD

In order to accomplish the above stated objectives, two members of this evaluation team **(Dr. Nazma** and Dr. Barkat) have reviewed all relevant documents, and visited four spots in the Rangunia Impact Area during July 30-31, 1995. The evaluation team members held discussion meetings with twenty-six persons comprising GOB officials! SC-staff, members of Women's **Savings** Group (WSG) and Women Development Committee, village health practitioners (VHP), school teacher (list of **persons** contacted is appended). Three focus group discussions, one each with the WDC, SC staff, and VHP were conducted. In addition, all relevant official documents available in the field were reviewed.

III. FINDINGS AND RECOMMENDATIONS

3.1. GOB Officials' Evaluation of the SCF Performance

Three GOB officials. namely the **Thana** Health and Family Planning Officer (THFPO), **Thana** Family Planning Officer **(TFPO) and Thana** Livestock Officer (TLO) were interviewed. All of them highly appreciated the **SCF** activities pertaining to awareness building, motivation, **community** mobilization, and linkage establishment activities. Among various activities of SCF, specially mentioned were the activities of the family health promoters **(FHP)** and the Union Vaccinators (UV). Some specific examples cited **by** the GOB officials are as follows:

o "National Immunization Day (NID) performance in SCF area was 100 percent and it was without the Government **support" (THFPO).**

o "Everyone in the SCF area know **how** to prepare ORS" (THFPO).

o "Sanitation awareness and awareness about pre-and-post-monson malaria is highly satisfactory" **(THFPO).**

0 "Sixty-six Poultry Vaccinators trained through SCF each earns Tk.500-800 per month" (TLO).

- "SCF plays a vital role in poultry farm development. By establishing linkages between general population and the **Thana** Livestock Office. SCF has done a great job of human resource development" (TLO).

- "There is no government sanction of Livestock and poultry development for the **Tila** people (other side of the river). Thus, the livestock development sub-center established for the **Tila** people through the assistance of SCF should be treated as a real response to development" (TLO).

- "I am confident about the family planning and MCH performances of the SCF staff" (TFPO).

Problem(s): In Rangunia **thana,** 21 posts of Health Assistants and 13 posts of **FWAs** are **lying** vacant. **Some** of these areas where posts are vacant were served by the SCF staff. According to both THFPO and TFPO, as a consequence of withdrawal of SCF stiff health **and** FP performances in those areas **will** slow down. However, THFPO is trying his levels best to **fill-**in the vacant posts as earliest as possible.

Lessons Learned: In any phase-over plan in the future, problems related to the vacant government posts at the grass-root level should be resolved well ahead of time. This aspect should be a built-in component of the phase-over plan.

3.2. Training to the Village Health Practitioners (VHP)

In **all**, fifty VHPs were imparted short training (4 days). The relevant GOB officials-THFPO, MOMCH-FP and **SC/Dhaka** staff were involved as trainers. The trainees **(VHPs)** reported that the training was extremely beneficial for them.

They could obtain various information which were **not** known to them earlier. The following Table shows some of the benefits of training in terms of new information received by the trainees and improper status of knowledge before training.

Subject/specific issue	Knowledge before training	Knowledge in-training
1. Emergency Obstetric Care (EOC): Convulsion in a 5 months pregnant woman	· Eclampsia	• This may be due to lack of calcium
2. Diarrhoea	• Don't **give drinking** water	• Give drinking water
	• Breastfeeding should be stopped	• Breastfeeding should continue
	· Prepare half packet ORS	• Prepare full-packet
	· Administer high spectrum antidiarrhoeal drug	• Nodrugneeded
	· Diarrhoea and Dysentry are the same	• Not the samething
3. EPI	· Don't immunize, if fever	• Not true
	• Lack of knowledge about when to give what immunization	• Now knows
4. Pregnant mother	· Should not eat much during pregnancy	Should eat for two
	• No need of TT	• TT needed
	• Home delivery is safe	• Each pregnancy is a complicated one
5. Jaundice	• Paracetamol needed to administer	• Not needed
6. Malaria	• Steroid therapy (combined therapy) needed	• Steroid therapy decreases potency
7. Pneumonia (ARI)	· No knowledge	• Can differentiate pneumonia and no-pneumonia

As to the benefits of training, almost all village health practitioners participating in the Focus Group Discussions, have said:

- **"Since we are the closest to the grass-root people, any training imparted** to us very quickly goes downward".
- "After having very practical knowledge about the most recent technologies, we now don't misuse medicines, and we are now more capable than before to do ethical medical practice".

- "We have disseminated knowledge. Thus, compared to the other areas in our villages you will find relatively less prevalence of diarrhoea, more antenatal care, higher use of safe drinking water, more pregnant mothers receiving TT, higher EPI performance".

- "You will also notice positive trickle-down effect of our areas on the adjacent villages".

Problems: With the development of medical sciences, new knowledge will come-up and should be disseminated at the level of the VHPs. After withdrawal of SCF/USA, who will do that? Need for refreshers training was mentioned by all VHPs. Who will provide that training after withdrawal of SCF?

Lesson Learned: SCF/Rangunia was instrumental in linking the VHPs with the Government Health and FP officials. The relevant Government officials acted as guest trainers. The THFPO suggested that in the future, provisions for some sort of regular refreshers training for the VHPs need to be instituted. Thus, this positive component of public health concern should be actively considered in the future SCF programs.

3.3. Women's Savings Group (WSG) and Women Development Committee (WDC)

Women's Development Committee (WDC) is an innovation by the local people. WDC formed in October 1994 will act as an organizational (institutional) alternative of SCF. The WDC as the umbrella for WSGs (17 in total) will be entrusted with the following responsibilities: coordinate and direct the activities of the WSGs; assist WSGs in the formulation and implementation of income-generating activities; undertake programs on health and environmental issues; help undertake activities for local resource mobilization; Linking WSGs with the relevant Government and NGO officials; undertake training programs for the WSGs; form new WSGs; coordinate activities of the WSGs and ensure solidarity among the members, expand program activities? etc. The organizational structure and roles and responsibilities of the members of WDC is well documented in its constitution. The total savings of 17 WSGs under the WDC is Tk.300,000.

The WDC members participating in the group discussion have said that due to their *long* association with SCF staff, they are already aware of the availability of possible local resources which can be gainfully used for the benefits of the women, children, and their families. The WDC members think that WSG leaders are capable enough to act as a link between the WSG families and the relevant sources of local resources (GOB, NGO, others). There already exist good examples of viability of WDC. One such example is "stock business". Under the income generation project, some WSGs bought seasonal agricultural products (potato, chili, etc.). WDC took the responsibility of storing the product in a

cold storage. In the process, WDC used their own transport "rickshaw van". WDC arranged the storage facility at a relatively lower cost. Thus, as an intermediary, WDC could save cost on both transportation and storage. Ultimately, the rate of return was higher than could be if the total business was handled by the individual **WSGs.**

Problems: The members of the WDC are not very experienced in business/trading activities. It is difficult to establish a strong factor which will act as **a** driving force to unite the **WSGs** under a general command of the WDC. It is not easy to establish the role of the WDC in the non-economic activities of the WSG. It is also difficult to say anything about the future of WDC (whether they will sustain or not) without male participation and support.

Lesson learned: Before phasing-out from an area, some experimentation with WDC is needed. WDC activities need to be monitored for sometime, at least SCF should maintain some liaison with the WDC for sometime to track their progress, learn about real field problems. provide solutions. All these experiences could be used in the future phase-out planning.

3.4. Local Infrastructure Building and Community Involvement

The community involvement in local infrastructure **building** should be treated as a major achievement of **SC/Rangunia project. The** description of the buildings constructed with substantial community contribution and their present market valuation is shown in Table 1. The total present market value of four buildings constructed in four 'impact area villages is about Bd. Take 2 million, of which about 37 percent was contributed by the community. After phasing-over all the infrastructure became the property of the Women's Development Committee, and they have decided to use those facilities for multipurpose activities (hospital? *women's* college, livestock development purposes, etc.).

Problems: It is early to foresee problems associated with the proper utilization of the buildings. It is also difficult to predict the decision making situation which WDCs might face if any of their buildings fail to serve their purpose(s).

Lesson **Learned:** Community people, if motivated? can contribute substantially for the construction of fixed assets. Women, motivated through **WSGs,** are capable enough to take decisions pertaining to the best use of community facilities.

TABLE 1: DESCRIPTION OF BUILDINGS CONSTRUCTED WITH COMMUNITY CONTRIBUTION

Village	Present market value (in Tk.)	% community contribution	Description of building	Transfer of ownership after phasing-out to:
Kulkurmai	650,000	30.8	1,800 sq.ft. on 17 decimal land	1. Chandragona Mission Hospital 2. WDC
Syedbari	600,000	48.3	1,800 sq.ft. on 27 decimal land	1. Women's college 2. WDC
Ichamoti	400,000	35.0	2,700 sq.ft. on 12 decimal land	1. WDC 2. Livestock department
Minagazirtila	200,000	25.0	800 sq.ft. on 4 decimal land	1. WDC 2. Livestock department
Total	1,850,000	36.8	7,100 sq.ft. on 60 decimal land	XXXXXXXXXXXXX XXXXXXXXXXXXX

Note: Present value is approximate market value. Estimated based on information obtained from Impact Area and Field Coordinators of Rangunia Project. Market *value of similar construction was also crosschecked in Rangunia.*

3.5. Phasing-over Experience

Regarding the phase-over experience the team had detailed discussion with all **SCF/Rangunia** staff, selected WSG members, and with the relevant GOB personnel. The experience is rich with both encouraging and discouraging findings, which are important for planning of sustainable programs.

- The most encouraging (positive) findings pertaining to phase-over are as follows:

  (a) all activities were completed within the stipulated time,

  (b) WDCs were formed as planned,

  (c) 31 WSG members **were** imparted a seven days training on "leadership and group management" from a reputed NGO **SAPTAGRAM** (Shastipur, **Kushtia**),

  (d) 61 members of WSG were imparted one day training on "group sustainability" from Community Development Centre (CODEC), Bogra,

(e) 36 members from 4 WDCs were trained on how to establish links with **GOB** and other resources. Linkage development workshops were conducted,

(f) All scheduled meetings of SCF staff with the GOB and NGO officials were held.

- Some of the discouraging findings (experiences) are as follows:

  (a) Although "phase-over" issues were discussed many times in the past, at least for the last few years, it was not really meant. Because, no serious step on phase-over was undertaken in the past. Thus, for most of the **SCF/Rangunia** staff, till recent past the inner meaning of phase-out sounded like "work hard, otherwise we will phase-out". So, the real phase-over was difficult to accept - psychologically.

  (b) The concept 'phase-over' was not a transparent built-in component in the whole activities. From the very beginning? staff were not well informed about the phase-over of program and staff.

  (c) Problems were faced in the hand-over of fixed assets.

  (d) In the staff phase-over process, the dedicated staff of **SCF/Rangunia** pot "termination letter" instead of a "certificate for good work in the past". This letter, -especially the word "termination" acted negatively on the morale of the staff.

Lesson Learned: Phase-over, after a long presence of 23 years, was obviously a complicated issue with various dimensions and consequences. Based on the limited experiences gathered from the field, we think that there should be a transparent and well-knitted phase-over strategy which will facilitate all activities pertaining to phase-over. The component of the future phase-over strategy could be as follows:

- Phase-over should be a built-in component in the total plan.
- Staff should know from the very beginning that program will phase-out.
- Phase-out should follow a step-by-step procedure. It should not be a sudden one. A step-by-step phase-out as shown below would be more acceptable and each-step is built upon the experiences of the previous step(s). With each phase-out of the program component/sub-component, the relevant staff also phases-out.

MODEL OF STEP-BY-STEP PHASE-OUT

Time	Program Component(8)				
1990	1	2	3	4	5
1991	1	2	3	4	X
1992	1	2	3	x	x
1993	1	2	x	x	x
1994	1	X	X	X	X
1995	X	X	X	X	X

Note: *Cross marked component(s) (x) is (are) phased-out one(s).*

- Orientation to the GOB officials and local leaders on phase-over should start from the very beginning. They should be given idea that phase-over is the essence of sustainability.
- There should be some principles of asset distribution before phase-overs.
- After phase-over, activities should be monitored/ tracked for sometimes (say 1/2 years).

LIST OF PERSONS CONTACTED AT RANGUNIA

A. SCP: Rannunia Office Staff

	Name		Designation
1.	Abdul Jabbar		Impact Area Coordinator
2.	Jahanpir Kabir	:	Field Coordinator
3.	Promade De Costa	:	Community Development Organizer, Tila/Ischamati
4.	Purnima Debi	:	Community Development Organizer, Syedbari
5.	Shanti Dutta		Community Health Organizer
6.	Swapan Barua	:	Sericulture Assistant
7.	Md. Alamgir	:	Office Assistant
8.	Mon ju Barua		Family Health Promoter
9.	Nurul Amin		Family Health Promoter
10.	Rina Barua		Family Health Promoter
11.	Kanchon Biswas		Night Guard
12.	Md. Alauddin		Care Taker

B. GOB Officials-

	Name		Designation
1.	Dr. Mofazzal Hossain Mian	:	Thana Health and Family Planning Officer
2.	Dr. Abdul Hai	:	Thana Livestock Officer
3.	Alauddin Al-Azad		Thana Family Planning Officer

C. Women Development Committee-

1. Rehana Begum : President
2. Notika Prava Barua : Vice-President
3. Mon ju Barua : Secretary
4. Lakhi Barua : Member
5. Krishna Chakravorty: Member

D. Others

1. Dr. Kalachand Acharjee (Clinic Doctor)
2. Md. Sahar Ali : Headmaster, BIJH, Government Primary School
3. Parimal Kanti Shill : Village Health Practitioner, Syedbari, Mariamnagar (Union)
4. Anil Kanti Das : Village Health Practitioner, Uttar Ghatochak, Parua (Union)
5. Nurul Azim : Village Health Practitioner, Nagarer Tila, Mariamnagar (Union)
6. Badal Das Gupta : Village Health Practitioner, Chandraghone, Kadamtali (Union).

APPENDIX 8

Pipeline Analysis