Fourth Annual Report

Photo by Sarah Choi

Christian Reformed World Relief Committee (CRWRC)

Bangladesh

Dhaka, Netrokona, Panchagor

Cooperative Agreement No. GHS-A-00-04-00010-00
September 30, 2004 – September 30, 2009

Date of Submission: October 31, 2008

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
BCG	Bacille Calmette-Guérin vaccine
BCM	Bengal Creative Media
CBO	Community Based Organization
CCI	Community Capacity Indicators
CCM	Community Case Management
CHA	Community Health Animator
CHV	Community Health Volunteer
C-IMCI	Community/Household Integrated Management of Childhood Illness
CRWRC	Christian Reformed World Relief Committee
CSP	Child Survival Project
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support Plus Project
CWI	Concern Worldwide International
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, and Tetanus vaccine
EOP	End of Project
EHF	Emergency Health Fund
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
GLP	Global Learning Partners
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
ICDDR,B	International Center for Diarrheal Disease Research in Bangladesh
KPC	Knowledge, Practices, and Coverage survey
LAMB	Lutheran Aid to Medicine in Bangladesh
LNRA	Learning Needs Resource Assessment
LQAS	Lot Quality Assurance Sampling
MAMAN	Minimum Activities for Mothers and Newborns
MOH	Ministry of Health
NGO	Non-Governmental Organization
NID	National Immunization Days
NS	Nutrition Surveillance
NSDP	NGO Service Delivery Program
OCI	Organizational Capacity Indicators
ORS	Oral Rehydration Solution
PD	Positive Deviance
PI	Peoples' Institution
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TFD	Theatre for Development
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

A. Major Accomplishments

The Christian Reformed World Relief Committee (CRWRC) Child Survival Project (CSP) is on schedule to reach the end of project (EOP) targets for number of primary and adolescent groups formed, number of beneficiaries served, and number of TBAs and CHVs trained (see Table 1). CSP continues to reach more children under five than expected. This is mainly due to the interest of mothers who are not in primary groups to have their children participate in growth monitoring and other CSP initiatives.

Table 1: Beneficiaries, Group Formation, and People Trained in the Child Survival Project Working Areas Through Year 4.

Particulars		Dhaka		Netrokona		Panchagor		TOTAL	
		Actual	EOP Target	Actual	EOP Target	Actual	EOP Target	Actual	EOP Target
Primary Groups		165	227	203	203	225	225	593	655
Primary Group Members		3,645	3,750	3,256	3,248	4,470	4,470	11,371	11,468
Adolescent Groups	Girls	50	40	7	6	12	12	69	58
	Boys	21	20	4	4	12	10	37	34
Adolescent Group Members	Girls	525	400	143	115	325	325	993	840
	Boys	208	240	80	82	270	270	558	592
Peoples' Institutions		15	15	3	1	1	1	19	17
Number of children under 5		1,861	1,810	2,473	1,662	1,657	1,600	5,991	5,072
CHVs Trained		187	166	203	203	120	120	510	489
TBAs Trained		85	88	74	75	79	75	238	238

In the fourth year, the CSP carried out two Nutrition Surveillance (NS) surveys using Lot Quality Assurance Sampling (LQAS) in January 2008 and July 2008. The NS questionnaire used a subset of questions from the baseline and midterm Knowledge, Practices and Coverage (KPC) survey. Although the questions asked during the NS survey were the same as the baseline questions, the sampling frame was different. The NS survey selected a random sample from direct beneficiaries (primary group members) and the baseline survey selected a random sample from the entire population of the three working areas. Although the results of the NS survey and the baseline survey cannot be directly compared, it is helpful to look qualitatively at how the direct beneficiaries are doing compared to baseline. The results of the most recent survey compared to the baseline and the end of project targets can be found in Annex 1. Most results show that the EOP target has been achieved among the direct beneficiaries (primary group members), or is progressing towards the target. The main accomplishments within each of the six strategic objectives are listed below.

Strategic Objective #1 – Improve Maternal and Neonatal Care: Every woman interviewed was able to name at least two maternal danger signs during prenatal, natal and postnatal period. Most women (at least 75% in all three project areas) reported using skilled health personnel during delivery (including trained traditional birth attendants). In addition, over two-thirds of pregnant women in all three project areas received at least four prenatal visits as well as at least two tetanus toxoid injections.

Strategic Objective #2 – Prevent and Properly Treat Diarrheal Disease: Oral rehydration therapy was used for children with diarrhea and soap was readily available in almost every household surveyed (at least 90% in all three project areas for both indicators). Zinc use during a diarrheal episode seemed to be on the rise in all three project areas as well (at least 50% in Dhaka and Netrokona and 100% in Panchagor). Additionally, over three-fourths of the women interviewed also reported giving more fluids and at least the same amount of food during an illness. It is important to note that Sathi may have difficulty reaching their target for the practice of increased fluids and continued feeding during an illness since the baseline value was so high.

Strategic Objective #3 – Detect Acute Respiratory Infection (ARI) and Make Appropriate Referrals: The knowledge indicator for child danger signs was as high as it was for maternal danger signs with every woman interviewed being able to report at least two danger signs/symptoms of childhood illnesses. At least 44% of all women interviewed in all three project areas reported seeking care for ARI during their child's last illness, which is an improvement over the baseline values. However, there is certainly room for improvement as the project enters its last year. Behavior change strategies to increase this care seeking behavior were designed using formative research and the BEHAVE framework in all three project areas during the past year. Therefore, CRWRC hopes to see a change in behavior due to the new activities that will be implemented in year five.

Strategic Objective #4 – Improve Child Nutrition: Exclusive breastfeeding practices have surpassed or nearly reached the end of project targets (at least 87% in all three working areas). Appropriate complementary feeding practices also seemed to be increasing in all three working areas, especially in Netrokona (94%). Vitamin A coverage was at least 75% in Panchagor and Netrokona; however, Dhaka only achieved 54% coverage. Lastly, the trend of decreasing rates of malnutrition continued in all three project areas, but there is still a long way to go to reach the 20% end of project target.

Strategic Objective #5 – Reduce Morbidity and Mortality from Vaccine: Complete immunization coverage was very high among the primary group members (at least 97% in all three project areas).

Strategic Objective #6 – Increase Awareness of HIV/AIDS: The knowledge indicators for HIV risk reduction were very high in all three project areas (at least 97% of the women interviewed were able to name at least two risk factors for HIV).

B. Activity Status

CSP activities continued according to plan in year four (Table 2 and 3). In addition to the work plans in the DIP, all three partner organizations followed the action plans developed following the Midterm Evaluation in July 2007 (Annex 2).

Table 2: Major Accomplishments in Project Objectives

Project Objectives	Key Activities	Status of Activities	Comments
Improve Maternal and Neonatal Care	▪ Trained TBAs	Complete	238 TTBAs trained. Peoples' Institutions added their own funds to small grants given by CRWRC to carry out TTBA training.
	▪ Ensured TBAs are performing their duties according to the DIP	On going	1,206 safe deliveries by skilled health personnel at the home 753 deliveries referred to the health facility 2 neonatal deaths
	▪ Participated as member of national neonatal health strategy development team	On going	Neonatal strategy will be finalized in November 2008. CRWRC is on two working teams.
	▪ Trained CSP staff on Kangaroo Mother Care	Complete	CSP staff from the three partner organizations received training on Kangaroo Mother Care from LAMB hospital. See Annex 3 for a case study on Kangaroo Mother Care.
Prevent and Properly Treat Diarrheal Disease	▪ Trained CHVs	Complete	510 CHVs trained
	▪ Ensured CHVs are performing their duties according to the DIP	On going	528 severe cases of diarrhea referred to an appropriate health center 789 cases of diarrhea treated with ORS at home
Detect ARI and Make Appropriate Referrals	▪ Facilitated workshop on ARI following IMCI module approved by MOH	Complete	136 village doctors were trained in all three project areas.
	▪ Ensured CHVs are performing their duties according to the DIP	On going	452 severe cases of ARI referred to an appropriate health center
	▪ Provided training on C-IMCI to village doctors and pharmacists	Complete	Training started in Panchagor and has been extended to Netrokona and Dhaka with support from MOH IMCI staff.
Improve Child Nutrition	▪ Developed growth monitoring groups and ensured proper growth monitoring techniques	Complete	New Government growth monitoring card has been approved by GOB and is being used in all working areas.
	▪ Implemented PD Hearth	On going	Dhaka: 2 PD/Hearth sessions with a total of 18 children, 13 graduated (72%) Netrokona: 5 PD/Hearth sessions with a total of 44 children, 32 graduated (73%) Panchagor: 4 PD/Hearth sessions with a total of 32 children, 24 graduated (75%)
	▪ Distributed vitamin A, iron tablets and anthelmintics with Ministry of Health	On going	During National Immunization Days (NIDs), CHVs distributed vitamin A and anthelmintics in all three working areas. CHVs were trained by the Government for NID (15 in Panchagor, 20 in Netrokona). Sathi currently manages five NID centers.
Reduce Mortality and Morbidity from Vaccine Preventable Diseases	▪ Coordinate with Government Expanded Program on Immunization to achieve better coverage	Complete	CHVs participated in Government measles campaign and NID program. 3,375 children completed their immunizations last year
	▪ Awareness raising on vaccination by theater team	On going	Peoples' Institution leaders raised awareness through the theater team and coordinated with the Government, local leaders, and other NGOs.

Project Objectives	Key Activities	Status of Activities	Comments
Increase Awareness of HIV/AIDS	▪ Peoples' Institution (PI) health sub-team arranged HIV/ AIDS awareness activities.	Complete	Community people raised awareness through drama and health lessons. All PIs recognized World AIDS Day on December 1 2007.

Table 3: Major Accomplishments in Cross-Cutting Intervention Areas

Cross-Cutting Interventions	Key Activities	Status of Activities	Comments
Community/ Household Management of Childhood Illness (C-IMCI)	▪ Selected and trained Super CHVs	On going	93 super CHVs selected and trained (out of 510 CHVs). Super CHVs received 5 days training on health topics using the Global Learning Partners 9 learning designs developed in 2006. CHVs also received newborn care management training material. See Annex 3 for a case study on one of the Super CHVs.
	▪ Increased use of emergency health fund (EHF).	On going	Funds currently over $2,300 USD and showing over 60% usage rate. See Results Highlights for an update on the use of the EHF. Funds are given as loans from the PI and primarily used for delivery or pregnancy complications and for child illness related to ARI or diarrhea.
	▪ CCM operations research in Panchagor approved	Complete	See Annex 4 for the CCM operations research abstract. The final report is also available upon request.
Child Survival Sustainability Assessment (CSSA)	▪ Used dashboards to monitor sustainability semi-annually for each project	On going	See Annex 5 for a list of indicators and dashboards for each project. All Peoples' Institutions have been using the CSSA and are on target for progress.
	▪ Trained partner organization staff in sustainability planning	Complete	All three partner organizations received sustainability training and developed sustainability action plans (Annex 2). Super CHVs were trained as part of the sustainability plan.
Behavior Change Communication	▪ Conducted Doer/Non-Doer analyses	Complete	Doer/Non-Doer analyses conducted after the Midterm Evaluation based on the KPC results.
	▪ Used BEHAVE Framework to address behaviors that have been difficult to change	Complete	BEHAVE Frameworks developed for ARI care seeking (Sathi, Pari, Supoth), ANC (Pari), Complimentary Feeding (Supoth). An example framework can be found in Annex 6.
	▪ Perform community dramas to communicate health messages	On going	All three project areas have active drama teams carrying out Theater for Development. Two teams have also received contracts from other organizations.

C. Constraints to Achieving Goals and Objectives

The CSP had some minimal constraints in achieving goals and objectives. Each challenge and the actions taken are listed below.

Challenge #1
In Sathi (urban Dhaka), there has been some staff turnover (two) due to availability of job opportunities for qualified health professionals in Dhaka.

Actions taken and/or to be taken: Sathi overcame this barrier by replacing these two staff with experienced Sathi staff from other programs who had experience in health programming. New staff were then recruited for their positions.

Challenge #2
Another constraint in all three working areas was the continual reassignment (transfers) of Government staff, which includes MOH staff at the District and Upazilla level. CSP staff had to orient the new Government staff on the CSP.

Actions taken and/or to be taken: CSP staff overcame this constraint by inviting the new Government staff to visit the field work of the CSP as well as visiting the new staff at their offices within the first month of their new assignment.

Challenge #3
The CHV drop out rate for Pari and Supoth (rural) was below two percent; however, it was ten percent in Dhaka. Again, this is primarily because of more work opportunities in the city – 50 percent of drop out CHVs in Dhaka received full time paid health work in other organizations.

Actions taken and/or to be taken: CSP staff and PIs have developed a policy for ensuring CHV service in the community. PIs and the health sub-teams are now trying to identify people interested in becoming CHVs. The new CHVs then work along side trained CHVs so that they can be used to replace those that drop out. Also, those CHVs that leave are asked to find and train their replacement.

D. Technical Assistance Required
In this past year, technical support was received from the Ministry of Health IMCI Division and Azimpur Maternity (Government of Bangladesh staff) for training the private practitioners in Dhaka. The CSP also received technical support from Concern Worldwide for a PD/Hearth follow-up training. Ongoing technical assistance for building staff skills was received from CRWRC's three subcontractor training institutions: Radda Barnen, LAMB and Joyramkura.

E. Program Changes
There were no substantial changes to the project description from the DIP or Midterm Evaluation.

F. Progress Towards Sustainability
Sustainability has been a major focus of the CSP over the past year. Following the Midterm Evaluation, each of the three partner organizations developed sustainability plans in Bangla with the assistance of the CRWRC Development Consultant (see Annex 7 for the combined sustainability plan for all three organizations in English). As part of the sustainability plan, much work has been done to build the capacity of the Peoples' Institutions and the health sub-

teams. In this past year, monthly training for capacity building on management, health and finance topics have been conducted for these groups.

In this past year, the CRWRC Development Consultant conducted sustainability training for all partner organization staff. Each partner organization designed and carried out the sustainability trainings for all Peoples' Institutions with the assistance of CRWRC. The Peoples' Institutions then set sustainability targets for their groups as part of their OCI, CCI, and CSSA targets.

One of the primary objectives in each sustainability plan was to develop a supervisory system for the CHVs and TTBAs that would replace the paid health staff. The position of "Super CHV" was developed during the Midterm Evaluation to move into this supervisory role. During the past year, 25 Super CHVs were selected based on literacy skills minimum (class 5 in rural areas and 8 in urban area), willingness to serve, recommendation of the PI, good results on post test trainings in basic courses, and good communication skills. During the past year, super CHVs were trained to oversee the work of all of the other CHVs. For Sathi, 52 Super CHVs were trained and selected. This is a large number, because Sathi works in four distinct areas and the PIs felt this many were needed to cover the areas. Supoth has trained and selected 18 Super CHVs, and 23 Super CHVs were selected and trained by Pari. The Super CHV training was designed by CRWRC in collaboration with Global Learning Partners and included a training of trainers on the nine lessons designed by CRWRC and GLP in 2006. These lessons included report writing, module writing, record keeping, communication skills with government, supervision skills and leadership skills. The initial workshop was five days, with a two day refresher workshop planned. Community Health Animators (paid CSP staff) also met monthly with the Super CHVs. The Super CHVs are also the primary link between the health sub-team and the local government and non-governmental health facilities. The health sub-teams organized and led quarterly networking and coordination meetings with the local government health facilities with support from partner organization staff as needed.

Another objective of each partner's sustainability plan was to place the responsibility of the community health work into the hands of the local PI. All five PIs developed their own sustainability plans in June 2008 and conducted area meetings with the entire community and government officials to explain the plan and get feedback. The health sub-teams of each PI have regularly visited the work of the primary groups, CHVs and TTBAs.

Another objective for all three partner organizations was financial diversification for the continuation of CSP activities. In Netrokona, Pari received a new grant from a Hong Kong donor for adolescent health. Pari hopes to transfer the CSP staff to this program as well as monitor PI activities as they develop this new program. In Panchagor, Supoth hopes that the PI will receive a small government grant for continuing CSP activities. They would like the funds to support one CSP staff in the area. In Dhaka, Sathi is currently looking at how to expand health program activities using the CSP staff. All three partners will continue their project work, and will not cease to exist after the CSP ends.

G. Responses to Recommendations from Midterm Evaluation

CRWRC and its partners not only focused on achieving their goals (according to the DIP) in year four, but they also focused on making progress on all ten recommendations from the Midterm

Evaluation. A list of the ten recommendations and the current status of each recommendation can be found in Annex 8.

H. Specific Information

1. Social and Behavior Change Strategy (First Year Only)

This is our fourth year of implementation; therefore, this section is not applicable.

2. Progress Towards Phase Out (Projects Entering Final Year)

Refer to Section F and Annexes 2 and 7 for information about phase out and sustainability.

3. Expanded Impact Project Reporting

This is not an expanded impact project; therefore, this section in not applicable.

4. Family Planning Reporting

This project does not include a family planning component; therefore, this section is not applicable.

5. Tuberculosis Reporting

This project does not include a tuberculosis component; therefore, this section is not applicable.

I. Management System

Financial Management System

One accomplishment in financial management over the past year is that all three projects and CRWRC are now maintaining their accounts on QuickBooks. Prior to year four, two of the three projects were computerized and one was still using a manual account system. All three projects and CRWRC also keep a back-up system of manual accounts.

Per requirements of USAID, CRWRC and the Government of Bangladesh, a yearly external financial audit is conducted by an audit firm selected by CRWRC from a list of USAID approved auditors. This financial audit for year three was conducted from October 20 to 28, 2007 with auditors visiting each of the projects to review records and verify accounts. The audit was conducted by Ahmed Zamin and Company. This report was submitted to USAID, CRWRC and the Government of Bangladesh on November 10, 2007.

The financial audit for year four is scheduled to be conducted on October 27, 2008. A letter of appointment has been submitted to the audit firm of Ahmed Zamin and Company and they have accepted these terms and conditions. CRWRC hopes to complete the audit and report by November 15, 2008.

Human Resources

All CSP staff have received ongoing training throughout the life of the project. This past year training included: technical training on Kangaroo Mother Care, technical training on primary health care, sustainability training, refresher training for lot quality assurance sampling (LQAS)

and a refresher training on the BEHAVE framework. CSP staff also received ongoing training on general development and management topics from their organizations.

All CSP staff receive yearly performance evaluations from their respective supervisors. The CRWRC CSP Manager gives input into these evaluations. Evaluations for year four took place from September 25 to October 5, 2008.

Communication System and Team Development
The CSP Manager meets with the three Health Coordinators, the Monitoring Officer and the Program Officer on a monthly basis. Written monthly reports are presented by each project at this time and variances are reviewed. Mini-trainings on management and specific CSP-related topics are included in these one to two day meetings. Also, each work plan is reviewed and finalized for the coming month. The CSP Program Manager has monthly communication with the Project Directors of each of the three projects regarding CSP activities. Pari, Supoth and Sathi Directors attend these meetings on a quarterly basis. The CSP Program Manager sends meeting notes and meeting summaries to each of the Project Directors. CRWRC Dhaka-based CSP staff visit each project on a quarterly basis. The Health Coordinators also meet with the health animators in their projects on a monthly basis. These meetings include activity updates, variance reports, planning and mini-workshops.

Local Partner Relationships
Local partner relationships remain strong within the CSP. One of the recommendations from the Midterm Evaluation was for, "CRWRC headquarters [to] document and share the CSP experience in Bangladesh as a case study in developing and managing local partnerships." This case study is in progress and should be completed in time for submission with the Final Evaluation Report in 2009.

The three CSP partner organizations have other donor organizations that fund other components in their projects. Supoth is in the second year of a five year grant from Danish International Development Assistance (DANIDA) that is incorporating elements of the CSP in other sub-districts in its coverage area. Pari received a three year grant from a Swiss Government-supported NGO for helping to strengthen health care systems in another part of Netrokona District. In July 2008 the Civil Surgeon of Panchagor invited the Panchagor Peoples' Institution to submit a proposal for a special Government, one-year fund (2010) for local CBOs to strengthen health programming. The Panchagor PI was selected for the funds, and this is currently being processed. These small funds will go towards further training and strengthening of referrals and relationships between the PI and the Government health facilities. This small grant is unavailable in the two other working areas of CSP.

PVO Coordination/Collaboration in Country
CRWRC is registered with the NGO Bureau of the Government of Bangladesh has completed the fourth year of a five year approval with the NGO Bureau. Each of the three partner organizations is also registered with the NGO Bureau as a local NGO. CRWRC and its partners are also active members of various forums in Bangladesh including the PRA Forum, the Self Help Forum, the National AIDS Programs Forum, the Arsenic Forum and the Voluntary Health Association of Bangladesh. In addition to this, CRWRC is a core group member of the White

Ribbon Alliance of Bangladesh, the National C-IMCI Working Group, and MotherNewborNet, which is supported by USAID and coordinated through the International Center for Diarrheal Disease Research in Bangladesh (ICDDR,B).

As a member of the Government facilitated C-IMCI working group, CRWRC participated in and contributed to the 2008 C-IMCI work plan. CRWRC is also represented on the neonatal working group which prepared the draft National Neonatal Strategy for the Government of Bangladesh.

CRWRC CSP Manager and staff meet regularly with Concern Worldwide (CWI), which also operated a Child Survival Program in Bangladesh. CWI has provided training support for PD/Hearth, as requested. CRWRC also had regular meetings with Plan International, Save the Children, Saving Newborn Lives, and the ACCESS project. CRWRC CSP staff plan to visit the ACCESS project in October 2008 for the purpose of learning more about sustainability. CRWRC also maintains close contact with ICDDR,B, Clinical Sciences Division. ICDDR,B staff were instrumental in sharing resources and reviewing the CCM proposal and reports. The CSP Coordinators and Dhaka-based staff visited Matlab in the fourth year as well for training in C-IMCI and the use of C-IMCI protocols developed by ICDDR,B.

Other Relevant Management Systems

CRWRC maintains regular contact with the subcontracting organizations, including LAMB, Joyramkura and Radda Barnen. These three contracts continue through the life of the project. CRWRC successfully completed a three-year subcontract with Bengal Creative Media for Theater for Development training. Members of these subcontracting institutions are now included in and contribute to the CRWRC quarterly Learning Circle meetings (as described in previous annual reports).

As noted, CRWRC is involved with the three partner organizations in other integrated community development activities as well as the CSP. These activities are also reported on a quarterly basis in a results based management format. CRWRC's Development Consultant provides extensive ongoing support and consultation to the non-CSP programs. In addition to the Specialized Partnership Agreements with Sathi, Pari and Supoth for CSP, CRWRC has partnership agreements with each of these partners that focus on community and organizational capacity and governance. These agreements are for two year periods and agreed to with the boards of each organization.

Organizational Capacity Assessment

In the second year of the project, the three partner organizations incorporated the Organizational Capacity Indicator (OCI) and Community Capacity Indicator (CCI) systems into the Child Survival Sustainability Assessment (CSSA). Following the baseline assessment, the CSSA has been monitored on a semi annual basis. Since the Midterm Evaluation, the CSSA has been monitored at the field level and led by the Peoples' Institutions with decreasing assistance from partner organization staff. The most recent CSSA dashboards can be found in Annex 5.

The three partner organizations carry out an extensive OCI assessment at the board level to assess the overall progress in each organizational capacity area. CRWRC provides consultancy to the boards of all three partners to increase their governance capacity.

J. Local Partner Organization Collaboration and Capacity Building

CRWRC works to develop capacity at the organizational and at the community level. CRWRC carries out organizational development with all three partners per the Partnership Agreement. In this past year this has included the following: training on grant writing, assistance with writing proposals for grants, board workshops, and leadership training.

CRWRC spends extensive time and effort assisting the partner organizations and the community-based organizations (also known as Peoples' Institutions) to develop networks and relationships with the Government and other NGOs in the community. All of this is measured through the OCI and CCI system within the CSSA. In the past year, the Peoples' Institutions and the health sub committees were actively linking with the Government at the Thana and Union level. Health sub-team members participated in the monthly Upazilla and Thana Government health meetings. The Health Coordinators of each partner organization met with the Deputy Commissioner and Civil Surgeons at their monthly meetings with all NGOs.

The Peoples' Institutions have also linked closely with UNICEF and the Government EPI department for carrying out immunization programs and NIDs in the community.

In each of the project areas, the partner organizations and the Peoples' Institutions collaborated with other NGOs for effective services, such as the Smiling Sun Franchise Program for referrals. In Dhaka, CSP-trained TTBAs referred people to the BRAC health program. The partner organizations have worked to build the capacity of the Peoples' Institutions to network with other Government and non-government organizations.

K. Mission Collaboration

CRWRC Bangladesh has maintained regular contact with the local mission via Mr. Kisan Chakraborty, Program Officer. Mr. Chakraborty participated in the Midterm Evaluation, including field visits to Panchagor. CRWRC has submitted all annual reports, semi annual LQAS data and CSSA dashboards to Mr. Chakraborty.

CRWRC has a very positive relationship with USAID Bangladesh, which has helped to improve the quality of the Child Survival Project. CRWRC became a member of the Government IMCI Working Group because of USAID's recommendation. USAID has kept CRWRC informed of mission activities and workshops and has sought CRWRC's input in strategic planning during the workshops. CSP staff attend the annual USAID partners meeting hosted by the mission.

On September 29, 2008 the CRWRC Technical Advisor and CRWRC Asia Health Coordinator met with Dr. Sukumar Sarker and Mr. Kisan Chakraborty to discuss the current progress in the CRWRC CSP and to discuss possible future collaboration and areas of focus in the mission.

L. Other Relevant Topics

There are no other relevant topics to report.

M. Annexes

Annex 1: Monitoring and Evaluation Table

Annex 2: Action Plans According to the Midterm Evaluation

Annex 3: Case Studies: Kangaroo Mother Care and Super CHV

Annex 4: Community Case Management Operations Research Abstract

Annex 5: Child Survival Sustainability Assessment Dashboards

Annex 6: Example BEHVE Framework

Annex 7: Combined Sustainability Plan for All Three Partner Organizations

Annex 8: Midterm Evaluation Recommendations and Status Update

Annex 9: Year Five Workplans

Annex 10: Year Five Budget

Annex 11: Results Highlight

Annex 1

Program Monitoring Plan: Results from Nutritional Surveillance, July 2008[1]

INTERVENTION AREA	INDICATOR **BOLD** = KPC Rapid CATCH Indicators	Partner	Base-line %	Final target %	LQAS %	Pro-gress
Strategic Objective I. Improve Maternal and Neonatal Care P=Panchagor N=Netrokona D=Dhaka						
Delivery by Skilled Health Personnel (including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel	P	18	60	100	
		N	21	50	96	
		D	35	71	75	
Antenatal Care Rate	Percentage of mothers who had at least 4 prenatal visit prior to the birth of her youngest child less than 24 months of age	P	31	79	100	
		N	6	30	78	
		D	34	85	67	
Tetanus Toxoid (TT)	**Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age**	**P**	**80**	**98**	**100**	
		N	**62**	**85**	**78**	
		D	**59**	**85**	**79**	
Knowledge on Maternal Danger Signs/Symptoms	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and postnatal	P	33	58	100	
		N	31	55	100	
		D	37	80	100	
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease						
ORT Use During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	P	64	84	100	
		N	56	75	92	
		D	55	80	100	
Increased Fluid and Continued Feeding During an illness [1]	**Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food**	**P**	**57**	**70**	**89**	
		N	**64**	**72**	**85**	
		D	**94**	**95**	**78**	
Zinc Supplementation During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness	P	14	78	100	
		N	11	90	49	
		D	9	90	57	
Availability of Soap for Hand Washing	**Percentage of mothers of children age 0-23 months that have soap readily available for hand washing.**	**P**	**53**	**73**	**100**	
		N	**15**	**55**	**100**	
		D	**37**	**82**	**97**	
Strategic Objective III. Detect ARI and Make Appropriate Referrals						
ARI Care Seeking	Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility	P	29	59	44	
		N	8	33	49	
		D	63	88	66	
Maternal Knowledge of Child Danger Signs/Symptoms	**Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms**	**P**	**70**	**86**	**100**	
		N	**73**	**90**	**100**	
		D	**62**	**92**	**100**	
Strategic Objective IV. Improve Child Nutrition						
Underweight	**Percentage of children aged 0-23 mos who are more than 2 standard deviations (SD) below the median weight-for-age (WA) of WHO/NCHS reference**	**P**	**38**	**20**	**30**	
		N	**41**	**20**	**36**	
		D	**39**	**20**	**32**	
Exclusive Breastfeeding [2]	**Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours**	**P**	**61**	**97**	**97**	
		N	**33**	**85**	**91**	
		D	**50**	**89**	**87**	
Appropriate Complementary Feeding Practice	**Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours**	**P**	**27**	**57**	**65**	
		N	**14**	**80**	**94**	
		D	**55**	**75**	**57**	
Vitamin A Coverage	Percentage children aged 6-23 months who received a Vitamin A dose in the past six months	P	62	91	75	
		N	61	75	79	
		D	53	80	54	
Strategic Objective V. Reduce Morbidity and Mortality from Vaccine						
Complete Immunization Coverage	**Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio**	**P**	**57**	**87**	**97**	
		N	**32**	**85**	**100**	
		D	**28**	**80**	**97**	
Strategic Objective VI. Increase Awareness of HIV/AIDS						
Maternal Knowledge of HIV Risk Reduction	**Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV**	**P**	**12**	**64**	**100**	
		N	**13**	**70**	**100**	
		D	**51**	**85**	**97**	

[1] Baseline data not collected for this indicator. The data presented was collected during Sept.'05 Nutritional Surveillance.
[2] Baseline data not reliable for this indicator. The data presented was collected during Sept. '05 Nutritional Surveillance.

Legend: Degree of Progress Towards End of Project Targets			
	Equal to or Above EOP Target		Below Baseline
	Above Baseline / Below EOP Target		

[1] Baseline data was collected in January 2005 using 30-cluster random sampling for the population of each working area. Nutritional Surveillance data was collected in July 2008 using LQAS for the primary group members in each working area.

Annex 2

SUPOTH

Action Plan According to Midterm Evaluation

Subject	Activities/ Intervention	Responsibilities	Time Frame
Linkage between community-based workers and PI health sub-team (HST), i.e., CHVs & TTBAs	1) Arrange orientation program about responsibilities/ roles of CHVs and TTBAs for sustaining work post-CSP.	HC/CHA/ PI-HST	Nov-07
	2) Arrange a meeting with PI, CHVs and TTBAs on linkage between PI and community-based workers.	HC/CHA/ PI-HST	Quarterly
	3) Continuing monthly meeting between CHVs/TTBA and 2 leaders of PI. PI to arrange meetings, syllabus, etc.	CHA/PI-HST	Monthly
Linkage with health facilities and key health workers.	1) Identify/select super CHVs	CHA/PI-HST	Oct-07
	2) Arrange a meeting with super CHVs, TTBAs and PI health sub-team on linkage their roles and responsibilities.	HC/CHA/ PI-HST	Nov-07
	3) Arrange a meeting with Government health personnel and super CHVs, TTBAs about linkage and networking.	HC/CHA/ PI-HST	Quarterly
	4) Arrange a meeting with Government health authority and PI about health service availability. Develop MOU between Government Health authority and PI.	HC/CHA/ PI-HST	Jan-08
Identify capacity areas for continuing training for PI health sub-team and primary groups.	1) Arrange a meeting with PI and HST for identifying their capacity areas lacking for sustainability.	HC/CHA/ PI-HST	Nov-07
	2) Plan with PI and HST according to their selected growth area.	HC/CHA/ PI-HST	Nov-07
	3) Arrange orientation with PI and HST on Supportive Supervision of CHV/TTBA	HC/CHA/ PI-HST	Nov-07
	4) Continue meeting with PI and HST to increase the capacity area about sustainability.	HC/CHA/ PI-HST	Quarterly
	5) Prepare work plan with PI about Sustainability and Seed fund uses.	HC/ PI leaders	Quarterly
	6) Develop and sign an MOU with PI about how to run program, continuing CHV and TTBA works.	HC/PI Leaders	Feb-08
To build and reinforce relationships with PIs and local health authorities and facilities	1) Arrange meeting to introduce PI to the local health facilities.	FS/CHT	Nov/Dec-07
	2) Emphasize or reinforce the quarterly meeting with PI, HST and local health facilities	FS/CHT	Quarterly
	3) Super CHVs identify cases and refer to the appropriate place.	CHV	Monthly

(including NSDP)	4) PI-HST communicates with local facilities for ensuring service availability. MOU to outline guidelines for responsibility.	CHT/PI	continuing
Management of the emergency funds with PIs and primary group.	1) Arrange meeting with PI leaders, HST and CCC/primary group leaders about emergency fund management and its utilities.	HC/FS	Dec/Jan-07/08
	2) Meeting with PI and community about raising more emergency funds.	HC /PI leaders, Elite persons	Bi-Six monthly
	3) Dissemination meeting with local elite person about emergency funds.	HC/CHA/PI	Feb-08
	4) Arrange workshop with PI leaders, HST and CCC/group leaders on emergency fund utilities. Output is a cooperation agreement between the communities and the PIs.	HC/PI/CCC leaders	Semi-annually
BEHAVE framework	1) Conduct Doer/Non-doer survey on selected issues.	HC/CHA	Oct-07
	2) Prepare BEHAVE Framework on issues according to survey reports.	HC/CHA	Oct-07
	3) Start work according to framework at the field level.	CHA/CHV	Jan-08

NOTE: CCC = Community Central Committee; CHA = Community Health Animator; CHT = Community Health Trainer; CHV = Community Health Volunteer; FS = Field Supervisor; HC = Health Coordinator; HST = Health Sub-Team; PI = Peoples' Institution

PARI

Action Plan According to Midterm Evaluation

Subject	Activities/ Intervention	Responsibilities	Time Frame
Linkage between community-based workers and PI health sub-team (HST), i.e., CHVs & TTBAs	1) Arrange orientation program about responsibilities/ roles of CHV and TTBA for sustaining.	HC/FS/CHT/FT	Oct-07
	2) Arrange a meeting with PI, CHV and TTBA on linkage between PI and community based workers.	HC/FS/CHT/FT	Quarterly
	3) Continue monthly meeting between CHVs/TTBAs and 2 leaders of PI	CHT/FT	Monthly
Linkage with health facilities and key health workers.	1) Identify/select of super CHVs	CHT/FT	Sept-07
	2) Arrange a meeting with super CHVs, TTBAs and PI health sub-team on linkage and their roles and responsibilities.	FS/CHT/FT	Nov-07
	3) Arrange a meeting with Government health personal and super CHV, TTBA about linkage and networking Develop MOU between PI and Government facilities.	HC/FS/CHT	Quarterly
	4) Arrange a meeting with Government Health authority and PI about Health service availability. Develop plan of action for their work together.	UH&FPO/HC	Jan-08
Identify capacity areas for continuing training for PI health sub-team and primary groups.	1) Arrange a meeting with PI and HST to identify their capacity areas needs for sustainability.	HC/FS/CHT	Nov-07
	2) Plan with PI and HST according to their growth areas identified as above.	HC/FS/CHT	Nov-07
	3) Arrange orientation with PI and HST on Supportive Skill Supervision	HC/FS/CHT	Nov-07
	4) Continue meeting with PI and HST to increase the capacity area about sustainability.	HC/FS/CHT	Quarterly
	5) Prepare work plan with PI about Sustainability and Seed fund uses.	HC/ PI leaders	Quarterly
	6) Conduct MOU with PI about how to run program, continuing CHV and TTBA work.	HC/PI Leaders	Feb-08
To build and reinforce relationships with PIs	1) Arrange a meeting to introduce PI and local health facilities and develop plan for ongoing communication (MOU as above) for their	FS/CHT	Nov/Dec-07

and local health authorities and facilities (including NSDP)	ongoing work together.		
	2) Emphasize or reinforce the quarterly meeting with PI, HST and local health facilities	FS/CHT	Quarterly
	3) Super CHVs identify cases and refer to the appropriate.	CHV	Monthly
	4) As per their needs (PI/ HST) they have communicated with local facilities for ensuring service availability.	CHT/PI	Continuing
Management of the emergency funds with PIs and primary group.	1) Arrange a meeting with PI leaders, HST and CCC/primary group leaders about emergency fund management and its utilities.	HC/FS	Dec/Jan-07/08
	2) Meeting with PI and community about raising more emergency funds.	HC /PI leaders, Elite persons	Semi-annually
	3) Dissemination meeting with local elite persons about emergency funds.	HC/CHT/PI	Feb-08
	4) Arrange workshop with PI leaders, HST and CCC/group leaders on emergency fund utility and develop MOU between community and PIs.	HC/PI/CCC leaders	Semi-annually
BEHAVE framework	1) Conduct Doer/Non-Doer survey on selected issues – per mid term KPC results.	HC/FS/CHT	Sept-07
	2) Prepare BEHAVE Framework on issues according to survey reports.	CHT/FT/PI	Oct-07
	3) Start work according to framework at the field level	CHT/FT/PI	Jan-08

NOTE: CCC = Community Central Committee; CHA = Community Health Animator; CHT = Community Health Trainer; CHV = Community Health Volunteer; FS = Field Supervisor; FT = Field Trainer; HC = Health Coordinator; HST = Health Sub-Team; PI = Peoples' Institution

SATHI

Action Plan According to Midterm Evaluation

Subject	Activities/ Intervention	Responsibilities	Time Frame
Linkage between community-based workers and PI health sub-team (HST), i.e., CHVs & TTBAs	1) Arrange orientation program about responsibilities/ roles of CHVs and TTBAs for sustainability.	HC/CHA/ PI-HST	Nov-07
	2) Arrange a meeting with PI, CHVs and TTBAs on linkage between PI and community base workers.	HC/CHA/ PI-HST	Quarterly
	3) Continue monthly meeting between CHVs/TTBAs and 2 leaders of PI	CHA/PI-HST	Monthly
Linkage with health facilities and key health workers.	1) Identify/select super CHVs	CHA/PI-HST	Oct-07
	2) Arrange a meeting with super CHVs, TTBAs and PI health sub-team on linkage their roles and responsibilities.	HC/CHA/ PI-HST	Nov-07
	3) Arrange a meeting with Government health personal and super CHVs, TTBAs about linkage and networking.	HC/CHA/ PI-HST	Quarterly
	4) Arrange a meeting with Government Health authority and PI about Health service availability.	HC/CHA/ PI-HST	Jan-08
Identify capacity areas for continuing training for PI health sub-team and primary groups.	1) Arrange a meeting with PI and HST to identify their capacity area needs for sustainability.	HC/CHA/ PI-HST	Nov-07
	2) Plan with PI and HST and develop actions for weak areas.	HC/CHA/ PI-HST	Nov-07
	3) Arrange orientation with PI and HST on Supportive Supervision of CHVs/TTBAs	HC/CHA/ PI-HST	Nov-07
	4) Continue meeting with PI and HST to increase the capacity area about sustainability	HC/CHA/ PI-HST	Quarterly
	5) Prepare work plan with PI about Sustainability and Seed fund uses.	HC/ PI leaders	Quarterly
	6) Develop and sign MOU with PI about how to run program, continuing CHV and TTBA work.	HC/PI Leaders	Feb-08
To build and reinforce relationships with PIs and local health authorities and facilities	1) Arrange meeting to introduce PI to local health facilities	FS/HST	Nov/Dec-07
	2) Emphasize or reinforce the quarterly meeting with PI, HST and local health facilities	FS/HST	Quarterly
	3) Super CHVs identify cases and refer to the appropriate place	CHV	Monthly

(including NSDP)	4) (PI/ HST) communicate with local facilities to ensure service availability.	HST/PI	Continuing
Management of the emergency funds with PIs and primary group.	1) Arrange meeting with PI leaders, HST and CCC/primary group leaders about emergency fund management and its utilities.	HC/FS	Dec/Jan-07/08
	2) Meeting with PI and community about raising more emergency fund.	HC /PI leaders, Elite persons	Semi-annually
	3) Dissemination meeting with local elite person about emergency fund.	HC/CHA/PI	Feb-08
	4) Arrange workshop with PI leaders, HST and CCC/group leaders on emergency fund utilities.	HC/PI/CCC leaders	Semi-annually
BEHAVE framework	1) Conduct Doer/Non-Doer survey on selected issues – per mid term KPC results.	HC/CHA	Oct-07
	2) Prepare BEHAVE Framework on issues according to survey reports.	HC/CHA	Oct-07
	3) Start work according to framework at the field level	CHA/CHV	Jan-08

NOTE: CCC = Community Central Committee; CHA = Community Health Animator; CHT = Community Health Trainer; CHV = Community Health Volunteer; FS = Field Supervisor; HC = Health Coordinator; HST = Health Sub-Team; PI = Peoples' Institution

Annex 3

PARI Case Study: Kangaroo Mother Care
October 2008

Mother's Love is the Best Nourishment of All

by Sarah Choi

Photo by Sarah Choi

The younger of the two, Badol, who is younger by 20 minutes, looked healthier and bigger than his twin sister, Borsha, who was recovering from pneumonia. The twins' neon green and orange outfits complimented each other, but they continued to fight for the sole right to their mother's arms. It was hard to imagine that this healthy boy was once malnourished and barely 2 kg at the time of birth.

On September 5th, 2007, Rina Gour(25) and her family was overjoyed and quite surprised by the birth of not one, but two, beautiful babies. Even the visiting doctors who checked Rina's health during the pregnancy did not know that she was expecting twins. Jahera Begum, the community's trained traditional birth attendant(TTBA) who assisted the delivery, was the first one to find out that Rina was having twins since the placenta did not come out after Borsha was born, and Badol's head soon came into her view. Once the news of the twins reached the Community Health Animator(CHA), Shinuka Sangma, she visited the family right away to weigh the infants for she knew the importance of identifying underweight children as soon as possible.

Infants who weigh less than 2 kg when they are born are classified as low-birth-weight(LBW) babies, and these malnourished babies need special supervision. Low birth weight is one of the causes of neonatal deaths, and countless babies die during the first 28 days because they do not receive the proper attention and care they need.[1] It is vital to take a good care of LBW children during this time since they are prone to respiratory problems, jaundice, bleeding, and other health problems, but many mothers lack the knowledge of how to look after their fragile children.

To equip mothers with the proper knowledge of how to care for their LBW children, CRWRC and its partners-SATHI, SUPOTH, and PARI-arranged Kangaroo Mother Care(KMC) Training for their CHAs in the summer of 2007. The CHA received a 3-day KMC Training at LAMB Hospital where they learned about the importance of skin-to-skin contact between the mother and the baby, especially when the child is underweight. Since their training last August, CHAs, as well as TTBAs, have been teaching pregnant mothers and new moms this method where the baby is constantly

[1] *Neonatal and perinatal mortality: country, region, and global estimates*. WHO, 2006

kept in the warmth of the mother's chest, and only consume breast milk from the very beginning.

Shinuka Sangma, the CHA for Lengura Union and one of the participants who attended the KMC Training, has personally witnessed the value of this method. When she went to weigh Rina's twins after they were born, Shinuka saw that Badol was not only reasonably smaller than his sister, but weighed just under 2 kg. Shinuka informed Rina, Rina's husband, Bishownath, and her in-laws that they would have to administer the Kangaroo Mother Care for Badol. An hour of KMC lesson was given to the family and Shinuka checked their techniques when she visited them each week.

"It was impossible for me to hold Badol for 24 hours a day, so my husband, mother-in-law, and sister-in-law who also learned about the Kangaroo Care, took turns to hold him in their chests when I needed rest," Rina shared while trying to console her crying daughter. One of the most fundamental elements of KMC is the support for the mother and child from the family members. It is important that the mother receives physical and emotional support from her family members so that she is able to be with the baby.

Through the constant skin-to-skin contact between Badol and his mother, as well as other family members, he reached the normal weight within three months. Whenever Rina attended the child growth monitoring sessions, she noticed that both Badol and Borsha were growing at a steady rate, and this made her very happy. "When my family members first saw my babies, they all thought that Badol was too weak to make it. My mother-in-law, especially, believed that he would die soon, but now she is so grateful that he survived through the Kangaroo Care," Rina said with a sense of pride that radiated through her smile.

Just as a joey that is born early is kept in its mother's pouch, attached to a teat, LBW babies should be nurtured in their mothers' chest and mature from the wholesome breast milk. Kangaroo Mother Care finds its inspiration from nature, but it is within a mother's nature to care for her child in the warmth of her embrace. The story of Rina and her twins have taught the whole community how important it is for mothers to demonstrate their love for their young, and how a simple practice can not only save a life, but enhance the bond between a mother and a child. It was not an expensive incubator that saved Badol's life, but the priceless love of his family for him.

SATHI Case Study: Super CHV
October 2008

The Story of a Super CHV

by Sarah Choi

A woman has many roles during her lifetime: a daughter, a friend, a sister, a wife, and a mother among many other titles. It was recently reported that an average Bangladeshi woman in rural areas works up to twenty hours a day, but despite the immense amount of work they do for their families, they hardly receive any recognition nor respect. It is a part of their job description to be a good wife and an honorable daughter-in-law who serves her family and silently works in the background, and many are restricted from going outside their homes.

Milon Tara(28), too, is a woman with many responsibilities; she is a mother to two beautiful children, Munna(9) and Sumaya Simi(2), a wife, and a Super CHV(Community Health Volunteer). In a society with numerous limitations for women, she has decided to make a difference in the lives of women and children in her community by becoming a Community Health Volunteer(CHV) in 2006.

This is the story of a Super CHV, Milon Tara:

Photo by Sarah Choi

When Milon began receiving health lessons from CRWRC's partner organization, SATHI, she was excited to put her newfound knowledge into action. She realized the importance of regular check-up's during pregnancy, and learned how to make oral rehydration solution for her child when he had diarrhea, but she noticed that her neighbors still did not know this valuable health information. Milon saw that pregnant mothers in her community were still under the influence of long-held traditional beliefs, and felt that she needed to help them.

"Mothers were still holding onto their superstitions. The believed that *shuji* (colostrum) was bad for their children, so they fed their newborns wheat powder with milk and sugar, instead. And, women did not give saline to their children when they had diarrhea. I wanted to change that," Milon said with a firm sense of responsibility in her voice.

With her willingness to work for others and good acceptance in the community, Milon was chosen to be trained as a CHV in her area of Mirpur. She received a 5-day training on primary health care followed by a 3-day refresher training from SATHI. Once she completed the training, she began teaching nutrition and health lessons to pregnant mothers and adolescent girls, and visited 15 to 20 households a week in order to make sure that mothers and children were well. Milon especially enjoyed monitoring children's growth through child-weighing sessions and participating in national health observances such as the National Immunization Day(NID) and HIV/AIDS Day.

"When I first began working as a CHV, people were not interested in health lessons, but now they understand the importance of health and voluntarily come to the

meetings to learn more. Mothers are extremely happy when they see their children growing, but tell me that they need to feed them more when their weight remains the same," Milon told us with a smile of satisfaction on her face. "And pregnant mothers now ask for TTBAs(trained traditional birth attendant) instead of TBAs(traditional birth attendant) when they are expecting."

Through her work as a CHV for 2 years, Milon has demonstrated her competence and passion for community health work, and this has earned her the title of Super CHV. To become a Super CHV, Milon had to go through leadership and networking training sessions since it is the responsibility of Super CHVs to train and supervise CHVs. The role of Super CHV was created by CRWRC in order to ensure the sustainability of their Child Survival Program. Super CHVs work closely with the government and the Peoples' Institutions so that their health program can carry on for years to come, even without the NGO in the picture. The already existing, unique governance structure of Peoples' Institutions, primary groups, and health subcommittees is the strong foundation on which this health initiative can sustain and grow stronger.

Milon has now been a Super CHV for 10 months, and she has witnessed positive changes both within her community and her life. She shared with us, "I used to think of myself as an ordinary woman, but through many trainings and experience in working with others, I have come to see myself differently. I know that I can do many things for my community and my community respects me for the work that I do. I am very happy and satisfied with my work as a Super CHV, and I want to continue to learn more from SATHI."

Milon leads a busy life as a wife, a mother, and a Super CHV who is also invited by other communities to teach health lessons. Radda Clinic which is run by a local NGO called, Barnen, calls her to come to their clinic to give health lessons on personal hygiene, nutrition, and more. Some may think of her as a Superwoman with all the work that she does inside and outside of her home, but she is just a woman who realized the potential that lies within her.

Annex 4

Community Case Management of Childhood Illnesses: An Integrated Approach

William T. Story[1], Nancy L. TenBroek[2], Shahnaz Parveen[2], Prity L. Biswas[2], Grace J. Kreulen[1]

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Background:
Pneumonia and diarrhea are the leading causes of death in under-five children in Bangladesh accounting for 28% of all under-five child deaths. The current Community Integrated Management of Childhood Illnesses (C-IMCI) strategy in Bangladesh emphasizes the need for strengthening existing facility-based health services. However, in areas where health facilities are inaccessible, care seeking is low. Community case management (CCM) is a strategy to deliver curative interventions for serious childhood illnesses at the household level using trained, supervised community members. The purpose of this project was to determine whether community-selected, unpaid community health volunteers (CHVs) could successfully identify, treat and refer cases of diarrhea and pneumonia in children at the household level.

Design and Evaluation Methods:
In 2005, 90 CHVs were selected by the community and trained in counseling and referral as part of the national C-IMCI strategy. In 2007, 39 of the CHVs received seven days of additional training from Government of Bangladesh C-IMCI Certified Trainers in pneumonia and diarrhea case management using clinical criteria and algorithms derived from UNICEF/WHO (2006) guidelines. The CHVs visited 357 children under two in two unions of the Panchagor District of Bangladesh from August 2007 to March 2008. The quality of CHV-delivered services was assessed for each case using a C-IMCI checklist that was developed in collaboration with the Ministry of Health and Family Welfare (MoHFW) and the International Center for Diarrheal Disease, Bangladesh (ICDDR,B). Community acceptance was evaluated by interviewing the care taker of each child in the project.

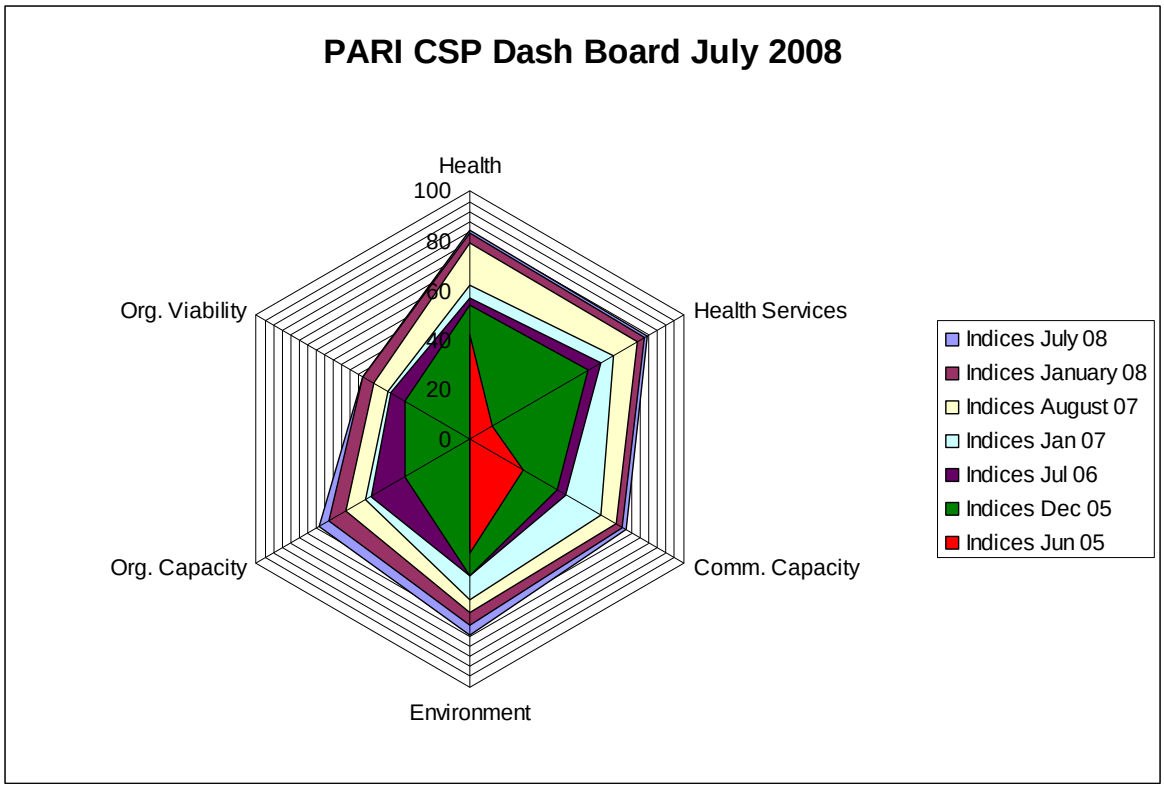
Results/Outcome and Challenges/Solutions:
Among the 255 cases of childhood illness managed by the CHVs, 25% presented with pneumonia, 72% with diarrhea, and 3% with both. CHVs correctly diagnosed and treated diarrhea and/or pneumonia in 85% of the cases. Forty percent were properly referred to a local heath facility; however only 23% were actually taken to a health facility. While 11% of mothers were satisfied with care received from health facilities, 91% of mothers were satisfied with the CCM services provided by the CHVs. Levels of satisfaction were higher when CHVs provided direct care to sick children compared to counseling alone.

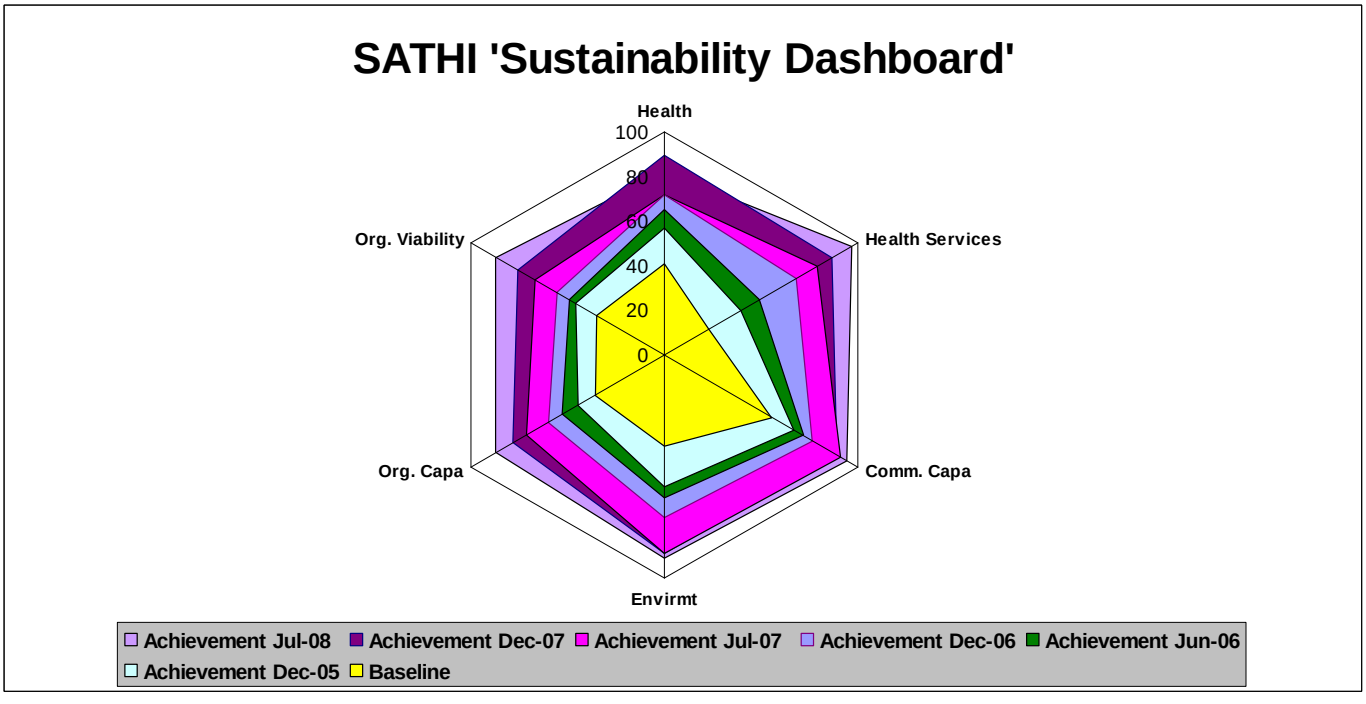
Conclusions:
The integration of CCM by trained CHVs into the national C-IMCI strategy is feasible and shows promise for improved care delivery to children at risk for pneumonia and diarrhea in rural Bangladesh. Close collaboration with the MoHFW led to a post-project agreement to continue supporting the CCM activities through providing the necessary drugs for pneumonia and improving the health information system.

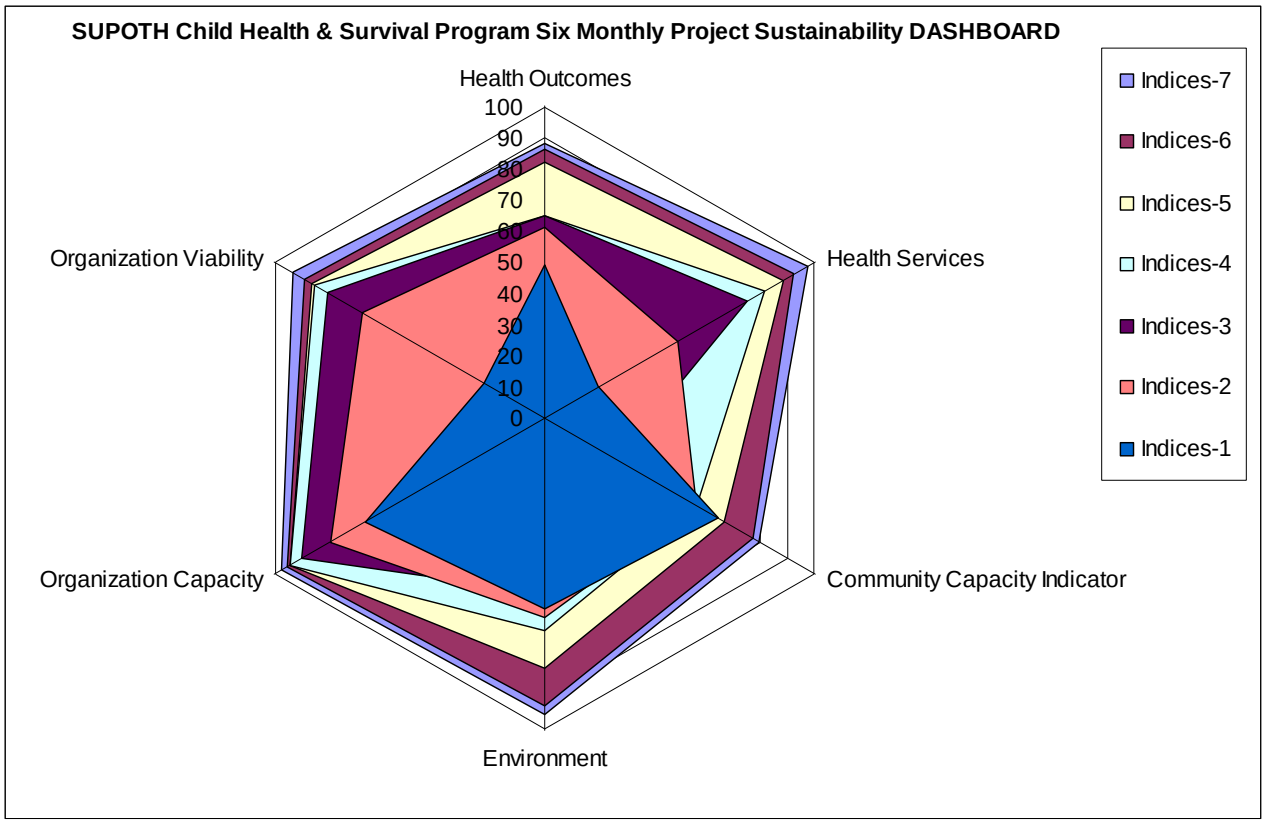
Partners:
USAID; ICDDR,B; MoHFW; NSDP; Save the Children, Bangladesh; and SUPOTH

Annex 5

Child Survival Sustainability Assessment Dashboards






SUPOTH Child Health & Survival Program Six Monthly Project Sustainability DASHBOARD
Health Outcomes
100
90
80
70
60
50
40
30
20
10
0
Health Services
Community Capacity Indicator
Environment
Organization Capacity
Organization Viability
Indices-7
Indices-6
Indices-5
Indices-4
Indices-3
Indices-2
Indices-1

Annex 6

Example BEHAVE Framework from Netrokona

Decisions	Responses
Who are the priority groups and supporting groups? *In order to help…*	Priority: Mothers of children under two. Children were affected by ARI, but mothers did not seek treatment. Most of these children are included in the growth monitoring and promotion program. Mothers come from Bengali, Garo and Hajong communities. Supporting: Husbands, in-laws, CHVs, TTBAs
What is the right behavior to promote? *to…*	Mothers of children less than 2 years old who brought their children suffering from ARI (cold, cough, fast breathing or chest in-drawing) to an MBBS Doctor or Health Center within the last two weeks.
What key factors (benefits and barriers) need to be addressed? *We will maximize these benefits and reduce these barriers…*	1. Increase Self Confidence (Self-Efficacy) 2. Increase availability of money for care seeking 3. Increase Family Support (especially from husbands and mothers in law) 4. Increase CHV/TTBA support 5. Improve transportation options
What activities will be/are being implemented to promote this behavior? *By implementing these activities…*	1. Specific messages on the benefits of seeking care for ARI from a hospital or a Doctor. These messages are to be developed and then disseminated through drama and songs by the health technical teams 2. Emphasis on the emergency funds in the Peoples' Institutions. Money to be kept by individual primary groups (banks) to make it easier to access. Also rules changed so money can be used for more than just deliveries. 3. Creating messages regarding importance of immediate and proper treatment – this will be given to the men's groups, and mothers in law groups in the communities. 4. CHVs and health sub-team members will accompany mothers of sick children to the health facility. 5. Peoples' Institution meetings with local Government to develop plans for improvement of bridges.

Annex 7

Child Survival Program
Sustainability Action Plan for 5th year

1) Health sub team will communicate and network with health center.
2) Health sub team will conduct monthly meetings with Super CHVs, TTBAs and theater team members.
3) Emergency health fund will be managed by the health sub team and the Peoples' Institution (PI) chairperson will supervise and receive a monthly report.
4) Super CHVs, TTBAs, Government, and NGO health workers will meet regularly.
5) PI leaders will participate in health center meetings three times per year.
6) Training/orientation for PI leaders on supportive supervision for CHVs and TTBAs with monthly meetings.
7) Action plan will be developed with PI leaders on seed fund (small grants) and health fund management.
8) MOU will be developed with PI and health center authority
9) Primary group leaders will be oriented on the health fund.
10) Dissemination workshop with local leaders will be held on health fund increase.
11) CHV and TTBA leaders will be selected for report collection.
12) Develop health teaching center in the community where Super CHVs and TTBAs will provide health education among women of reproductive age, pregnant and lactating mothers, and adolescents.
13) PI leaders will ensure the NID program reaches the community.
14) PI will create school for education.
15) Form a theatre center in the community.
16) Community action plan will be developed by PI leaders, local leaders, and school teachers for receiving health service from the community health center.
17) Gender-based committee will be developed in the PI.
18) PI will establish a central office.

Annex 8

Midterm Evaluation Recommendations and Status Update

1) Explore and test approaches to reinforce supervision and support linkages between community-based workers and PI health sub-teams.

As mentioned in Section F of the Annual Report, training has been given to the Peoples' Institutions (PI) and health sub-teams on leadership and supervision. Specifically, the Super CHVs, who are also part of the health sub-team of the PI, received training on health topics, leadership and supervision. The PI and the Super CHVs have regular meetings, and the PIs rotate to visit the Super CHVs for supervision purposes. The PI has also established a system to train new CHVs if some of them leave.

2) Explore and test approaches to reinforce supervision and support linkages with health facilities and key health workers, e.g., health assistants and skilled birth attendants.

The majority of the testing of approaches to reinforce the supervision and support linkages with Government health workers has taken place in Panchagor as part of the Community Case Management operation research. CHVs meet regularly with MOH clinic staff as well as other local village clinics staff. The MOH clinics have also agreed to improve the referral system by keeping better records of referral outcomes and following up with the CHVs and TTBAs who made the referrals. PIs also meet with health facility staff and local Government officials to advocate for appropriate services. In Dhaka, there are close linkages with the Smiling Sun Franchises for referrals and review of referrals.

3) Identify capacity topics and indicators for continuing training of PIs, health sub-teams and primary groups for sustainability in long-term planning, networking, communication, advocacy, supportive supervision, and transitioning project paid health animators.

As mentioned in Section F of the Annual Report, CRWRC facilitated a workshop for all three partner organizations who, in turn, facilitated a workshop for Peoples' Institution members. The PIs developed indicators for sustainability during this workshop. The PIs have taken over the role of continuing to form primary groups so that the partner organization staff can focus on strengthening the capacity of the PIs and health sub-teams.

4) Implementing Partners should build on the local power base of PIs to reinforce relationships with local health authorities and facilities, including those supported by NSDP, to ensure the availability, access, affordability and quality of services.

As mentioned above, CRWRC and its partners continue to emphasize developing the capacity of the local PIs. Relationships are being strengthened between the PI and the health facilities so that there is mutual respect between each other.

5) Continue to explore options to improve access to urgent health care by improved management and expansion of emergency health funds.

CRWRC and its partners are looking at many ways to increase the emergency health funds (EHF) and the usage of the funds. One way in which the PIs are building the EHF is by

approaching the wealthier members of the community to contribute to the fund. More details on the EHF can be found in the Results Highlight.

6) Give special attention, using the BEHAVE framework, to technical interventions for which the mid-term targets were not met.

As mentioned in Section B in the Annual Report, CRWRC and its partners used Doer/Non-Doer Analysis and the BEHAVE framework to target the following behaviors: ARI care seeking (Sathi, Pari, Supoth), antenatal care (Pari), and complimentary feeding (Supoth). An example of one of the BEHAVE Frameworks for Netrokona can be found in Annex 6.

7) Continue to explore why some implementing partners have done particularly well in certain areas in order to document those achievements and share them with other partners as part of the Learning Circle.

During the last Learning Circle meeting in August 2008, all three partners involved in the Child Survival Program presented on a best practice including the Super CHV concept, Emergency Health Funds, and networking with the Government health facilities. CRWRC has also had numerous volunteers visit Bangladesh from the US and Canada to document success stories from the Child Survival Program. Lastly, CRWRC has a student intern who is looking at all three projects to compare their impact on sustainability. Two of her stories are included in Annex 3 of this report.

8) CRWRC headquarters should document and share the CSP experience in Bangladesh as a case study in developing and managing local partnerships.

The Child Survival and Health Technical Advisor and the Learning and Innovation Coordinator are reviewing case study templates and potential journals for publication. The case study will be complete in time for the Final Evaluation in 2009.

9) Examine options for support systems for community-based treatment in rural areas using evidence from the Community Case Management Operations Research in Panchagor.

Following the community case management (CCM) operations research, the Government agreed to continue to allow the CHVs to deliver ORS and cotrimoxasol at the household level. The Government also agreed to supply the cotrimoxasol and to improve their record keeping at the health facilities in order to track cases of childhood illness better for follow up. The Peoples' Institution in Panchagor has applied for a small grant from the Government to continue the CCM work as well. CRWRC continues to talk with the National IMCI division of the MOH to share lessons learned from Panchagor and move things forward in others areas. The annual workplan meeting of the IMCI working group will be in January and CRWRC will talk about expanding CCM into Netrokona.

10) Examine options for program consolidation and expansion in existing unions and eventually to neighboring unions.

Peoples' Institutions are looking for additional funds to expand their work in all three areas. CRWRC has been meeting with the USAID mission and the MOH to explore opportunities to consolidate programming in Netrokona (tribal area) focusing on neonatal health.

Annex 9

SUPOTH

Child Health and Survival Program (CSP)

Nilphamary Sadar, Nilphamary.

Activity Plan for 5th Year (October, 2008 to September, 2009)

	Name of Activity	1st Quarter-2008			2 nd Quarter-2009			3 rd Quarter-2009			. 4 th Quarter-2009		
		Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Jul	Aug	Sep
01.	Activity/Plan Review meeting with Federation General Committee members (Yearly and 06 monthly)	-	51 persons	-	-	-	51 persons	-	-	-	-	-	51 persons
02.	TBA Refreshers Training at LAMB	-	26 persons	14 persons	-	-	-	-	-	-	-	-	-
03.	CHV Refresher training at Field level	-	-	-	26 persons	26 persons	13 persons	-	-	-	-	-	-
04.	Skill Supervision for CHVs by LAMB	-	-	-	-	20 persons	-	20 persons	-	-	-	-	-
05.	Workshop with U-5 Children's father on importance of child growth monitoring activity.	-	-		-	-	-	50 per. in kamatka zaldighi	-	50 per. in chaklah at	-	-	-
06.	Training for thana federation, Health Sub committee &CCC on report Writing and CHVs + TTBAs supervision.	-	-	-	18 persons	-	-	--	18 persons	-	-	-	-
07.	GLP training for super CHV		12 persons	12 persons	-	-	-	-	-	-	-	-	-
08.	Refresher training for Village Doctors		30 per. kazaldig hi	-	-	-	-	-	-	-	-	-	-
09.	Nutrition Survey				120 House Hold	-	-	-	-	-	120 House Hold	-	-

10.	Dissemination workshop on 6th round Nutrition Survey			50 per. in chaklahat	-	50per. in kamatkazaldighi	-	-	-	--	-	-	
11.	Meeting with Health Facilities Sectors (GO & CBO)			21 persons						21 persons			
12.	Data collection for six monthly Dash Board				CCI & COC						CCI & COC		
13.	Review meeting with village doctors.		30per.. in chaklahat										
14.	Materials distribution among new CHV+TTBA			48 persons									
15.	Workshop with Thana Federation on members Dash Board						35persons						21 persons
16.	COC workshop with federation						51 persons						
17.	Workshop with Chairman, Member, School teacher and Other elites for create health fund				45 persons Kazaldighi		45 persons Chaklahat						
18.	Adolescent Health fare.									50 persons in Kazaldighi	50 per. in chaklahat		
19.	CHV gathering												120per. in 2 unions.
20.	Organize Drama by Drama group				2 Nos in Chaklahat	-	2 Nos in Kazaldighi	-	-	-	-	-	-

21.	TTBAs seminar.											79per. in 2 unions.	
22.	Sustainability training for federation, health sub committee & CCC members				18per		18per		-				
23.	Workshop with Husband of pregnant women for importance on prenatal, natal & postnatal.				-	-	-	50per. in kamatka z-aldighi	-	50per. in chaklah at	-	-	-
24.	Participants training on household practicing garden nurseries				50 per in Chakla hat		50 per in kazaldi ghi						
25.	Final KPC survey								300 house hold in program & control area.				
26.	Final Evaluation										1 time		
27.	Dissemination workshop on Final KPC.											100per. in two unions.	
28.	Special group meeting with malnourished children's mother about nutrition.							50per. in chaklah at		50per. in kazaldig hi			
29.	Special Health Related day observation	Like as- (HIV/AIDS, Breast Feeding day, World Health Day, World Population Day) As per Government Schedule											
30.	Federation HSC meeting	Second Week of every month											

PARI Development Trust
Durgapur CSP
Annual Work plan for 2008-2009

Sl no	Particulars	Total participant	1st quarter			2nd quarter			3rd quarter			4th quarter			Comments
			Oct/ 08	Nov	Dec	Jan/ 09	Feb	Mar	Apl	may	June	July	Aug	Sep/ 09	
1	CHV meeting	203 pers.	x	x	x	x	x	x	x	x	x	x	x	x	Monthly mtg
2	TTBA meeting	74	x	x	x	x	x	x	x	x	x	x	x	x	,,
3	CCC meeting	406	x	x	x	x	x	x	x	x	x	x	x	x	,,
4	PI meeting	60	x	x	x	x	x	x	x	x	x	x	x	x	,,
5	Village Doctor review meeting	60		30	30										2 batches
6	Refresher meeting for village doctors on IMCI	60							30	30					2 batches
7	PI sustainability training	60				60									3 unions
8	GLP training(Super CHV)	36				12	12	12							3 Batches
9	KPC survey orientation	10 staffs								10					1 time
10	KPC survey	300 Ques.									300				final KPC
11	Nutrition survey	120				120									1 time
12	Dissemination meeting	120		20				20	20				60		6 batches
13	CSP project audit	1 time		x											yearly
14	TTBA field follow-up	All pregnant Mo.				6 days			6 days			6 days			3 times
15	PD Hearth session	6/60			3/30	2/20	1/10								6 batches
16	TTBA refresher	74				25	25	24							3 batches

17	CHV refresher training	203						120	83						2 days
18	Health sub committee meeting	60	x	x	x	x	x	x	x	x	x	x	x	x	monthly
19	Health sub committee (emergency fund) training and refresher	45 x 2					45					45			2 times
20	Meeting with health personal	Tantative		15	30		15	30		30	15		45		Quarterly
21	Training on CCI and dashboard for leaders(CCC and PI)	60					40	20							3 batches
22	Adolescent Health fair	250					120								yearly
23	Annual General meeting	3/600					200	200	200						3 unions(PI)
24	TTBA gathering	74					74								yearly
25	CHV gathering	203						203							yearly
26	Kangaroo care refresher training (TTBA and CHV)	277							93	93	91				3 unions
27	Orientation on seed fund policy for PI leaders	60			20	20	20								3 PIs
28	Meeting with theatre team	60 x 2			40	20				20	40				2 times yearly
29	Audit training for PI and CCC leaders	60				20	40								3 batches
30	Meeting with pregnant mothers husband	120						60	60						3 unions
31	NGO coordination meeting(Upazila and District level)		x	x	x	x	x	xx	x	x	x	x	x	x	monthly (PARI host)
32	Day celebration / observation	150 x 5			200		100	100	100					x	5 days
33	Staff meeting	14	x	x	x	x	x	x	x	x	x	x	x	x	monthly
34	Coordinators meeting		x	x	x	x	x	x	x	x	x	x	x	x	monthly
35	PMT meeting		x	x	x	x	x	x	x	x	x	x	x	x	monthly
36	Meeting with local Chairman and members	78				13x3					13x3				2 times yearly

37	Meeting with local elite and government official for ending of the project	150										100	50		3 unions
38	Exchange visit(SUPOTH and SATHI)	8						8							1time
39	Exchange visit for PI leaders (PARI CDP and CSP)	18				9					9				2 times
40	Drama show	3						1 no	1 no	1					3 unions
41	Quarterly meeting PI leaders	60 x 4			60			60			60			60	3 unions

SATHI (A project of CRWRC)
Child Survival Program
5th year activities plan (Oct-08-Sep-09)

Activities	Timeframe	Status/Achievement	Target	Plan	Responsibilities
TOT for CHV(15 person)	Oct-08	55	70	One batch (15 person)	CHAs, HC
PI leaders training on supportive supervision	Non-Dec-08	0	75	4 batches	CHA, HC
CHV refresher training	Feb-Mar-09	165	151	8 batches	CHAs
Super CHV refresher training	Non-Dec-08	0	70	5 batches	CHAs
Pharmacist review meeting with honoree.	Feb-Mar-09	41	55	4 batches	Doctors
Quarterly meeting with H/C	Dec-08, Mar-09, Jun-09	75	75	continuous	CHAs, PIs
Planning meeting with PI leaders	Nov-Dec-08	75	75	One time	CHAs, PI leaders
TTBA follow up by Radda - MCH	Jan-Mar-09	72	72	8 visits	Radda
Bank account open (Manik)	Non-Dec-08	1	4	3 accounts	PI leaders
NID program	Nov-08, Jun-09	5	7	2 times	CHVs, PIs
Dissemination workshop	Non-Dec-08, Jul-Aug-09	5	7	2 times	HC,CHAs
CHV/TTBA gathering	April-May-09	4	5	1 times	PI leaders
CHV monthly meeting	Oct-08-Sep-09	monthly	12	continuous	CHAs, PIs
TTBA monthly meeting	Oct-08-Sep-09	monthly	12	continuous	CHAs, PIs

Health sub team meeting	**Oct-08-Sep-09**	**monthly**	**12**	**continuous**	**CHAs, PIs**
Health fund collection	**Oct-08-Sep-09**	**monthly**	**12**	**continuous**	**CHAs, PIs**
Quarterly meeting with theater team	**Nov-08, Feb-09, May-09**	**56 person**	**4 meet:**	**Quarterly**	**CHAs, PIs**
Adolescent gathering	**Mar-09**	**Yearly**	**1**	**1times**	**PI leaders**
Father meeting U-2 Children	**Feb-Mar-09**	**2**	**4**	**4 batches (80 person)**	**CHAs, PIs**
Meeting with PM husband	**Dec-08-Jan-09**	**4**	**8**	**4 batches (80 person)**	**CHAs, PIs**
Community Materials	**Dec-08**			**As per need**	**HC, CHAs, PIs**
Life performance on ARI	**Mar-09**	**5**	**4**	**4 batches (800 people)**	**Theater team, PIs**
Nutrition Survey	**Jan-09**	**6**	**7**	**1 round (100 child)**	**CSP team**
KPC survey	**Jun-09**	**2**	**3**	**1 round (300 child)**	**CSP team**
Workshop with local leaders	**Jan, Jun-09**	**8**	**10**	**2 times (100 person)**	**CSP team**
Day observation on health	**April, May, Dec-09**	**3**	**3**	**3 times**	**PI leaders**
Dashboard data collection	**Jan-09**	**8**	**9**	**1 time**	**CSP team**

Annex 10

Year Five Budget

[See attached Excel Spreadsheet]

Annex 11

Results Highlight

Innovative Ideas – *Super CHVs*

The problem being addressed: During the life of a child survival project, supervision and training for the unpaid community workers, such as community health volunteers (CHVs) and trained traditional birth attendants (TTBAs), is provided by paid project staff. At the end of the project it is difficult to find ways to continue to pay these staff to continue providing support. Therefore, one of the primary threats to the sustainability of a child survival project is providing continued supervision and training to this cadre of unpaid community workers.

The project's input to address it: CRWRC developed to position of "Super CHV" during the Midterm Evaluation as an alternative way to provide supervision and training when the financial support is reduced. During the past year, 25 Super CHVs were selected based on literacy skills (minimum class 5 in rural areas and 8 in urban area), willingness to serve, recommendation of the PI, good results on post test trainings in basic courses, and good communication skills.

The magnitude of the intervention: During the past year, Super CHVs were trained to oversee the work of all of the other CHVs. For Sathi, 52 Super CHVs were trained and selected. This is a large number, because Sathi works in four distinct areas and the PIs felt this many were needed to cover the areas. Supoth has trained and selected 18 Super CHVs, and 23 Super CHVs were selected and trained by Pari.

Specific results: The Super CHV training was designed by CRWRC in collaboration with Global Learning Partners and included a training of trainers on the nine lessons designed by CRWRC and GLP in 2006. These lessons included report writing, module writing, record keeping, communication skills with government, supervision skills and leadership skills. The initial workshop was five days, with a two day refresher workshop planned. Community Health Animators (paid CSP staff) also met monthly with the Super CHVs. The Super CHVs are also the primary link between the health sub-teams and the local government and non-governmental health facilities. The health sub-teams organized and led quarterly networking and coordination meetings with the local government health facilities with support from partner organization staff as needed.

Promising Practices – *Peoples' Institution Model*

The problem being addressed: In Bangladesh, most NGOs working in integrated community development follow a community mobilization model which consists of villagers or slum dwellers forming small groups of 15-20 people. The small groups participate in literacy, health, income generation, and agriculture programs developed by the NGO. Often, when the NGO leaves, the small groups tend to dissolve due to dependence on the NGO. CRWRC's mission is to help communities develop their own sustainable community-based organizations (CBOs) that will continue to function after the local NGO moves to other areas.

The project's input to address it: In the early 1990's, CRWRC developed a three-tier system of group formation beginning with the primary groups which are formed at the village level. This was supplemented by Central Committees, which helped to oversee the daily activities of the primary groups in the small geographic unit called a union. As these groups developed and flourished, the communities and CRWRC's partner organizations realized that a CBO would help primary groups with advocacy, ensuring the continuation of activities at the local level, networking with Government and other NGOs, procuring resources, and assisting the broader communities in which they lived. The CBO, also know as a Peoples' Institution (PI), represents a larger geographic area and is registered with the Government. At the beginning of the CSP in 2004, CRWRC and its partner organizations worked with the PIs to develop a stronger health support system in the community that would ensure sustainability of the CSP interventions. The PIs ensure that the CSP activities are reaching all members as well as the broader community. Each PI has a health technical team that is responsible for selecting TBAs and CHVs for training, as well as establishing linkages with local clinics and Government health services. This system is designed to be embedded in the community and not dependent on the external NGO.

Following the Midterm Evaluation, much effort was given to strengthen the PIs so that they will have the capacity to continue the work in promoting child survival following the end of the project. A staff workshop was conducted on sustainability, and then a sustainability workshop was designed for PIs in late 2007 and early 2008.

The magnitude of the intervention: The PI model includes all 593 primary groups and almost 20,000 individuals in the CSP (over 12,000 adult and adolescent group members and almost 6,000 children under five), as well as an additional 900 primary groups and 20,000 individuals in the non-CSP activities of the three projects.

Specific results: Each of the six PIs under the CSP program is now functioning with a leadership executive body and a health technical team made up of at least six members. The PIs meet formally on a monthly basis to review reports of activities by the various technical teams. The six health sub-teams directly oversee the work of the CSP in their localities. They have selected the 510 CHVs and 238 TBAs for training and continue to work with the local Government to procure resources and provide necessary health services. The health sub-team is also working to involve the broader community in the programs and arranges semi-annual nutrition surveillance information dissemination meetings, monthly drama events, fathers meetings, and other gatherings for the entire community. They are working to involve the whole community in improving and sustaining health care for all community members.

In the past year, PIs started overseeing the Super CHVs and the TTBAs. They are also holding quarterly meetings with the local Government health facilities, and attending District meetings of the Government as requested. In Panchagor, the PI was invited by the District MOH to submit a small proposal for funding for strengthening CCM and training activities following the end of the grant period. We are currently awaiting a response on this proposal.

Promising Practices – *Monitoring of Child Survival Sustainability*

The problem being addressed: In order to ensure the long-term success of their projects, it is critical for NGOs to build key factors of sustainability into their planning, implementation and monitoring activities. However, planning for and monitoring sustainability can be quite complicated. Sustainable health outcomes are the result of a number of interacting and interconnected variables that are related to the entire development process. It is important for NGOs to assess the key factors that influence sustainable health in order to determine which areas need to be addressed in the future.

The project's input to address it: CRWRC and its partner organizations used the Child Survival Sustainability Assessment (CSSA) framework with the health technical teams of the Peoples' Institutions in order to ensure the community's commitment to and ownership of sustainable health outcomes. CRWRC used the CSSA framework in conjunction with the Organizational Capacity Indicator (OCI) and Community Capacity Indicator (CCI) systems that were already in place for each partner organization prior to the Child Survival Program. The OCI and CCI systems track the capacity growth of the local NGO, the community-based organizations (also known as Peoples' Institutions), and the primary groups in the communities using an appreciative inquiry approach. Each group has developed key indicators and a scoring system, which it uses to measure its own progress. The same participatory model is used to assess the other areas of the CSSA framework, including health outcomes, health services, and the enabling environment.

Every six months, each partner organization assesses its progress towards sustainability with the community. The information is depicted using a dashboard diagram and shared with the health technical teams and other primary group members. The NGO and health technical team make decisions together about the future direction of the project to achieve sustainable results and develop an action plan.

The magnitude of the intervention: The six health technical teams who are part of the Peoples' Institutions are directly involved in making program decisions that impact 7,000 primary group members and over 100,000 members of the broader communities.

Specific results: All three partner organizations reported excitement and commitment by the health technical teams and primary group members regarding the CSSA framework. Community members appreciate the dashboard diagram and look for areas of growth and areas in which to improve. The PIs are now doing this monitoring, with minimal assistance from staff. They review the targets and update six monthly. The PIs now record monthly their "signs of sustainability" and this is shared at the monthly Coordinator's meetings.