

**EXTERNAL END OF PROJECT EVALUATION:  
CAPACITY BUILDING FOR STRONGER  
COMMUNITIES**



**December 2014**

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## List of Acronyms

ASA	Association for Social Advancement
BD	Bangladesh
BRAC	Bangladesh Rural Advancement Committee
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
CSG	Community Support Group
CHDP	Community Health and Development Project
DOTS	Directly Observed Treatment Short-course
GFATM	The Global Fund to Fight Aids, Tuberculosis and Malaria
GOB	Government of Bangladesh
ICDDR, B	International Centre for Diarrhoeal Disease Research, Bangladesh
NGO	Non Governmental Organisation
PG	Primary Group
PTA	Parent Teacher Association
SA	Salvation Army
SAS	Strategic Action Society
SMC	School Management Committee
TB	Tuberculosis
UHDP	Urban Health and Development Project

# Executive Summary

## Background: Capacity Building for Stronger Communities

The overall objective of the project *Capacity Building for Stronger Communities* is that “2000 poor and marginalised people, specifically women and youth of the project area will have developed their capacity to solve their health, educational and social issues, through awareness raising of their rights, development of skills in organised groups and provision of needed health services.”

The project operated by the Salvation Army is being implemented through two programmes in two sites in Bangladesh, each with its own history and components. The two programmes are:

- **Community Health and Development Project (CHDP)** in six villages in Dumuria, rural southwest Bangladesh: works directly with over 1800 participants through three components: community development, education and health
- **Urban Health and Development Project (UHDP)** in Mirpur 11, Dhaka: works with 600 participants

## Aims, objectives and methodology of the evaluation

The **overall aim** of the evaluation is: “to assess the project’s impact and sustainability in Mirpur Section 11, Dhaka and Dumuria Upazila, Bangladesh and the relevance of a next phase of the project.”

The **objectives** of the evaluation are:

1. Assess the **major achievements** of the project to date in relation to its stated objectives and intended outputs (results).
2. Assess to what extent the **community support groups** have matured.
3. Assess how the project addressed the **gender issues** identified in the proposal.
4. Assess the key factors affecting **sustainability** of the project
5. Make **recommendations** for the strategic direction of the next phase of the project.

A range of methods were used as part of the evaluation including a desk review of the annual reports and other paper work (evaluations, mid-term reviews etc.), individual interviews, focus group discussions, field visits and observations.

The report first highlights the findings of the evaluation by the sight, subsequently it summarises the findings according to the objectives of the evaluation and makes key recommendations.

## Findings: Project

### CHDP

Overall the project has been very successful in all three areas: community development, education and health. The targets have been reached and the programmes provide much needed services and groups.

### **Organisational:**

**Objectives and indicators:** Overall CHDP has fulfilled its objectives and reached its target indicators through a rights based approach to development, supporting and facilitating CSGs and other community groups, an extensive training of project participants, building the capacity of selected schools’ SMCs and

PTAs and providing family planning and health services.

**Gender:** The project has a focus on women. There are women only savings, literacy and health information groups as well as pre and post-natal health services that target women specifically. Gender balance is monitored and ensured in CSG participation and leadership. Women reported having greater financial independence, better health and control over their reproductive health and more independence and respect as a result of the project.

At a staff level there is a good gender balance (55% female), however there is a poor representation of females at a management level (2 out of 7).

**Other NGOs and services:** There are a number of government schools in the area but very limited health services (one other clinic). UHDP work closely with the government, particularly in the area of health. While there are only a handful of NGOs in the area, the SA and the CSGs particularly need to network more with existing ones and look at where they can collaborate with them.

### ***Community Development Programme:***

The community development programme consists of CSGs, savings groups, adolescent groups, adult literacy groups and the sewing centre.

**Achievements:** The CSGs are functioning well with limited support; there are a number of successful savings schemes through savings groups and the CSGs; adolescent groups meet regularly to discuss various issues and are a source of social support for young people; women have benefited from receiving on-going tailoring training and work from the Sally Ann store through the sewing centre; each of the six villages has run successful literacy schemes for women which have been practical (basic literacy and numeracy skills) and helped build up their confidence and independence.

**Challenges/areas for improvement:** The CSGs have faced difficulties in being able to register with the government as CBOs due to practical and legal challenges; the CSGs, savings and adolescent groups need to be better connected with NGOs in the area; reaching the most marginalised and poor members in the communities at times is challenging; the adolescent groups still need a significant amount of support from the SA; orders from the Sally Ann store are often irregular; the literacy courses are reliant on having a trained teacher and teaching materials which may not be sustainable in the long-term.

### ***Education Programme***

The education programme works through 10 government schools, specifically it has worked closely in building up the SMCs and PTAs in each school.

**Achievements:** There are 10 SMCs which are established, running well and actively supporting their schools; 9 PTAs have been established within the last year; each school has two volunteer teachers who give extra tuition to disadvantaged children, the schools have started to support the teachers financially; the schools have reported good exam results and low drop-out rates.

**Challenges/areas for improvements:** The PTAs still require considerable support and strengthening; the SMCs and PTA are anxious about continuing their work without SA support.

### ***Health Programme***

The health programme provides important and much needed services to the area, it has three key components: family planning, village health groups and the clinic.

**Achievements:** With government support the SA provide family planning services in each of the six villages, reaching women in their homes; the low-cost clinic provides important pre-natal, post-natal and delivery services to the community as well as a drop-in clinic with the doctor; there are regular health information sessions in the six villages which are accessible to the community.

**Challenges/areas for improvement:** The sustainability of the clinic and keeping it open without on-going funding is a challenge; the project's ambulance is not currently functioning as it would be expensive to fix and maintain; there are no health volunteers on the programme which would help with the programme's sustainability; the health information groups lack an organisational structure and planning.

## UHDP

UHDP provides important TB and leprosy services and has a successful community development programme through working closely with women's groups. While overall the programme is successful there have been some shortcomings in terms reaching some of the targets.

### **Organisational:**

**Objectives and indicators:** The planned objectives and indicators have been reached for the project in terms of implementing a rights based approach, capacitating the community through trainings, training of lab staff, establishing and maintaining a database for TB patients, follow-up of leprosy cases and networking with other NGOs and government services. However there have been some shortcomings in terms of the planned health activities and objectives. There have been fewer than planned identified TB and leprosy cases (370 and 20 respectively in the last year, instead of the planned 550 and 30 targeted). There are also fewer than planned health volunteers (110 rather than the 300 planned).

**Gender:** The project works closely with women, the community development project focuses exclusively on women and there is evidence as a result, women have greater financial security (through vocational trainings), confidence and respect.

At a staff level while overall women are under-represented (40%), at a project level there is good gender balance (50% female) and at the management level over-representation of women (75%).

**NGOs and other services:** UHDP have excellent relationships and collaborations with both the government and NGOs in the area.

### **TB Programme:**

The TB programme identifies and treats TB in the community through its clinic and DOTS centres. It also provides on-going education and support in the community and participates in research activities.

**Achievements:** An established well respected clinic in the community where TB cases are identified and treated; enthusiastic volunteers who are based in the community (*bari* mothers) and provide education and support regarding TB; successful DOTS centres which are based in the community; a number of education sessions have been conducted; an impressive increase in the rate of TB patients cured (from 82% in 2010 to 90% in 2014); involvement in research regarding TB with ICDDRB; excellent collaboration with the government and NGOs.

**Challenges/areas for improvement:** There remains a huge stigma in having/having had TB; poverty means that poor patients are unable to afford adequate nutrition; there is a high proportion of staff to patients (particularly given the many volunteers); multi-drug resistant TB provides extra challenges to the patients and service providers.

### **Leprosy programme**

The leprosy programme identifies and treats leprosy cases, educates the community regarding leprosy and provides on-going support and treatment to previous leprosy patients and their families.

**Achievements:** The clinic is well known for its activities and well respected; the services offered to patients are very specialised; the programme has a good relationship with the government; important on-going work with previous patients and their families.

**Challenges/areas for improvement:** Leprosy is often a debilitating and stigmatised condition; there is a lower level of community involvement than the other two components of UHDP.

### **Community development programme**

The community development programme works closely with women through primary groups, youth groups, adolescent groups and organises vocational training and literacy classes for women.

**Achievements:** The PGs are running very effectively and have a clear exit plan; the youth are very active and involved in all aspects of the project; the adolescent groups are an important form of social support to the young people; a high level of employment following vocational trainings; there is a clear exit plan for the SA; excellent collaboration and networking with NGOs; the adult literacy groups are very appreciated; there is a very low staff to participant ratio; and a very low level of dependence on the SA.

**Challenges:** There are many social problems in the bihari camps where the programme runs; there

are high levels of illiteracy, particularly among women; the registration of the PGs as CBOs could be a challenge in the future.

## **Findings: Overview**

### ***Major achievements of the project:***

- The CSGs in Dumuria being able to function with limited support and are ready to continue independently.
- Successful work with government schools in Dumuria means the schools in the area have been significantly strengthened.
- The clinic in Dumuria provides essential services to the community at an affordable rate.
- There has been highly successful cooperation with the government as the SA in operates the national TB and leprosy programmes in Mirpur 11.
- Volunteers for the TB programme have proved an effective, sustainable, community based way of identifying and providing on-going support to patients with TB and their families.
- With limited staff support, excellent planning and networking the community programme in Mirpur 11 allows poor women access to vocational trainings, adult literacy and savings.

### **CSGs:**

- In Dumuria the CSGs are running effectively and with limited staff support. They are working towards legal recognition, although this is proving to be difficult. They need to network and tap into local resources more.
- The primary groups in Mirpur 11 have an exit strategy and are working towards independence, they have good networks with external NGOs.

### **Gender:**

There has been considerable progress regarding women's rights and their situation in their homes and communities, specifically the evaluation found evidence of:

- Female and male project participants have a basic knowledge of women's rights.
- Women have increased access to money, literacy and reproductive services.
- Women report that their husbands and communities have a greater respect towards them.
- Women are represented on leadership committees in all the groups.
- Female staff are well represented in the SA.

However, there remain challenges regarding gender, they include:

- Females are under-represented in supervisory roles at UHDP.
- There remain no female presidents of the CSGs.
- Males remain dominant in the homes.
- Females still report harassment.

### **Sustainability**

Sustainability of the project sites:

- **CHDP:** the CSGs are able to function independently and they need support to take over the activities of the community development programme in Dumuria; the work in the schools is largely sustainable and should continue after the SA exit; the health programme is currently not sustainable without support and funding.
- **UHDP:** the leprosy and TB programme work closely with the government but still rely on the SA to continue. The TB programme works closely with many volunteers in the community. The community development programme works through primary groups which are able to function with limited support.

## Lessons learned

The key lessons that can be learned from this evaluation include:

- It is important to have a clear exit plan from the beginning of a community development project.
- The process of a group (PG and CSG) becoming a CBO should be outlined when forming a group.
- There needs to be clear, realistic and measurable objectives.
- It is important to have clear plans to achieve the project objectives.
- Working with the poorest of the poor needs to be carefully planned and implemented.
- Working closely with community groups and volunteers is effective and sustainable.
- Working with the government where possible is important.

## Future recommendations

In light of the findings the evaluation makes the following recommendations for the project:

1. **CHDP: CSGs should continue to work independently in Dumuria, taking over the work of the SA.** In order to prepare for this they need to work towards registering the CSGs as CBOs; increase networking with NGOs and government organisations for extra support and services; and look at how the CSGs can take over development and some health and education activities.
2. **CHDP: Plan to make the clinic self-sustaining.** As the clinic is an essential service it is recommended that options are explored to make it self-sustaining so that it can continue to run. Options that can be explored include increasing the fees for patients who can afford it, approaching the government to see what support they can give and work with the CSGs to see what support they are prepared to give.
3. **UHDP: Look at how the three project components can work more closely together and learn from each other.** For example the TB volunteers could also increase awareness about leprosy; the leprosy programme could utilise more volunteers like the other two components; and the community development programme could learn more about TB and leprosy and work towards decreasing stigma through its group work.
4. **UHDP: Replicate the community development model in other areas of the camp.** With the assistance of the existing primary groups more groups can be set up in the camps, specifically with the *bari* mothers and men. This model needs limited staff input and is highly sustainable.
5. **UHDP: Providing supplementary food for TB patients who are under-nourished and poor should be considered in the next project proposal.** Under-nutrition is a risk factor for TB and TB causes under-nutrition. Volunteers, staff and patient have highlighted many patients cannot afford adequate nutrition and in urban settings it is difficult to rear animals and grow many vegetables.
6. **Future projects: As the SA move into other areas to implement community development, it is important that they plan ahead and learn from their extensive experiences.**



# 1 Introduction

## 1.1 Purpose, aims and objectives of the Evaluation

The project “Capacity Building for Stronger Communities” is a project operated by the Salvation Army in two sites in Bangladesh: Mirpur Section 11, Dhaka (urban setting) and in six villages in Dumuria Upazila (rural setting). The Salvation Army has been long established in both these areas (in Dhaka for over 40 years and Dumuria for over 20 years). The project being evaluated is at the end of its second phase, this is therefore the end of project evaluation. The project has received one more year of funding (until the end of 2015), following this SA will look at on-going funding for both Dumuria and Mirpur 11 as well as new areas<sup>1</sup>. Therefore a key element in this evaluation is to look at sustainability of the project and make recommendations for the future.

Specifically, The **overall aim** of the evaluation is:

“To assess the project’s impact and sustainability in Mirpur Section 11, Dhaka and Dumuria Upazila, Bangladesh and the relevance of a next phase of the project.”

There are five specific **objectives** for this evaluation. The objectives are:

1. Assess the **major achievements** of the project to date in relation to its stated objectives and intended outputs (results): this includes looking at important achievements, shortcomings and best practices of the project.
2. Assess to what extent the **Community Support Groups** have matured: the evaluation looks at the role of CSGs in the community, their ability to network with other agencies and advocate for services and their ability to function independently.
3. Assess how the project addressed the **gender issues** identified in the proposal: this involves looking at woman’s participation and representation in the groups, leadership and organisation as well the effect of the project on women’s lives and changes in attitudes towards women.
4. Assess the key factors affecting **sustainability** of the project: the evaluation explores the sustainability and lasting impact of the different aspects of the project.
5. Make **recommendations** for the strategic direction of the next phase of the project.

See appendix 1 for the specific terms of reference for the evaluation.

## 1.2 Background to the project

The overall **goal** of the project Capacity Building for Stronger Communities is:

“By the end of the project period, 2000 poor and marginalised people, specifically women and youth of the project area will have developed their capacity to solve their health, educational and social issues, through awareness raising of their rights, development of skills in organised groups and provision of needed health services.”

This is implemented through four specific **objectives**:

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<sup>1</sup> In Dumuria the SA plan to continue health and education components of the programme, they will look to start community development in new areas.

**Objective 1:** By the end of the project period, 2000 poor and marginalised women, men and youth in communities have been trained extensively to develop their knowledge, skills and organisational capacity.

**Objective 2:** By the end of the project period, 50% of the communities, via their community support groups or school management committees, have developed their capacity to advocate for and enhance the quality of education in their primary schools.

**Objective 3:** By the end of the project period, community health will be improved through the provision of essential health services and the development of 300 volunteers' capacity to intervene on health issues that threaten their communities and increasing the community's capacity to deal with their health issues.

**Objective 4:** By the end of the project period, organisational capacity will be developed to implement and monitor rights based development activities in the projects.

The project is being implemented in two different sites through two different programmes, each with their own history and components. The sites are:

1. **Community Health and Development Project (CHDP)** in rural southwest Bangladesh. The three components under this site are: community development (which includes CSGs, adolescent groups, savings groups, literacy groups, training centre), education (working with 10 government schools) and health (clinic, family planning and village health groups).
2. **Urban Health and Development Project (UHDP)** in Mirpur 11, Dhaka. The project site (which includes a clinic) is located near to Bihari camps, and many of the participants are Biharis<sup>2</sup>. The three components under this site are: TB programme (based at their clinic and works closely with volunteers in the community), leprosy programme (based at the clinic and involves a community component) and community development project (working with female primary, youth and adolescent groups).

### **1.3 Report overview**

Due to the different geographical locations and different natures of the two sites of projects they were visited and assessed separately. This report first outlines the methodology used for the evaluation. The next chapter reports the findings for CHDP, the subsequent chapter reports the findings of UHDP. The final chapter summarises the findings according to the four objectives (achievements, CSGs, gender and sustainability) before outlining specific recommendations.

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<sup>2</sup> The Biharis are a long-established but disadvantaged and often discriminated against ethnic group.

## 2 Methodology

An external independent consultant led the evaluation. She was assisted by two SA staff (who work on different projects to those evaluated). A range of methods were used as part of the evaluation including a desk review of the annual reports and other paper work (evaluations, mid-term reviews etc.), individual interviews, focus group discussions, field visits and observations. The desk review concentrated on the planned and actual outcomes, to assess whether targets had been met. Existing networks and NGOs were asked about and recorded when in the field in order to map the relevant services in the area; particularly Dumuria.

The methods used during the field visits were “people-centred” and participatory. The field visits lasted 10 days. Following the field visits the preliminary results were shared with the staff allowing for their input, subsequently the report was drafted. The following visits and discussions were had:

### CHDP, Dumuria:

- Interviews with the project manager, accountant, 2 health workers, the health supervisor, 2 education staff, 2 community development staff and the training coordinator.
- Group discussion with: 2 health groups, 2 savings groups, 2 adult literacy groups, women from the training centre, 2 SMCs, 2 PTAs, 2 Adolescent groups and 3 CSGs.
- Meetings with 5 members (including the chairman) from the Union Parishad and 1 medical officer and 1 family planning officer at the Upazilla health complex.
- Visits to 1 teashop, 2 tailor shops and 2 homes where project participants had set up businesses.

### UHDP, Mirpur 11:

- Interviews with the leprosy staff, TB staff, community development staff, 3 TB patients and home visits to three leprosy patients.
- Meetings with the National Leprosy Programme, The National TB Programme, ICDDRB and two other NGOs (Islami foundation and Bapsa clinic).
- Group discussions with 1 youth group, representatives from 10 primary groups, 1 adolescent group, 10 *bari* mothers and a group of local stakeholders.
- Visits were made to 2 DOTs centres and both the leprosy and TB clinic.

See appendix 2 for the list of meetings and see appendix 3 for an outline of the questions asked.



Figure 1: Members of the evaluation team talking with a community group

## 3 Community Health and Development Project, Dumuria



Figure 2: CHDP headquarters

### 3.1 Organisational

#### 3.1.1 Overview

The CHDP in Dumuria consists of 30 members of staff (including 7 support staff) and works directly with over 1800 participants across six villages through three programmes: community development, education and health<sup>3</sup>. There are:

- 6 CSGs (1 in each village): 499 members, over 60% female.
- 20 women's saving groups (2-5 in each village): 280 members.
- 26 adolescent groups (2-7 per village): 372 members (11 male groups and 15 female groups)
- 6 adult literacy groups (1 per village): 120 members, all female
- 10 schools; 10 SMCs (117 members, 40% female) and 9 PTAs (90 members, 50% female)
- 20 volunteer teachers, 35% female, (2 from each school) are giving extra tuition to 404 disadvantaged students (51% female).
- 121 village health groups (16-25 per village with a total of 1,562 female participants).
- At the clinic there are services for pre and post-natal women and a delivery service. There is a drop-in service for anyone to see the doctor. An estimated 40 patients a day uses the clinic, with a total of 7,644 patients being served in 2014 and 6,851 in 2013.

#### 3.1.2 Objectives and indicators

The overall aim of the project, to capacitate poor and marginalised people, is achieved through its four objectives. The objectives have specific measurable target indicators for both projects (CHDP and UHDP). Overall, the targets have been met and CHDP is contributing towards the achievement of the projects aims

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<sup>3</sup> This number has been estimated according to the number of participants in the various groups and work with the PTAs and SMCs in the school. The number would be much higher if the number of people who attend the clinic and total number of school children were included.

and objectives. The breakdown of the objectives and targets are as follows:

**Objective 1: 2000 poor and marginalised women, men, youth in communities have been trained extensively to develop their knowledge, skills and organisational capacity.**

This objective is being reached through the development of training plans and numerous trainings provided through the different groups. They include vocational skills, social issues, literacy and reproductive rights. The number of trainings provided has exceeded the targets. An additional target under this objective was the registration of the CSGs as community organisations. This has not been achieved due to regulations for registration (see section 3.2). Overall, a high number of participants have been reached through the group activities and implementation of trainings.

**Objective 2: 50% of the communities via their CSG or SMC have developed their capacity to advocate for and enhance the quality of education in their primary schools.**

This objective concentrates on education. It is difficult to assess whether the specific target has been achieved, as it is unclear what number 50% is<sup>4</sup>. The education programme works closely with 10 government schools in the 6 villages that the SA works. The activities listed under this target include strengthening the SMCs, PTAs and CSGs to advocate for quality education and to be aware of the resources. The SA effectively reformed and reorganised already existing SMCs and PTAs in the relevant schools with impressive results (see section 3.3). The SMCs are functioning effectively, and there are regular guardian meetings at the schools.

**Objective 3: Community health will improve through the provision of essential health services and the development of 300 volunteers' capacity to intervene on health issues that threaten their communities and increasing the community's capacity to deal with their health issues.**

Under this target, the planned activities and targets relate primarily to UHDP in Mirpur 11, Dhaka. However, CHDP do have a much needed health programme that includes a clinic, family planning services and health education. The project serves the community and is highly appreciated (see section 3.4). The target numbers of women seen for family planning and child and maternal health care set by the GOB have been exceeded.

**Objective 4: Organisational capacity will be developed to implement and monitor rights based development activities in the projects.**

In order to achieve this objective the project activities include providing training to group members on human rights; staff and community groups trained and implementing participatory monitoring tools on groups' effectiveness, which are in-line with rights based activities; and increased co-ordination with NGOs and government agencies. According to the reports the CSGs have been trained and are implementing these tools. There have been several trainings on human rights and during the evaluation groups did refer to human rights trainings and appeared to have a basic awareness of their rights. According to the latest annual and mid-term report there has been an increase in networking with NGOs in the area, however there is scope for improvement in this area (see section 3.1.4).

### **3.1.3 Gender**

A key concern of the evaluation is gender, both in terms of representation and changes in attitudes and roles of women. While it was often difficult to assess the latter two aspects of gender the evaluation team attempted to do so through discussions, observations and asking for examples. The overall findings in relation to gender at the organisational and project level are as follows:

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<sup>4</sup> It is unlikely that this number has been reached as the number of people in the "communities" in which the SA work is in the thousands, half of whom would not be directly advocating and enhancing education quality. However, if the target is measured in terms of 50% of the communities are affected by the education programme in Dumuria the target may have been reached, as the programme should have a positive effect on the school children and indirectly their parents of the schools in which the SA work.

### **Organisation: staff representation:**

There are a total of 30 staff (including 8 support staff) based at the Dumuria office, 14 of whom are female (almost 50% representation). At the project level 12 of the 22 staff are female (55%). However, while representation of females on the staff is good, at a supervisory level it is poor. The manager is a male. Seven staff are in a supervisory or coordination roles (including the manager), however only two of the seven staff are female. Neither of the women (training coordinator and handicraft supervisor) is responsible for managing staff. Thus while there is a good representation of women in the staff, particularly at a field level, there is room for much improvement at the managerial level.

### **Project level:**

The project does have a focus on women, and ensures at a minimum equal representation in the groups. Specifically for women there are savings groups, health information groups and adult literacy groups. An increase in financial capacity and literacy was reported by participants in the groups to empower them and enable them to have more control over their lives (particularly financially) and meant that men in their families and communities were more likely to respect them. The men in the community support groups, in addition to the women, spoke of increased awareness of women's rights and respect for women, partly at least, due to the SA's many years of working in the area. Reported examples of changes in attitudes towards women in the project included:

- Women reported many changes in their circumstances over the last few years. They have greater independence and are able to spend time outside the household to attend groups and trainings.
- Women reported being listened to by their husbands now and being treated more equally within the household than previously.
- Women are more aware of their reproductive and human rights as a result of trainings.
- Many women reported being able to take loans and start small businesses or buy livestock. This gave them greater financial security and means a greater deal of respect from their families and communities.
- As a result of adult literacy programmes women are now more able to manage their accounts, open and manage bank accounts giving them greater financial responsibility and independence.
- Women reported their husbands are more likely to listen to them and respect them when they have basic literacy skills.
- Women reported having an increased awareness of family planning and are able to plan and control the number of children they have.
- Men reported seeing women as more equal than they had previously and more likely to listen to women both in their homes and the groups.
- Men reported being aware of woman's rights.

While there does appear to be greater improvement in attitudes towards women and changes in their roles, there remains much room for improvement. The women still are responsible for almost all household tasks and many reported that they remain unequal within the home. Additionally, in some of the mixed meetings attended by the evaluation team men did dominate the conversation (this did however vary across the different CSGs). In terms of leadership, females are well represented in leadership positions within the CSGs. Each group has a committee of up to 10 members (including a president, assistant president, secretary, assistant secretary and cashier). Out of the 58 members in leadership across the six CSGs, 31 (53%) are female. The vice president role is allocated to a woman and women are well represented across the groups and their leadership committees. However, every single president of the six CSGs is a male. This indicates that there remains room for improvement in terms of female leadership. It appears that it remains difficult for women to have leadership over males.

### 3.1.4 Sustainability and existing NGOs and government organisations

When considering the long-term sustainability of the project, particularly as the CSGs plan to run independently, it is important to be aware of existing NGOs and government organisations and services in the area that project participants may increasingly use in the future.

The government has a duty to provide basic health and education in all areas of Bangladesh. It provides education through its schools, including the ten schools that SA works with at the moment. The government works through BRAC to implement its TB programme and through the SA to implement its family planning programme (see section 3.4). Additional services provided by the government identified include:

- Within the six villages there is one government clinic that is overseen by an unqualified practitioner with limited services (limited to dispensing medication).
- Within the upazilla there is one government health complex with qualified staff that provides basic procedures, pre-natal and post-natal care and deliveries. The complex is a considerable distance from Dumuria (18 km). Emergencies are referred to Kulna medical hospital.
- Kulna medical hospital has 250 beds and is the only hospital in the district. It is 25km from Dumuria.

It was reported during the evaluation that there are a limited number of NGOs in the area, the ones that do exist are concerned primarily with micro-credit (with some exceptions). Overall there was limited networking with NGOs in the area, partly due to the limited number of NGOs, however this did vary across the different CSGs. It is important that all the CSGs identify and network with existing NGOs in the area. Identified existing NGOs during the evaluation include:

- Working with micro-credit: ASA, Grameen Bank, Janata, Proshika, Shamata, Bondhu Foundation, Unoyom, BRAC, SAS.
- Health: BRAC runs the government TB programme, Rupantar works in sanitation and provides health trainings, Wasek Ali (a local NGO) works with drug users.
- Education: ASA runs at least one pre-school, Wasek Ali gives small education grants.
- Other: Balaka gives legal aid, Nasakali provides some skills training and does some work in agriculture, SAS gives training on income generating activities.

## 3.2 Community development programme

Overall the community development aspect of the project is running well with limited support (particularly for the savings groups and CSGs). There are 5 staff that work with the community development programme. The community development programme includes CSGs, savings groups, adolescent groups, adult literacy and the sewing centre.

The **main achievements** of the community development projects are:

1. **The CSGs are functioning well with limited support.** All six community support groups meet on a monthly basis. They have established rotating leadership (selection or a vote takes place every two years). The groups each have a welfare and a savings scheme, to which all members contribute and they manage. The groups are aware of and have a relationship with local government. The groups have different long-term plans and ideas and are keen to register as independent organisations, however there are many challenges to achieving this (see below).
2. **Successful savings schemes.** Both the community support groups and savings groups have

successful savings schemes where members contribute a small amount monthly (20-50 taka), members of the group are able to take loans primarily to start small businesses. Within the CSGs the loans are overseen by a loan committee, the savings groups are primarily set-up to promote savings. Within the savings groups it was reported that all members of the groups needed to agree before a loan was given, the amount would depend on previous loans and length of time the member had been part of the group; there is a set amount of time to repay the loans depending on the amount. Members of the CSG loan committees oversee different members of the CSG according to their locality; they assess and oversee the giving and repayment of loans. Overall it was reported that the savings schemes were successful and there were several examples of members of the groups having successful businesses as a result of taking loans.

3. **Adolescent groups meeting regularly.** There are 26 adolescent groups (11 males and 15 females). The group members can attend from class 7 through to graduation from an honours degree. They have an established leadership system and meet monthly. Representatives from the groups attend trainings of social issues and rights (dowry, trafficking, gender etc.) and share what they have learnt with the group during the meetings. The group is also a space that adolescents have as a source of support as well as fun through song and dance. Adolescents from different groups have been involved in various activities such as peer educating, dramas and working on projects such as planting trees. The groups visited had ideas for future plans such as setting up a study space/library and having a school fund for poor students. The groups and staff report changes among adolescents such as them being more supportive towards each other, accepting of differences and the boys being less likely to smoke.
4. **Women receiving on-going trainings and work at the sewing centre.** The sewing centre at the project office gives on-going sewing training to women in the area. There are two three-month training sessions a year which 5-10 women receive. Following the training women are able to make products for the Sally Ann store in Dhaka for which they are paid. Many women will buy a sewing machine so that they can work at home, if they are unable to afford a machine they can work at the sewing centre. There are currently 96 women in the area who make products for the Sally Ann store. Several of the women will also do tailoring for other people. Being able to tailor means the women can make up to 4,000 taka a month (a reasonable wage in the area).
5. **Successful literacy schemes.** Each one of the six villages ran one eight-month adult literacy course for 20 women. The women all had either never been to school or had briefly gone when they were younger. The scheme is very popular and has a high success rate. The women reported that the course had taught them to read, write, count, manage basic accounts as well as inform them about social issues. It enabled them to keep their household accounts better, pay bills, use the bank and help their children with their homework. They also reported it gave them greater confidence and being able to read means their husbands, families and communities now have a greater respect for them. The teachers of the adult literacy groups are local and trained by the SA.

**Challenges/areas for improvement** of the community development project include:

1. **Registration of the community support groups.** The plan of both CHDP and the community support groups has been to apply for registration from either the government's Social Welfare Department or the Cooperative Society as independent community based organisations. Registration would enable them to formalise their organisations and apply for government and other forms of funding. However, they have been unable to register with the Social Welfare Department due to being unable to fulfil specific criteria i.e. owning land. Furthermore the government recently stopped all registration with the Cooperative Society.
2. **Networking.** The CSGs, adolescent and savings groups need to build up contact with NGOs in the area. There does appear to be a lack of NGOs in the area (outside of microcredit), hence several of the groups had limited knowledge of NGOs in the area. However, there was one CSG who highlighted several NGOs in the area – this CSG had clearly made an effort to identify NGOs and potential collaborations with them. This highlights the different levels of knowledge and collaborations with NGOs according to the groups. It is important that all the CSGs particularly build



- up their liaisons with NGOs in the area.
3. **Reaching the poorest of the poor:** while it is evident that a significant number of the participants are poor, not all of them are. This is partly because many have managed to better their situations due to the groups and loans. However, it does appear that several members of the leadership and group members are middle-class or not very poor. While it is not always a disadvantage to have a range of backgrounds in a group, it is often the case that better off member of a group will dominate. Furthermore the purpose of the project is to serve the most poor and marginalised. The staff have recognised this as an issue and did introduce stricter criteria for entrance to the CSGs, this is an important lesson learnt.
  4. **Adolescent groups still need a significant amount of support.** While the adolescent groups are appreciated and run well they rely on staff support, a member of SA will attend and help facilitate all their meetings. Also by definition of the group (being a young adolescent group) mature members of the group who are often in charge of their running will graduate from the group.
  5. **Women from the sewing centre are reliant on orders from Sally Ann store, which can be unpredictable.** While the orders from Sally Ann store are a valued source of income, the orders are unpredictable and the orders that do come are distributed between many women. The money from these orders (while good) cannot be relied on as a steady source of income.
  6. **The adult literacy group is reliant on having a trained and willing teacher and teaching materials.** The adult literacy courses were well received and appreciated by the community. However if they are to continue in the future teachers need to be identified and materials provided.

#### Sustainability:

All the groups were asked about their future plans and on-going sustainability. While there was some anxiety about the SA leaving, the CSGs are clearly capable and ready for a handover. Their main concern is registering the CSGs. The savings groups are running effectively with limited support. The adolescent group needs on-going support. The adult literacy groups need organisation and teachers to be identified. While planning their exit the SA could look at how the CSGs can support the adolescent, savings groups and adult literacy groups. Networking with NGOs and government organisations is also important in order to be aware of services as well as looking to other places to receive support and trainings when/if needed.



Figure 3: Literacy group member



Figure 4: Project participant and her husband who started a business with her loan

### **3.3 Education Programme**

There are two SA staff that work within the education programme. The education programme works through 10 government schools. Specifically it has worked closely in building up the School Management Committees (SMC) and Parent Teaching Association (PTA) in each school. It has done this by helping to select members for the committees, providing training on their roles and responsibilities, leadership and other relevant subjects and assisting them to make annual plans through holding a workshop with them. Another aspect of the programme is having two volunteer teachers for each school. These volunteer teachers are paid a small salary and provide extra tuition to the poorest students in the schools. It is planned that the SMCs will continue to function and monitor the school's progress after the SA withdraw their support from the schools, so it is crucial that they are strong. Members of the SMC are selected every three years and include interested members, community leaders, community members and teachers. The leadership also rotates. The roles of the SMC includes supporting volunteer teachers and the PTA, supporting the government's "open school" programme, monitoring the progress of the school, checking attendance and following up on children who do not attend school and organising extra-curricular activities such as sports days.

**Successes** of the schools programme include:

1. **Established SMCs in all 10 schools:** the SMCs have all been established and are aware of their roles and responsibilities. The SMCs that the evaluation team met with appeared enthusiastic and reported many changes in the school since they have been active. Changes include better school results, lower drop-out and more children getting tuition. They were also aware of the government's roles and responsibilities. They appear capable of continuing to work without SA support.
2. **PTAs set up in 9 schools:** the PTAs have only recently been established (within the last year). The PTAs that the evaluation team met with appeared aware of their roles and responsibilities, however as they are newly formed they still need support to fully function. The main roles of the PTAs are to maintain relationships with the students and teachers, meet every three months and support the SMC and volunteer teachers.
3. **Volunteer teachers:** the volunteer teacher scheme has been very positive. The schools appeared very enthusiastic about them and reported having very committed teachers that are able to provide much needed tuition to students who cannot normally afford extra tuition. The schools had planned different ways to support the teachers financially. At one of the schools the students were asked to pay a small fee for the tuition (50 taka a month), at another school the SMC and CSG contributed towards their salary so students did not have to pay.
4. **Good exam results and low student drop out:** the schools visited reported that their schools had good exam results and student drop-out had decreased.

**Challenges and areas for growth:**

1. **PTAs need to be strengthened:** as the PTAs are all relatively new they require extra support. The SA and SMCs need to work together to strengthen the PTAs before the SA withdraw from the area. There is still one PTA that needs to be established.
2. **Anxiety about the Salvation Army withdrawing their support from the schools:** the SMCs and PTAs are anxious about continuing without SA support. However, the SMCs appear very capable but do need to be encouraged.

## Sustainability:

The SMCs, PTAs and volunteer teachers are all an established part of the government schools. They are well situated to continue. The SMC can take over the role of supporting the PTAs and the volunteer teachers (with support from the CSGs). Being part of a government school the groups are well situated to continue to oversee and support the quality of the school long-term.



Figure 5: A school the SA work with



Figure 6: Meeting with an SMC



Figure 7: A newly formed PTA

### 3.4 Health Programme

The health programme is supported by 1 health supervisor, 6 village health workers and the clinic staff (medical officer, senior nurse, clinic assistant and a health aid). There are three different aspects to the programme: family planning, village health groups and the clinic.

The **achievements** of the health programme include:

1. **Government family planning is implemented through the SA:** in collaboration with the government the SA provide family planning services to the area. The health workers are assigned to each of the six villages. They provide family planning advice and contraceptives in the villages. The SA holds biannual camps providing long-acting and permanent method contraceptives. Women spoke about the benefit and convenience of having health workers being able to provide contraceptives at home. The government provide the contraceptives, monitoring and resources.

2. **An affordable clinic:** The clinic sees pre and post-natal women weekly as well as provides deliveries. It costs 30 taka for the first visit and 25 taka for follow-up visits. A delivery costs 750 taka. There is a system where very poor patients are exempt from charges. The service was highlighted as being the only such affordable service in the area. Not having the clinic was expressed as a major concern by most of the groups and the staff.
3. **Health information sessions:** health workers in the villages provide these sessions during the health groups. Women reported that it is convenient to have the sessions in their villages.

#### Challenges and areas for growth:

1. **The clinic's sustainability:** while this is a much-needed service, the sustainability of keeping the clinic open is a challenge. As it is a service for the poor funds are needed to keep in running, charging high fees for the clinic is not an option if it is to stay a service for the poor.
2. **An ambulance:** the people in the area lack an ambulance. Both the SA's ambulance and the government ambulance (the only ambulances in the area) are not functioning. The SA's ambulance would be expensive to fix and run.
3. **Lack of health volunteers:** the health activities are reliant on health workers. By not building up health volunteers (as objective three of the project aims to do) none of the health activities are sustainable. Had they been built up the health groups and information sessions at least could have been continued.
4. **Health groups are not currently sustainable:** while these are a good idea, they are not sustainable as they stand as they rely entirely on the health workers. They are also not well planned, they would be more effective if they were planned and run by group members themselves.

#### Sustainability:

The health programme is the least sustainable component of the project as it is a service that is provided rather than being run by the community itself. The family planning programme is in collaboration with the government, presumably the government will take over or find another provider if the SA were to stop its services (i.e. due to lack of funds) although there are no guarantees. The clinic is 31% funded by the low fees and runs on a low cost (part-time staff, basic equipment and subsidised medicine)<sup>5</sup>, if it is to be continued alternative sources of funding need to be found (see section 3.5).



Figure 8: The CHDP clinic



Figure 9: A baby born at the clinic and her mother

<sup>5</sup> The clinic costs 2,197,278 BD taka to run last year, the equivalent of 24,430 euros. 670,490 taka (7,455 euros) were raised through fees in the past year.

### **3.5 Moving forward: future plans**

Overall the project in Dumuria has been very successful in all three areas: community development, education and health. They have generally reached their targets and provide much needed services and groups. Looking forward there are key considerations that need to be considered before the SA withdraw from the area. In light of the findings the following suggestions of the evaluation are:

1. **There needs to be a clear exit plan.** The SA are withdrawing from their community development work at the end of 2015, there needs to be a clear exit plan with all the activities needed to be completed before they withdraw.
2. **Registration of the CSGs.** This is a key concern of the project. The SA need to continue to work with the CSGs to look for solutions. The option of the six CSGs joining together to apply for registration should be explored. The SA and CSGs should also explore options with local government, with whom they have good relations. If the CSGs do not get their registration by the end of 2015, SA should still plan on withdrawing and plan with the CSGs accordingly.
3. **CSGs to take over the adolescent groups, savings, adult literacy and health groups.** Currently all these groups operate separately. If they are to continue they need extra support. The CSGs are ideally situated to take over these groups. The CSGs can create sub-committees (health, education, savings etc.) to oversee the groups.
4. **SMCs, with the support of the CSGs, should continue to monitor the progress of the schools and oversee the PTA and volunteer teachers.** The SMCs are capable and enthusiastic, the SA needs to look at building their capacity in being able to monitor and oversee the PTA and volunteer teachers. This way the schools will continue to be accountable and functioning.
5. **Options as to how the clinic can continue should be explored.** The clinic is a much-needed resource for the poor in the area. If it is to continue the SA need to work closely with the health staff and CSGs to look at how it can do so. Options that could be explored include charging more for the clinic (though if it is to be a service for the poor the charge should be affordable), liaise with the government as to what their responsibilities are and how much support they are willing to provide and work with the CSGs to see how much support they can give to the clinic (i.e. could they provide some of their welfare fund?).

## 4 Urban Health and Development Project, Mirpur 11, Dhaka



Figure 10: Rooftop view of the bihari camps

### 4.1 Organisational

#### 4.1.1 Overview

UHDP works directly with 600 project participants within the Bihari camps in Mirpur 11, through three programmes: TB, leprosy and community development. There are 27 staff (including 9 support staff) based at UHDP. In addition to direct work with leprosy and TB patients and women in the community development groups, UHDP provides education sessions and has close relationships with community members. The main activities of UHDP includes:

- TB clinic and 10 DOTS centres providing treatment to 370 patients
- Training and awareness raising through 100 TB volunteers (*bari* mothers)
- Leprosy clinic providing treatment and on-going support to 26 patients and 170 previous patients
- Community development work with 10 primary groups, 1 youth group, 2 adolescent groups, 2 adult literacy groups and vocational trainings.

#### 4.1.2 Objectives and indicators

The overall aim of the project to capacitate poor and marginalised people is achieved through its four objectives. The objectives have specific measurable target indicators for both projects (CHDP and UHDP). Overall, UHDP is contributing towards the achievement of the projects aims and objectives. The breakdown of the objectives and targets are as follows:

**Objective 1: 2000 poor and marginalised women, men and youth in communities have been trained extensively to develop their knowledge, skills and organisational capacity.**

In order to achieve this objective the project groups have annual plans for the training of project participants in both vocational skills and awareness of social issues. These training plans are completed on an annual basis and numerous vocational skills training and training on social issues across the different groups have been completed. No loans have been given yet due to the savings groups being relatively recent (they were formed August 2013) and the groups still being built up. UHDP works with fewer participants under this objective than CHDP. This is because CHDP works with a higher number of participants overall, and focuses on community development whereas UHDP primarily focuses on health (TB and leprosy specifically).

**Objective 2: 50% of the communities via their CSG or SMC have developed their capacity to advocate for and enhance the quality of education in their primary schools.**

This objective primarily relates to work conducted with schools under CHDP.

**Objective 3: Community health will improve through the provision of essential health services and the development of 300 volunteers' capacity to intervene on health issues that threaten their communities and increasing the community's capacity to deal with their health issues.**

The activities under this objective include identification and education of specifically TB and leprosy cases. The training and work of two lab staff is a target that has been met, the establishment and use of the database for TB patients is a target that has been met and is an effective way of monitoring statistics. The number of identified TB and leprosy cases has been lower than their targets in the last year. 370 TB cases were identified last year, as opposed to the planned 550. 20 new leprosy cases were identified as opposed to the planned 30 cases. The figures illustrate the difficulties in predicting the identification of new cases, see sections 4.2 and 4.3 on TB and leprosy identification and management for an analysis on its effectiveness. The number of leprosy patients receiving on-going support and footwear however has exceeded the planned target.

The development of community volunteers is key to this target. This has been done effectively through *bari* mothers (TB volunteers) and the community pharmacists at the DOTS centres (see section 4.2). However, the project has fallen significantly short of its 300 volunteer target (110 in total). While 300 volunteers were trained as planned, only 110 were selected as volunteers (100 *bari* mothers and 10 DOTS volunteers) due to practical reasons. Thus while the SA is doing important work, particularly with TB, through utilising volunteers it has not utilised as many volunteers as the objective clearly states and none in health areas outside of TB.

**Objective 4: organisational capacity will be developed to implement and monitor rights based development activities in the projects.**

The activities under this objective relates to networking with the government and NGOs and the implementation of participatory monitoring tools on the project's effectiveness, in-line with rights based development. UHDP has effectively liaised with the government and NGOs (see section 4.1.4). There has been an increased focus on human rights and the community development side of the project has begun to participatory monitoring tools in the groups in Mirpur as planned.

### **4.1.3 Gender**

**Organisation: staff representation:**

At an organisational level there is a reasonable gender balance. While only 40% of the staff are female (11 of the 27), at the project level 50% of the staff are female (9 of 18). At a supervisory level, while the manager is a male all three programme co-ordinators (TB, Leprosy and Community Development) are female.

**Project level:**

The TB and leprosy programmes serve both men and women. The TB programme works closely with female volunteers in communities. The stigma of TB and leprosy affect both male and females, though slightly differently: females for example have reported that it may affect their chances of marriage.

The community development programme works exclusively with women. The women spoke of the groups being a source of support and the adolescents spoke about challenges they face as women such as harassment. Few of the women spoke about fundamental changes in attitudes towards women in the past few years. The volunteers (*bari* mothers) spoke about having greater freedom to spend time out of the home and the respect they got for their work. The vocational skills training has meant that women in the project have greater financial stability. The literacy course enables women to have more control over their lives as they are not dependent on others to do their accounts or read for them. While it is positive that the project does work closely with women to change their lives, if fundamental attitudes are to be changed working with men is crucial – something that the project currently lacks.

#### 4.1.4 Sustainability and existing NGOs and government organisations

UHDP works closely with both the government and NGOs. All the agencies spoken to by the evaluation team were positive about the SA's work and the SA benefits too from the collaborations. This is positive in terms of sustainability and project participants receiving streamlined, effective services.

The leprosy and TB programmes work with:

- **The National TB Programme**, through GOB and funded by the GFATM. The SA is responsible for implementing the government's TB programme in Mirpur 11. The government provides medication, technical support and some training.
- **The National Leprosy Programme**. The SA is responsible for implementing the government's leprosy programme in Mirpur 11. The government provides medication, technical support and some training.
- **ICDDR**. ICDDR who are conducting research looking at the management of childhood TB and gene expert analysis of sputum samples, ICDDR uses cases from from SA for its research.

The community development programme works with:

- **Bapsa**. An NGO, funded by CIDA, that has a clinic and provides reproductive advice, services and contraceptives. The adolescent group have been introduced to this NGO and receive education sessions from them.
- **Islamic foundation**. Provides free education to children of group members.
- **Andivas**. This NGO works in the area of road development and water sanitation in the camps. Some of the women from the PGs volunteer with them.

## 4.2 TB Programme

There are 11 staff on the TB team including the manager, a doctor, lab staff and field supervisors. The activities of the TB team are based at the clinic as well as in the community (specifically the Bihari camps). The activities and role of the TB programme includes:

- **Implementing the government's national TB programme in Mirpur 11**: The SA are responsible for identification and treatment of TB in Mirpur 11. They are supported by the government, who



- provide medication and technical support.
- **Oversee 10 DOTS centres:** in Mirpur 11, where patients are able to take medication in a local pharmacy.
- **320 identified cases of TB in 2014:** the patients are diagnosed at the clinic.
- **370 patients treated regularly:** through the clinic and DOTS centres. They are also offered on-going support and education while being treated.
- **Health education and awareness raising:** through sessions, workshops and volunteers. 1,571 education sessions were provided in the last year.

**Key achievements** identified during the evaluation include:

- **Established clinic that is respected in the community:** the clinic is well run and respected by the community and the government. People have trust in the clinic and will take relatives or go themselves. Due to its longstanding work in TB it was selected by the government to implement the government's TB programme in the area. The programme has good relations with NGOs in the area. Doctors and other organisations refer suspected patients to the clinic.
- **Community based work through *bari* mothers:** for the past year the TB programme has been working closely with 100 volunteers known as "*bari* mothers" (home mothers). They are local women from the community who are trained and supported by SA. They educate community members on TB, identify suspected cases and provide on-going support to TB patients. They are local women who are known and trusted in the community and were found to be highly motivated. There is good liaison between the SA and the *bari* mothers, once a patient is diagnosed with TB they are put in touch with a *bari* mother for on-going support.
- **Community based DOTS centres:** 10 pharmacies and their pharmacists were selected in the community to provide daily medication to local patients. The evaluation team found the pharmacists visited were highly motivated, followed up on patients and knew to be discreet. Having the DOTS centres in the community means that patients do not have to travel long distances to take their medication. The pharmacists receive on-going support and training from the SA.
- **Education sessions through volunteers and education sessions:** the high number of sessions means patients, families and community members are aware of the risks, symptoms and treatment of TB.
- **Results of cured TB patients are impressive:** there has been an increase of 82% of patients cured in 2010 to 90% of patients cured in 2013<sup>6</sup>.
- **Involvement in research:** the SA works closely with ICDDRB who are conducting research looking at the management of childhood TB and gene expert analysis of sputum samples, ICDDRB uses cases from the SA for its research. The results from the childhood TB should help to inform future recommendations in this area and the gene analysis means patients benefit from highly sensitive technology.
- **Excellent collaboration with the government and NGOs:** it was clear during the evaluation that the SA is well-respected and open to work with its partners. This has led to positive collaborations with the national TB programme and ICDDRB particularly.

**Challenges and growth areas** in the TB programme include:

- **Huge stigma of TB:** there remains a huge stigma in having TB. Patients spoken to reported being isolated from their communities, not being allowed into tea shops, having difficulties finding a husband and losing their jobs due to having TB. While the SA has done a lot of work regarding education it needs to think of creative ways to begin to challenge stigma. For example they could consider working with influential people such as Imams in mosques, work within schools and

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<sup>6</sup> This is in-line with the government statistics on cure rates, overall Bangladesh is doing well in reducing number of deaths from TB.

through mediums such as drama.

- **Poverty means poor patients are unable to afford adequate nutrition:** good nutrition helps those who are undernourished (under-nutrition is a risk factor for TB and TB causes under-nutrition). The *bari* mothers raised the point that while they encourage patients to eat well, this was often difficult for patients that are very poor.
- **High proportion of staff to patients:** While the TB staff clearly do an excellent job, given the high number of volunteers (110) who carry out much of the work, there does seem to be a high staff to patient-ratio.
- **Multi-drug resistant TB:** this form of TB provides extra challenges as it means patients have to have a much longer course of treatment (up to two years as opposed to six months).

### Sustainability:

There is clearly a demand for the TB programme in Mirpur 11. The networking with the government and DOTS providers in the community mean that much of the work is sustainable. Additionally, having the volunteer *bari* mothers in the community is an effective, sustainable way of raising awareness and identifying patients. While the clinic will always need funding, close links with the government mean that they are able to assist by providing medication and technical assistance.



Figure 11: Two TB patients



Figure 12: Outside a DOTS centre

### 4.3 Leprosy Programme

The leprosy programme has 5 staff including a clinical in-charge, a control assistant, a physio-technician, control supervisor and doctor. There are also two volunteers. The work done by the leprosy team includes:

- **Working with 26 patients directly:** medication and on-going support is given.
- **There are 14 patients (of the 26) that are complicated cases:** they are seen regularly for treatment, support and exercise. Footwear is provided to those who need it. If patients require surgery they are referred to the appropriate places.
- **Follow up for 170 previous patients:** visits and on-going support are provided to the patients and their families.
- **Patient to patient care:** patients are encouraged to share and support each other.
- **Skin camps:** camps are advertised and people attend with symptoms of leprosy and are referred. 20 of the new patient this year were identified through the skin camps.
- **Contact surveys of patients:** are conducted after a diagnosis by staff in order to assess whether the

patient has been likely to infect anyone else and to identify potential patients.

- **Awareness raising through education sessions and workshops:** this year 280 education seminars have been conducted.

**Achievements** identified by the evaluation include:

- **Respect in the community:** the clinic is well known for its activities and well respected.
- **Very specialised service:** the services offered to patients are very specialised. It is the only centre in the area where leprosy care and support is given, including physiotherapy and footwear as needed.
- **Networking with the government:** the programme has good relations with the government who provide the medication, treatment cards and guidelines.
- **On-going work with patients and their families:** the staff provide on-going holistic support to patients after they complete their treatment; this is important as leprosy can be a very debilitating and stigmatised condition. On-going support includes ulcer care, reaction and relapse management, referral and support in getting neuritis and reconstructive. They also provide health education and emotional support to both the patients and their families.

**Challenges and growth areas** are:

- **Leprosy is often a debilitating and stigmatised condition:** due to the physical effects it may have as well as the stigma patients can often be isolated and lose their jobs. There is very little social support for them in the community.
- **Lower lever of community involvement:** unlike the TB programme, the leprosy programme is based in the clinic and does not rely on volunteers. This could be due to there being few patients, there could also be scope to combine some of the TB volunteers work with leprosy work.
- **High staff to patient ratio:** while the staff do oversee almost 200 patients (including previous patients) there are only 26 patients that are currently being treated. This could be interpreted as a high staff to patient ratio.

**Sustainability:**

The leprosy programme does rely on funding and staff, however it does work closely with the government who provide them with medication and support. There is potential to work more closely with volunteers in the area.



Figure 13: Hand of a leprosy patient

#### **4.4 Community Development Programme**

The community development programme has 1.5 members of staff. Its activities include work with the following groups and participants in Mirpur 11:

- 100 primary group members (10 groups)
- 15 youth in their own group
- 30 adolescents
- 45 women received training for different trades
- 20 women currently in Adult Literacy classes

The **achievements** of the programme include:

1. **The primary groups are running very effectively:** the groups have been running for 16 months. At the beginning of the year they make an annual plan. They decide what trainings and vocational skills they need and will decide who goes to which training among themselves. They meet monthly and discuss social issues and save money (100 taka a month). The groups each have a total of 16,000 taka and a welfare fund of 8,000 taka. They have not yet started giving loans, when they do each member of the group will need to agree to the loans. The groups are well established and they already have a clear exit plan.
2. **Involvement of youth:** the youth are very active, being involved in both the primary groups and supporting the adolescent groups. They have their own group in which they feel they have separate issues to discuss, while they are still able to be part of the primary groups. They help in running the adolescent groups.
3. **Adolescent groups as a source of social support:** the adolescent groups meet once a month. They discuss issues and attend trainings. They feel the group is a good source of social support, and helps them to deal with difficulties in growing up in the area as women. The groups also has had input from the NGO Bapsa on reproductive health, they have a good relationship with the NGO and feel comfortable discussing issues with the doctor based their.
4. **High level of employment following trainings:** the SA has helped 45 women in the area receive vocational training. Between 50 and 100% of the women received either part-time or full-time employment following the trainings.
5. **Clear exit plan:** from the beginning of the project there has been a clear exit plan. The groups all look ahead and have a plan to continue without SA support. The exit plan, which was present from the beginning of the groups has contributed to their lack of dependence on the SA.
6. **Excellent networking with NGOs:** the group members and the SA have good relationships with NGOs in the area. The NGO Bapsa works closely with the adolescents, the Islamic foundation gives free education to their children and 3 of the women from the PGs work with the NGO Andivas in the area of road development and water sanitation.
7. **Adult literacy groups:** two adult literacy groups currently run. The aim of the programme is to ensure all the primary group members are literate. The women reported that they are now able to manage their accounts and help their children with their homework. They also reported that there is a high level of illiteracy among Biharis in the area so adult literacy is much needed.
8. **Low staff-participant ratio:** despite there only being 1.5 staff the community development programme works with over 100 women and there is potential to expand. This is because the group members are not dependent on the staff, the programme works closely with other NGOs, the youth are able to support the adolescent and the programme overall has been planned extremely efficiently.

**Challenges and growth areas** for the programme include:

1. **Social problems in the camps:** in the areas where the programme works there are many social problems. They include high levels of drug addiction, harassment of women and girls and high levels of unemployment. Dealing with these issues is challenging and the women expressed that the groups provide a much needed social space.
2. **High levels of illiteracy, especially among women:** currently adult literacy is just among group members, however the *bari* mothers and group members expressed that it is much needed in the community.
3. **Group registration could be a challenge:** the groups have not yet attempted to register as a community based organisation (CBO). However, they do plan to and it is possible that it could be a challenge.

### **Sustainability:**

Due to the effectiveness of the groups, their exit plan, their lack of dependence of the SA, their support for each other and their linkages with other NGOs the community development programme is not reliant on the Salvation Army and is highly sustainable. This is a model that could be replicated and there is much scope for it to be expanded.



Figure 14: Meeting of PG members

## **4.5 Looking forward: future plans**

Overall the project is functioning well. The health components are providing much needed services, the community development programme is particularly effective. Liaison with the government and national TB and leprosy programmes are excellent. However, it is unclear why objective 3 has not been achieved (300 volunteers working in the community) and both health components (TB and leprosy) are staff-heavy. In contrast the community development programme only has 1.5 members of staff. This programme utilises its project participants and liaises well with existing NGOs making it very effective, highly sustainable and a model that could be replicated.

Looking forward the following suggestions should be considered:

1. **TB and leprosy programmes should look at how they can more effectively challenge stigma:** while there has been a lot of work on raising awareness and education on TB and leprosy, stigma remains

very strong. It is important to look at innovative ways to challenge stigma, i.e. could involve Imans, volunteers and the community.

2. **Volunteers for the health components should continue to be built up:** there is the potential for increasing amounts of support and medication dispensation to be provided in the community through volunteers and pharmacies. This builds up the overall sustainability of the project.
3. **The three components could look at ways of working together:** the TB volunteers for example could learn about leprosy and teach this to the community, the community development groups could visit and learn more about the TB and leprosy clinics, the leprosy patients could learn from the community development project as to how to form support groups if they felt this was something they needed.
4. **The community development programme could expand to other areas:** the *bari* mothers are keen to start savings and adult literacy groups. The PGs could assist them to do this with limited costs.

## Conclusions and Recommendations

### 4.6 Summary of findings

Overall the project has achieved most of its objectives and has had a positive impact on the lives of well over 2000 project participants who are increasingly capacitated to address their social, health and educational needs. However, the levels of success and positive practices do vary across the sites and components.

Looking at the objectives of the evaluation overall findings are as follows:

#### 4.6.1 Major achievements

The major achievements/good practices of the project include:

1. **The CSGs in Dumuria being able to function with limited support.** The groups are now well established and close to being able to function independently. This means the community work in Dumuria is sustainable and the community can continue to address its own issues.
2. **Successful work with government schools in Dumuria.** Through working with and strengthening local government schools the quality of education has increased in the area, furthermore it is sustainable as the SMCs will remain in the schools after the SA withdraws. The volunteer teachers mean that the poorest children in the school will have access to extra tuition.
3. **The clinic in Dumuria provides essential services to the community at an affordable rate.** This is a valuable service, however in order for it to be sustained some innovative solutions will need to be found.
4. **Successful cooperation with the government in operating their national TB and leprosy programmes in Mirpur 11.** The joint efforts of SA's long established work and the GOB means that patients in the area are able to have quality, free access to medication and treatment for TB and leprosy.
5. **Volunteers for the TB programme.** The *bari* mothers programme has proved an effective, sustainable, community based way of identifying and providing on-going support to patients with TB and their families as well as raising awareness of TB in the community.
6. **Community run community programme in Mirpur 11.** With limited staff support and excellent planning and networking there is an effective community programme in the area allowing poor women access to vocational trainings, adult literacy and savings.

#### 4.6.2 Community Support Groups

In Dumuria the CSGs are running effectively and with limited staff support. They are working towards legal recognition, although this is proving to be difficult. The CSGs have different ideas for projects they would like to implement. They need to network and tap into local resources more (although this does vary across the different CSGs).

The primary groups in Mirpur 11 have an exit strategy and are working towards independence, they have good networks with external NGOs.

### 4.6.3 Gender

The project does focus on women and overall has a positive effect on woman's lives. However, there is still room for improvement. Positive aspects of the project regarding gender include:

- Both male and female project participants expressed a basic knowledge of women's rights.
- Women have an increased control over their lives due to increased access to money, literacy and reproductive rights.
- Women report that their husbands respect them more than previously and they have greater freedom. This is due to an increase in access to money, literacy and knowledge.
- Women are represented on leadership committees in all the groups.
- Female staff are well represented in the SA.

However, there does remain room for improvement in the following areas:

- Both the SA projects have male managers, in Dumuria females are under-represented in supervisory roles.
- There remain no female presidents of the CSGs.
- Males remain dominant in the homes.
- Females still report harassment, particularly young women in Dhaka.

### 4.6.4 Sustainability

Sustainability has been a major concern of the evaluation and has been discussed throughout the report. In summary:

**CHDP:** the CSGs are able to function independently and they need support to take over the activities of the community development programme in Dumuria; the work in the schools is largely sustainable and should continue after SA exit; the health programme is currently not sustainable without support and funding.

**UHDP:** the leprosy and TB programme work closely with the government but still rely on the SA to continue. The TB programme works closely with many volunteers in the community. The community development programme works through primary groups which are able to function with limited support.

### 4.6.5 Lessons learned

It is important to learn from a project in order not to repeat earlier mistakes and improve future work. The key lessons that can be learned from this evaluation include:

- **It is important to have a clear exit plan from the beginning of a community development project.** This way the project is more likely to be sustainable and the participants will not be dependent on the project.
- **The process of a group (PG and CSG) becoming a CBO should be outlined when forming a group.** Thereby the group will have a clear aim and will work towards being independent from the beginning of the project.
- **There needs to be clear, realistic and measureable objectives.** For example objective 2 of the project is not measureable (50% of the community advocating for education).
- **It is important to have clear plans to achieve the project objectives.** While the project generally did this, it failed to do so for objective 3 and hence 300 health volunteers were not trained.



- **Working with the poorest of the poor needs to be carefully planned and implemented.** There needs to be clear plans as to how the poorest participants are reached and if necessary criteria for group members.
- **Working closely with community groups and volunteers is effective and sustainable.** Where the project has done this it has been very effective and sustainable, this is an important lesson for future projects.
- **Working with the government where possible is important.** When the SA has managed to do this (i.e. through schools and the leprosy and TB programme) it has been effective and has a positive impact.

#### 4.7 Future recommendations

In light of the above findings the evaluation makes the following recommendations for the project:

1. CHDP: CSGs should continue to work independently in Dumuria, taking over the work of the SA. In order to prepare for this the following issues must be considered:
  - Work towards registration as independent CBOs (either combined or separately).
  - Increase networking with NGOs and government organisations for extra support and services.
  - Look at how the CSGs can take over education, health and development activities. They could organise separate committees for each area within the CSG.
2. CHDP: Plan to make the clinic self-sustaining. As the clinic is an essential service it is recommended that options are explored to make it self-sustaining so that it can continue to run. Options that can be explored include:
  - Increasing the fee for patients who can afford it, however as the clinic is intended to serve the poor it is important to keep the costs relatively low.
  - Approach the government to see what support they can give, it is fundamentally the governments' responsibility to provide essential services so this option should be explored.
  - Work with the CSGs to see what support they are prepared to give the clinic i.e. can they contribute to its running costs?
3. UHDP: Look at how the three project components can work more closely together and learn from each other. For example:
  - The TB volunteers could also increase awareness about leprosy
  - The leprosy programme could utilise more volunteers like the other two components
  - The community development programme could learn more about TB and leprosy and work towards decreasing stigma through its group work.
4. UHDP: Replicate the community development model in other areas of the camp. With the assistance of the existing primary groups more groups can be set up in the camps, specifically with the *bari* mothers and men. This model needs limited staff input and is highly sustainable.
5. UHDP: Providing supplementary food for TB patients who are under-nourished and poor should be considered in the next project proposal. Under-nutrition is a risk factor for TB and TB causes under-nutrition. Volunteers, staff and patient have highlighted many patients cannot afford adequate nutrition and in urban settings it is difficult to rear animals and grow many vegetables.
6. Future projects: As the SA move into other areas to implement community development, it is important that they plan ahead and learn from their extensive experiences (see section 5.1.5).

# Appendixes

## **Appendix 1: Evaluation terms of reference**

### **Terms of Reference for External End-of-Project-Evaluation of project PD 2991: Capacity Building for Stronger Communities November/December 2014**

#### **1. Project background and context**

The Salvation Army Bangladesh (TSA-B) is a well-established organization that has been active in Bangladesh since the 1970's. It is an International NGO that was founded by William Booth who set the main principle for the organization: 'to be servants to the most needy'. Their key strategy is to working in integral mission, so that all will have wholeness of life.

The project: 'Capacity Building for Stronger Communities' operates at two project sites: Mirpur Section 11, Dhaka (urban setting) and in six villages (Andulia, Krishnanagar, Deruli, Komrail, Raghunathpur and Sahapur) of Dumuria Upazila (rural setting).

The Salvation Army operates the Urban Health and Development Project (UHDP) in Mirpur, Dhaka. This began in 1972 with a mobile medical relief team. Development programs were added in the 1980's. The project began with a maternal and child health center, and then expanded into leprosy and self-help ground development. The TB work began in 2001, in partnership with the Government. The project is located in Mirpur 11, which is the area of the Bihari camps, and inhabited mainly by the Bihari population. The project expanded from its initial exclusive general primary health focus to include an integral approach of services delivery including leprosy and TB management, community development and water and sanitation. The maternal and child health care services phased out in the end of 2009 and water and sanitation interventions in 2011. The primary donors for the project are NORAD and The Leprosy Mission. The Salvation Army Norway Territory also contributes funds to the project.

The Salvation Army operates the Community Health and Development Project (CHDP) in Dumuria Upazila. This began in 1990 at the context of water inundation in Bildkatia. Several years the life of the people in communities of surrounding villages was affected by water logging; damaging livelihood, houses, schools, roads, bridges, tube wells, etc. This resulted in deteriorating health, poor education, and bad social and economic conditions of the community people. In this situation The Salvation Army Bangladesh was invited to support the communities with necessary interventions. At the initial stage TSA-B started to support the communities through the Community Health and Development Project (CHDP) in partnership with World Vision; covering 6 affected villages named Andulia, Deruli, Komrail, Raghunathpur, Krishnanagar and Sahapur of Raghunathpur union, Dumuria, Khulna. The main components of the project were: Child nutrition, growth monitoring and maternal health care, outdoor clinic services, diarrhea control, home based AN/PN care, primary health training for mothers, safe drinking water and sanitary latrine distribution, a sponsorship program and running of 3 Primary Schools for poor children of the communities. At the same time there were interventions for renovation of damaged roads, bridges and tube wells and 100 tin shed houses were distributed among the community people who had lost their houses. The initial project support caused significant changes in the life of community people. For example: the child and maternal mortality rate significantly decreased in the project area. The prevalence of common diseases was controlled due to awareness and knowledge about primary health, use of safe drinking water and sanitary latrines. Severe incidences of diarrheal diseases came almost to zero. Primary School education run by the project became a model to the community people due to the quality and standard maintained. In the end of 2009 the schools were closed. After phasing out with World Vision the project is at its second phase continuing with NORAD/Digni and The Salvation Army Norway Territory as donors.

The goal of the project is: "By the end of the project period, 2000 poor and marginalized people, specifically women and youth of the project area will have developed their capacity to solve their health, educational and social issues, through awareness raising of their rights, development of skills in organized groups and provision of needed health services."

As its first aim the project works to develop the organizational capacity of women, men and youth in communities through forming of Community Support Groups (CSGs), Adult Literacy Groups, Savings Groups, Adolescents and Youth Groups. Group members receive appropriate, needs-based training. The groups will have worked out a plan to address relevant issues in their local communities. The project offers various vocational skills training like tailoring, handicrafts and beauty parlour for income generating purposes of the beneficiaries of the project areas. Savings group members can apply for a loan as per their group regulations for economic development. Awareness training is provided on social issues, rights and reproductive health issues. Youths actively participate in developing and facilitating

community dramas to educate their communities on social issues and diseases. Training on leadership, management and financial management of the various groups is provided and group leaders are elected through a democratic election process. CSGs work towards legal recognition by the Government. This is the essence of Objective # 1: By the end of the project period, 2000 poor and marginalized women, men, youth in communities have been trained extensively to develop their knowledge, skills and organizational capacity.

The second aim for the project is to develop and strengthen the capacity of the School Management Committees (SMCs) and Parents Teachers Associations (PTAs) to advocate for quality education in existing Government Primary Schools. Due to changes in the Government policies with regard to Primary Schools, The Salvation Army decided to close their three Primary Schools in Dumuria Upazila at the end of December 2009. As a result of this inevitable action the education staff of The Salvation Army in Dumuria works with existing Government Primary Schools to fulfil Objective # 2. Quarterly gatherings with parents and guardians are conducted. Training on child rights, child labour, child protection, dowry and early marriage is provided to SMC and PTA group members. Program to Program visit to other successful SMC and PTA educational advocacy programmes for staff members and community people are carried out. SMCs and PTAs are strengthened and motivated to upgrade primary education in their communities. SMCs have developed their capacity on group management, advocacy and knowledge of child rights. SMCs are actively networking with GO/Education Department for resources and support of quality education in the schools. This is the essence of Objective # 2: By the end of the project period, 50% of the communities, via their Community Support Groups or School Management Committees, have developed their capacity to advocate for and enhance the quality of education in their primary schools.

The health activities in the project evolve around two centers in Dhaka and Dumuria, Mirpur Clinic and Andulia Clinic respectively, where health staff members attend to the needs of poor patients of the project areas. Mirpur Clinic offers Leprosy and TB diagnosis and treatment and supports DOTS centers in the communities which provide TB information, collect sputum tests and follow-up on TB positive patients. Volunteers conduct home visits and actively educate community members on TB, DOTS treatment and Leprosy. Andulia Clinic offers Mother and Child Healthcare; antenatal and postnatal care, safe delivery services as well as Family Planning services. Trained Traditional Birth Attendants (TBAs) actively support deliveries in their communities. Community people are educated on primary health care issues and family planning methods. This is the essence of Objective # 3: By the end of the project period, community health will be improved through the provision of essential health services and the development of 300 volunteers' capacity to intervene on health issues that threaten their communities and increasing the community's capacity to deal with their health issues.

The fourth and final aim for the project is to strengthen The Salvation Army Bangladesh's own capacity to implement and monitor more rights based development activities in the projects. Training for staff members on monitoring and evaluation of groups and development of participatory monitoring tools is conducted. Field staff is able to educate and train group members on human rights and other social issues. Staff members and Community Support Group members are monitoring and evaluating activities through participatory monitoring tools. This is the essence of Objective # 4: By the end of the project period, organizational capacity will be developed to implement and monitor Rights Based development activities in the projects.

## **2. Purpose and objectives of the End-of-Project-Evaluation**

### **Overall aim:**

To assess the project's impact and sustainability in Mirpur Section 11, Dhaka and Dumuria Upazila, Bangladesh and the relevance of a next phase of the project.

### **Objectives:**

The End-of-Project-Evaluation should assess the **major achievements** of the project to date in relation to its stated objectives and intended outputs (results):

- Assess what has been actual achieved, the likelihood of future achievements in a next phase of the project, and the significance/strategic importance of the achievements.
- Refer to quantitative assessments (data collection) as far as possible.
- Include also qualitative evidence e.g. opinions on the project's effectiveness based on impressions and interviews with beneficiaries, other stakeholders and local government officials, etc.
- Describe any major failures of the project to date, explaining why they have occurred.
- Describe any unforeseen impacts (whether positive or negative).
- Describe the best practices of the project at both project areas.

The End-of-Project-Evaluation should assess to what extend the **Community Support Groups** have matured:

- To what extend the CSGs are empowered to play an active part in their communities.

- To what extent the CSGs are consolidated, functioning independently, and aiming at their own legal identity as Community Based Organization(s) (CBOs).
- To what extent they are networking and sharing across their communities e.g. one representative from each CSG to meet regularly in order to achieve greater influence in their communities.
- To what extent the CSGs advocate for resource tapping from the local Government as regards primary health care services, education, etc.

The End-of-Project-Evaluation should assess how the project addressed the **gender issues** identified in the proposal:

- Assess what has been actually achieved with regard to capacity building of women e.g. participation in community activities, awareness and understanding of women's and child rights, access to legal aid and knowledge on primary health issues and safe deliveries.
- To what extent did the project develop the women's skills for earning and saving from income generating projects?
- Is there any evidence of power shifting to more equality in the homes with the husbands and families as a result of bringing in some of the family income by the wives?
- What is the level of representation and leadership roles for women in CSGs and their executive committees?
- Describe the gender balance of project staff members, volunteers at the project areas and the primary direct target group.
- To what extent are women involved in adult literacy programmes, program to program visits, networking discussions and advocacy activities?
- To what extent did participation in these activities build up support, confidence and relationships between women in the different areas?
- Is there any evidence that fundamental men and husbands have changed their attitude towards women's participation in project activities?
- Is there evidence that the project activities have brought about vital change in the status of women and girls in the project areas?
- Describe the level of capacity/capability of women to solve their health, educational and social issues.

The End-of-Project-Evaluation should assess the key factors affecting **sustainability** of the project:

- To what extent are the DOTS centres / providers in the communities of Mirpur sustainable?
- Is there need and evidence for continuation of the TB and leprosy programme in Mirpur?
- What level of capacity/capability do the volunteers display on TB and leprosy awareness raising in Mirpur?
- What is the level of sustainability of the clinical services for Mother and Child Healthcare in Andulia, Dumuria?
- To what extent are volunteers actively involved in awareness raising on primary health care issues and Family Planning methods?
- Is there evidence that the Adult Literacy programme should continue in Mirpur as well as in Dumuria Upazila?
- To what extent have the School Management Committees (SMCs) and Parents Teachers Associations (PTAs) matured?
- Has the project contributed to a decreased unemployment rate among the youth in the project areas?
- What is the social and political environment/acceptance of the project?
- Has the project contributed to lasting benefits/services?
- Is there evidence of organisations/partners/communities that have copied, up-scaled or replicated project activities beyond the immediate project areas? Is such replication or magnification likely?

Assess and make recommendations on the key **strategic options** for the next phase of the project i.e. exit strategy, scale-down, replication, scale-up, continuation, major modifications to strategy:

- Comment on any existing plans.
- Make additional recommendations.
- Propose direction and relevant intervention modalities for a possible next phase of the project / continuation of the work.

### **3. Methodology**

a) Comprehensive **desk studies** of:

- Relevant project key documents including the application (Project Proposal), financial and narrative six monthly progress & annual reports, mid-term evaluation report, evaluation report on TSA Leprosy control project (June 2014), etc.
- Previous relevant program documentation.

b) Preparation of **background notes**.

c) **Field visit:** 10 day visit to CHDP, Andulia and UHDP, Mirpur to meet with key stakeholders including debriefing with key stakeholders.

There will be organised meetings with representatives from all levels of project staff:

- Interviews and meetings with relevant Salvation Army project staff, project accountant and volunteers.
- Meetings and interviews with project beneficiaries.
- Meetings with resource persons and organisations working in fields covered by The Salvation Army Bangladesh and **mapping of relevant stakeholders**.
- Meeting with The Salvation Army Bangladesh leadership and Finance Department at CHQ.

d) **Report writing.** Audience for review of draft report and finalization of report: The Salvation Army Bangladesh, The Salvation Army Norway and NORAD / Digni.

e) The review will be conducted in a **participatory manner**, which contributes to enhance The Salvation Army Bangladesh's capacity and its ownership of the review process.

### **4. Outputs**

The End-of-Project-Evaluation assignment will have the following **outputs**:

- Inception note (3-4 pages outlining review methodology, timetable and division of labour among team members).
- Short background notes on key features in The Salvation Army's methodology.
- Mapping of stakeholders working in the field of leprosy and TB management, community development, MCH care and primary education in The Salvation Army working areas and identification of how The Salvation Army Bangladesh is positioned best with its key strengths and skills in this work.
- A final report not exceeding 35 pages (exclusive annexes), inclusive a 3-4 pages executive summary.
- Workshop/debriefing with evaluation team, The Salvation Army leadership and projects office team to discuss findings and preliminary recommendations at The Salvation Army Dhaka Head Office.

### **5. Time schedule:**

- End-of-Project-Evaluation will be conducted from 30 November–10 December 2014, including a visit to CHDP, Andulia and UHDP, Mirpur.
- Debriefing at Dhaka CHQ with the leadership of TSA, Projects Officer, Asst. Projects Officer, Community Development Projects Director, Project Manager UHDP, Mirpur and Project Manager CHDP, Andulia on December 11, 2014.
- Draft Report will be submitted by email on December 22, 2014 to The Salvation Army Bangladesh and forwarded to The Salvation Army Norway and Digni.
- Comments from The Salvation Army Bangladesh, The Salvation Army Norway and Digni to draft report at the latest on January 8, 2015 to evaluator/consultant.
- Evaluator/consultant will submit final report to The Salvation Army Bangladesh on January 15, 2015.
- Final report will be forwarded to The Salvation Army Norway and Digni/NORAD.

<b>TIMETABLE</b>	<b>END-OF-PROJECT-EVALUATION</b>	<b>PD 2991 – UHDP, MIRPUR &amp; CHDP, ANDULIA</b>
<b>DATE</b>	<b>PLANNING</b>	<b>COMMENTS</b>
Sunday 30 Nov 2014	Visiting TSA Dhaka Head Office & team preparations. Flying to Jessore in late afternoon!	One night in TSA Kholadanga Training Centre
Monday 1 Dec 2014	Travel by car to CHDP, Andulia Evaluation CHDP, Andulia	On site – day 1 Travel to Khulna & Checking in hotel
Tuesday 2 Dec 2014	Evaluation CHDP, Andulia	On site – day 2
Wednesday 3 Dec 2014	Evaluation CHDP, Andulia	On site – day 3
Thursday 4 Dec 2014	Evaluation CHDP, Andulia	On site – day 4
Friday 5 Dec 2014	Checking out of Khulna hotel. Travel back to Jessore & Evening flight back to Dhaka	Project closed on Friday & Saturday
Saturday 6 Dec 2014	Day off	
Sunday 7 Dec 2014	Evaluation UHDP, Mirpur, Dhaka	On site – day 1
Monday 8 Dec 2014	Evaluation UHDP, Mirpur, Dhaka	On site – day 2
Tuesday 9 Dec 2014	Evaluation CHDP, Mirpur, Dhaka	On site – day 3
Wednesday 10 Dec 2014	Draft report writing (1 day) by Evaluator/Consultant	
Thursday 11 Dec 2014	Evaluation team debriefing at TSA Dhaka Head office	With TSA leadership, Projects Office team, PM Albert Sarkar & PM Leo Sarkar
Friday 12 Dec 2014 – Sunday 14 Dec 2014	Draft report writing (3 days) by Evaluator/Consultant	
Monday 22 Dec 2014	Draft report <u>by email</u> at TSA Head Office	(Projects Office team involved in Christmas celebrations)
Tuesday 6 Jan 2015	Discussion draft report on TSA Head Office & making comments	By PM Albert, PM Leo, PO Maj. Coby, APO Capt. Nipu & CDPD Victor
Thursday 15 Jan 2015	Final report at TSA Head Office	

Attention: CHDP, Andulia: On site evaluation – 4 days & UHDP, Mirpur: On site evaluation – 3 days!

## **6. Staffing:**

The End-of-Project-Evaluation will be a joint effort with participation from all groups involved: participants in development work, project staff members, project managers, and administrators from Bangladesh Command Head office. The external consultant / evaluator will be the team leader.

The evaluation team will consist of:

- Ms. Hannah Jennings            Consultant & team leader
- Capt. Nipu Baroi                    Asst. Projects Officer (APO)
- Mr. Victor Mondal                    Community Development Projects Director (CDPD)

The evaluation team will undertake (on site) field visits and interviews on their own and give their independent recommendations, but will work in close collaboration with the Project Managers Mr. Leo Sarkar and Mr. Albert Sarkar. The team leader will report to The Salvation Army Bangladesh's Officer Commanding, Lieut. Colonel Alistair Venter and the Projects Officer, Major Coby de Lig-Oosterheerd.

## **7. Terms and conditions:**

- The consultant / evaluator will always keep contact with the Leadership of The Salvation Army Bangladesh Command through the Projects Officer whenever there is need of making a decision outside the scope of the ToR.
- The Salvation Army will provide the necessary logistics, accommodation and local transport.
- Remuneration will be given for sixteen (16) days for this assignment: 2 days desk studies/preparations, 2 days travel, 7 days on site visits, 1 day workshop & 4 days report writing = 16 days.
- The consultant / evaluator's remuneration (consultancy fee) per day will be US\$ 300 for this assignment. Calculation:  $16 \times 300 = \text{US\$ } 4,800$  which will be paid in BDT; including Tax, excluding VAT. Mode of payment will be by cheque.
- The consultant / evaluator will receive 50% of the remuneration after signing the Agreement (ToR) in the presence of the Officer Commanding, Lieut. Alistair Venter and the remaining 50% after completion of the final report on 15 January 2015.
- This Agreement could be reviewed under both parties' understanding regarding date and accomplishment of the work in case of unavoidable circumstances.

The Agreement (ToR) is signed with both parties common understanding.

\_\_\_\_\_  
Ms. Hannah Maria Jennings  
Consultant  
London / Dhaka

Date:

\_\_\_\_\_  
Lieut. Colonel Alistair Venter  
Officer Commanding  
The Salvation Army, Bangladesh

Date:

## ***Appendix 2: List of meetings during the evaluation***

### **CHDP**

#### **Day 1:**

1. Project manager
2. All project staff
3. Health staff
4. Health group, Duruli
5. Savings group, Duruli
6. CSG, Ragunathpur

#### **Day 2:**

7. Health group, Shahpur
8. Clinic, Andulia office
9. Literacy group, Ragunathpur
10. Savings group, Shalpur
11. Community development staff
12. Education staff
13. Adolescent group, Shahpur (male):
14. CSG, Krishnanagar
15. Businesses/houses of participants

#### **Day 3:**

16. Sewing centre, Andulia office
17. Adult literacy, Ragunathpur
18. SMC, Krishnanagar
19. PTA, Ragunathpur
20. CSG, Andulia
21. Businesses of participants

#### **Day 4:**

22. Accountant
23. PTA, Deruli
24. Government: medical and family planning officers
25. SMC, Komrail
26. Adolescent group, Krisnanagar
27. Local government: Union Parishad chairman and members

### **UHDP:**

#### **Day 1:**

1. Leprosy staff
2. Leprosy patients, home visits
3. Government: National leprosy programme coordinator
4. Government: National TB programme officer
5. NGO: ICDDR B collaborators

#### **Day 2:**

6. TB staff
7. Primary group representatives
8. Adult literacy class
9. Youth group
10. NGOs: Bapsa, Islami foundation
11. Adolescent group

#### **Day 3:**

12. TB patients; see notes
13. DOTS centres
14. *Bari* mothers (volunteers)
15. Clinics: leprosy and TB
16. Local leaders



## **Appendix 3: Outline of evaluation questions**

### **FGD/interview guidelines:**

1. Everyone should introduce themselves at the beginning.
2. The purpose of the meeting should be outlined. It should be made clear that there are no right or wrong answers. We would like to learn from the participants and it is important that we find out what is good and what could be done better.
3. One person should be allowed to speak at a time without interruptions.
4. Attempts should be made to include everyone in the groups, and we should encourage participation from quieter members of the group.
5. Where possible limit the group to a maximum of 15.

### **Participant group general questions:**

- Tell me about your group. How many members? Activities? How long it's been running? Any leaders etc.
- How do the SA support the group?
- What are the best things about this group/service?
- Have you seen any changes in your family/neighbourhood/community?
- What is the relationship like with the community?
- Can you give an example of something positive/how it has helped you/your family/your community?
- What could be done better?
- Specific aspects: adult literacy, volunteers, health activities, savings groups. What do you do? How? What have you learnt?
- Do you have contact with other groups/services? Tell me about them.
- Without SA support would the group keep running? How?
- Does the group have legal status? How are you progressing?
- How do you see the group in five years time?
- Is there equal participation of male and female? How is it different? Are there mixed groups? How many are leaders?
- Could these groups work in other areas? How?

### **Schools**

- Tell me about your interaction with the SA
- What support have you received? What further support do you need?
- How has it been positive? Any examples?
- What could be done better?
- What trainings were received?
- Tell me about the SMCs. What do they do? How long have they been running? What support do they receive? What more could be done?
- Tell me about the PCTs. What do they do? How long have they been running? What support do they receive? What more could be done?
- What trainings were received? How were they?
- What would you do without the SA? Are there other resources you use?
- How many males/females on the SMC and PCT? Do you address gender?

### **Health volunteers:**

- Tell me about your role.
- What support and trainings have you received? What other support do you receive? From who?
- What else do you need?
- Tell me about your role in educating regarding family planning methods, primary health care issues. What do you teach?
- Have you seen changes in the community? Examples.
- What is the biggest change you have seen in the community?
- What still needs to change?
- What other health services are available in the area? How much contact do you have with them? What further contact do you need with them?
- Without SA would you continue? How?

### **Clinics:**

- Tell me about the work of the clinics.
- How many people do you see in a day, week, month, year? How many people do you treat?

- What work do you do in health promotion/awareness raising?
- Have you seen changes in the community? What kind of changes? Can you give any examples.
- What other services are in the community? How much interaction do you have with them? What type of interaction?
- Are there other services in the area similar to this one?
- In the long-term (in the next year, five years) how do you view the clinic/activities?

#### **TB/Leprosy clinics**

- Tell me about the work
- How many people do you see a day/a month?
- How many people do you treat a year for TB? For leprosy?
- What is the completion rate?
- How many do you follow up?
- What type of follow up?
- Are there other places they can get treatment? Govt./NGO

#### **Staff**

- Tell me about the activities of the project. Tell me about the groups, clinic, school work.
- What is most useful?
- Have you seen changes in the community? Among individuals/families? What changes? Can you give examples?
- How accepting of the project are community members?
- What is no longer necessary?
- What could be improved?
- How sustainable is the project? How would the groups, clinic etc. run without the SA?
- What other services are available in the area? How much interaction/collaboration do you have with them? What is the nature of the interaction/collaboration?
- Are there services in the area that you do not work with now but could do in the future?
- Have any of the projects been replicated, up-scaled? If so, tell me about it.
- Would any of the projects benefit from being replicated or scaled up?
- What is the gender balance among staff, volunteers, project beneficiaries?