EVALUATION REPORT

WALK FOR LIFE PROJECT

Bangladesh 2018 – 2022

By Pro-edge Associates Limited | June 2023

Australian Aid

Action on Poverty

CONTENTS

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The Evaluation Team

November 2022

ACRONYMS AND ABBREVIATIONS

AOP	Action on Poverty
ADC	Additional Deputy Commissioner
CS	Civil Surgeon
DGHS	Directorate General of Health Services
DPE	Directorate of Primary Education
DSS	Department of Social Services
FGD	Focus Group Discussion
GF	Glencoe Foundation
IDI	In-depth Interview
KII	Key Informant Interview
M&E	Monitoring and evaluation
MSR	Medico-Surgical Requisites
NCDC	Non-Communicable Disease Control
NITOR	National Institute of Traumatology and Orthopaedic Rehabilitation
NGO	Non-Governmental Organisation
OECD/DAC	Organisation for Economic Co-operation and Development / Development Assistance Committee
OPD	Organisation of Persons with Disabilities
RMCH	Rajshahi Medical College and Hospital
SDG	Sustainable Development Goals
SHG	Self Help Groups
SWF	Sancred Welfare Foundation
TOR	Terms of Reference
WFL	Walk For Life
WHO	World Health Organisation

EXECUTIVE SUMMARY

Background:

Clubfoot is yet another neglected non-communicable disease that affects almost 200,000 children each year globally, of whom 91% are born in low-income and middle-income countries (LMIC) (Global Clubfoot Initiative (GCI), unpublished data, 2017). Children born with clubfoot if remain without proper treatment may inevitably live with pain, and physical difficulties in stepping and climbing, and face social stigma and exclusion from many aspects of daily life such as education and employment. Mothers, in particular, of babies born with clubfoot are often faced with unwanted behaviours from their in-law's families. The program was established in 2009 with support and funding from the Glencoe Foundation, an Australian private organisation that helps motivated young people realise their potential through medical and educational assistance. During this time the Walk for Life (WFL) program has also been supported by various other donors. Action on Poverty began providing additional support to the WFL program using funds from the Department of Foreign Affairs and Trade (DFAT) in 2013 through the Australian NGO Cooperation Program (ANCP). The primary objective of the WFL program has been **to improve the quality of life of children under the age of three born with clubfoot – a congenital genitial birth defect which causes a lifetime of disability and discomfort without treatment – using the "Ponseti method".**

In 2019-2020 financial year, the WFL clinics became independent from government and began to apply a fee-for-service model for those who could afford to pay while continuing to extend free treatment to those who could not afford to do so. This was part of a longer-term strategy for the program to become sustainable. However, as Bangladesh was impacted heavily by the COVID-19 pandemic in 2020, it significantly reduced the ability of most users to pay for treatment. Without ongoing treatment and follow-up, child patients risk relapse. So the ANCP funded WFL project was extended to 30 June 2022 to ensure that the pandemic disruption did not interrupt the treatment of clubfoot of patients. The project was also redesigned to meet the challenges of the situation by extending support for food and transport costs, COVID-19 personnal protective equipment supply, free treatment to impoversihed clubfoot children, and strengthening biosecurity protocols within the program and associated clubfoot treatment clinics. These covid-pivot changes have been incorporated into the implementation of the WFL project since July 2020. July 2021 to June 2022 was a second extension year given ongoing uncertainty from Covid-19. It should be noted that the Glencoe Foundation is in the process of transferring the WFL program to the Sancred Welfare Foundation, which is a local NGO.

This review is built on the previous learnings from the project/program evaluations undertaken in 2014 and 2018. It is to assess the results brought by the ANCP funded WFL project from 2018 to 2022, its lessons learned, and recommendations for continuity and possible changes for future programming and approach.

Main findings:

Coherence Rating: Good

The project was assessed as 'Good' under the criteria of coherence. The project under this evaluation was operated by private clinics during September 2019 to June 2022, and these were assessed to be working in alignment with three out of the five pillars of the National Clubfoot Management Strategy (June 2019), which are raising awareness, providing services, and ensure service quality utilising Ponseti method to treat clubfoot of children, some of who now come to clinics as young as several weeks old – thanks to the operation of the project over more than a decade now, since 2009 that has created a level of awareness among the communities, especially poor people.

WFL service providers also reached out to some government community clinics, health workers, doctors and nurses and taken up initiative to raise awareness in the vicinity of the WFL clinics in

operation. They also continued to receive referrals from government hospitals where they used to operate during earlier phase, and satisfied clients continued to refer patients.

Effectiveness Rating: Good

The program effectiveness was assessed as 'good'. Effectiveness was assessed at the outcome level of children, as well as the project's capacity to stand the shock of the COVID-19 pandemic. Children with successful clubfoot treatment utilising the Ponseti method were seen standing, walking, running, and their parents were immensely happy and satisfied. Overally, parents were happy with the services provided by WFL clinics. Some of these children who completed their treatment are now going to schools. Several newborn children as young as just over three weeks and above were seen at the clinics, often accompanying by both parents and/or other family members. Parents were guided to take off the plaster/casting, which also acted as one way of demonstration for other parents present there. However, a few of the children and particularly their mothers may still face the issue of stigma in their community and with their in-laws, which still need to be considered to be included in counseling mechanism.

During the project period, a total of 79 new children were enrolled in the services in these three districts, and many children continued to receive follow-up services free and paid or partially paid.

COVID-19 responses: The program was initially affected by COVID-19, when the clinics were closed for just three months (April 2020 to June 2020). The response of the WFL clinics in adopting COVID-19 mitigation strategies was effective as it included making provision of humanitarian assistances including food services for a selected group of parents of children with clubfoot, ensuring services maintaining necessary hygiene and wearing of masks etc. with assistance of organisations such as Action on Poverty (AOP).

During this period under evaluation, the WFL project continued service delivery amidst the lockdown due to the COVID 19 pandemic for some months led by Clinic managers (cum physiotherapists) under the supervision of the Glencoe Foundation, which is currently handed over to a local organisation named Sancred Welfare Foundation in Bangladesh). With assistances of various donors, the WFL project in the private facilities was able to also extend relief services for COVID-19 to 480 families of children with clubfoot.

Efficiency Rating: Satisfaction

The program has utilised its resources and represented good value for money. The program had a budget of BDT. 9,547,726.00 as of June 2022, which approximately 7.54% of the budget remains unutilised. The underutilisation of the budget was mainly from line items for awareness-raising activities, which could not be conducted due to limitations caused by the COVID-19 pandemic.

The program has also effectively leveraged the global resources of AOP and others to provide free services to some poor patients.

Added value of AOP: As no initiative was taken locally to arrange free of cost or partially costed service delivery for those who are poor, it was only due to the assistance provided by AOP and other foreign donor agencies that some poor child patients with clubfoot, were able to receive services from this WFL project. Besides, the project also provided COVID-19 related assistances to all of these 480 families. The WFL clinics were prompt to transform some of the services e.g., technical counselling online. Regular follow-up over phone also started to tackle the patients' inability to come to clinics due to lockdown. COVID-19 protocol such as wearing masks, sanitizers were made available by the clinics.

Impact Rating: Good

At the service user level, the project has had encouraging impacts as children with cured clubfoot following the services are not just able to avoid difficulties in stepping and walking, but they are better accepted by their extended family and community. High level of satisfaction was shown by parents of

children with cured clubfoot; parents who came with new cases of clubfoot in their children were also optimistic with the services. The evaluation exercise also created scope for some of the newcomers to see practical changes that occurred in the lives of the cured patients, who were brought by parents to the clinics for interview purposes.

Individuals interviewed for the evaluation said the WFL program had led to a mind-set change at the family and community levels over the last several years. Overall, the project performance was ranked as ‘good’ under the impact criterion. However, it is still necessary to improve the level of awareness and counselling protocol to existing parents in order to prevent treatment drop-out as well as generate resources and/or work to ensure alternate facilities providing free or low-cost ensuring high-quality Ponseti treatment.

Sustainability: Satisfactory

Overall, the program was rated as satisfactory on the sustainability criterion. The program has made significant shift in sustaining the WFL program in private clinics, which are providing services to a good number of children whose parents can afford the services offered by these clinics. Moreover, funding support of organisations including AOP and other international organisations have contributed significantly to make services available for many poor and low-income group of parents andtheir children. It is recommended that the WFL program to have a business plan, and strategy for the clinics to offer services to a wide-range of clients including the poor (with mechanism of perhaps diverting a certain portion of clinic profit to cater the poor. Moreover, motivating the availability of services also at the public facilities parallelly at those districts would be essential to sustain services for all range of people. Advocacy initiatives to promote the implementation of the NCMS 2019 are needed, to ensure that the WFL activities for example at RMCH and 'Ma-o-Shishu Hospital' can continue, particularly for the poor.

The Glencoe Foundation (GF) country office, now under the leadership of the Sancred Welfare Foundation (SWF) or the clinics need to connect poor patients (who cannot be accommodated to be supported through limited foreign fund) with e.g. the assistances provided by local philanthropists, or profits made by the private WFL clinics. The WFL clinics operating under the project also did not appear to have any business model/plan available or perform activities related to CSR (corporate social responsibilities) to assist poor patients from their earned profit when donor support for free gets exhausted. Though it was not possible for GF to take fund locally, they could easily follow the well-established practice of connecting patients with philanthropists (individual and/or organisations) that is being practiced by other organisations.

Recommendations

	Priority	Addressed To:
Strengthen engagement and advocate with government secondary or tertiary hospital to make club foot treatment in Ponseti method available at RMCH, 250 bedded hospitals in Jashore and Ma-o-Shishu Hospital.	High	WFL clinics, SWF, AOP and others
Strengthen project monitoring both by number and to check quality, and accountability, as well as transparency of services and finance. And ensure systems are in place to avoid any serious health related complicacy (e.g., autoclaving) of unaware patients' families.	High	SWF, AOP
Develop and then strictly follow standard treatment protocols while doing any invasive procedure including tenotomy to avoid using the same instrument for surgery of more than one child without autoclaving	High	WFL Clinics, SWF, AOP and other donors
Strengthen engagement with Non-Communicable Diseases Control, Directorate General of Health Services (DGHS) and the Ministry of Health and Family Welfare (MoHFW)	High	WFL Clinics, SWF and AOP
The project's engagement to contribute to achieve the SDG-3 'health and wellbeing" must be monitored, validated and represented as such. A clear pathway to meaningful engagement of clinics is necessary during the redesigning, development of project TOC, log-frame, implementation, monitoring process and plans of the project. Vendor/event base activity will not bring impactful change completely.	High	WFL Clinics, SWF, AOP
Investigate public-private partnerships to sponsor free treatment support to the poor and marginalised people in the community to ensure sustainability of the services.	High	WFL Clinics, SWF, AOP
A percentage of the WFL clinic income/profits from paid and partially paid services must be diverted to support free services to poor patients. Processes need to be built to strictly monitor this both at programmatic and financial levels.	High	WFL Clinics, SWF, AOP
GF/SWF/AOP need to develop a comprehensive advocacy strategy and plan to work with Ministry of health to successful inclusion of clubfoot treatment in the government facilities.	High	WFL Clinics, SWF, AOP
Establish the relationship with district level government departments, community clinics to raise mass awareness and strengthen the referral mechanism so that patients (service users) can receive different type of services as per their needs.	High	WFL Clinics, SWF, AOP
Ensure engagement with community structures such as OPDs/SHGs begins earlier in the programme to ensure longer term sustainability. Train OPDs/SHGs on inclusion and utilise them to ensure they can refer the clubfoot patients in the right place to access the service.	High	WFL Clinics, SWF, AOP
Advocate with the governments to develop the Master trainer on clubfoot using Ponseti in the public level to support the patients all through Bangaldesh. Utilise the Maymenshing, Sylhet and NITOR	High	AOP

experience with the government. This will help to address capacity gaps which exist in the public sector.		
Advocate with the Government to give equal importance of clubfoot treatment, monitor the allocation of budget and proper utilisation of the budget for the treatment of clubfoot patients.	High	WFL Clinics, SWF, AOP
Use the evidence generated by the research conducted by the WFL to advocate with government and other development partners to strengthen the implementation of national clubfoot guideline.	High	AOP
To sustain the clinic modalities of the work GF/AOP should support to develop the comprehensive organisational development plan and business plan for the clinics.	Medium	SWF

INTRODUCTION

Clubfoot, the cause of which is still unknown, has multiple impacts on the life of the child having this deformity of legs as well as when he or she becomes an adult. Globally, an estimated 200,000 children are affected by clubfoot annually, a large proportion of whom cannot access its treatment[i]. It is one of the most common ranges of foot abnormalities describing a condition where the foot is rotated inward and downward. Untreated or neglected clubfoot deformity inevitably leads to long-term physical difficulties with stepping and climbing. Moreover, it can have extended negative impacts on almost all aspects of the child's life as it can negatively impact upon social inclusion, decrease access to education, limited socialization and mobility, it can potentially limit employment opportunities of the adult with clubfoot, and it contribute to increased family poverty[ii]. Club foot is usually congenital, almost a half of clubfoot cases affect both feet. A considerable number of babies born each year with clubfoot around the world are born in low- and middle-income countries[iii] [iv]. Boys are about twice more likely to develop clubfoot than girls. Children with club foot born in poor families living in remote localities are highly likely to go untreated and or fail to continue getting services, particularly, when services are unaffordable even if given the scope of paying in instalments.

Clubfoot can be treated either through surgery or through the unique manipulation and casting maneuvers used in the Ponseti technique[v]. An estimated 5,000 cases of clubfoot occur in Bangladesh per annum[vi], with incidence approximated at 1: 900 births **(**www.walkforlifeclubfoot.org**).**

In 2009 the Glencoe Foundation, the National Institute of Traumatology and Orthopaedic Rehabilitation (NITOR), BRAC, and the ICDDR,B initiated clubfoot service delivery using the Ponseti method, the global "gold standard' for clubfoot correction without surgery, in some of the government hospital facilities. This was a result of successful joined-up advocacy and the political will of the Government of Bangladesh to improve the quality of affordable services for children with clubfoot in Bangladesh. The WFL intervention at that time was declared a successful National Clubfoot Program, which is still being provided at several government facilities including in Rangpur, Sylhet, Mymensingh, and Dhaka. Support from the public sector also included providing of the clinic venue free of cost at 34 government hospitals/health complexes, free technical support of the orthopaedic surgeon, regular overseeing by the concerned government hospital authorities, and implied approval to operate health service deliveries as it was done under the supervision of one of the government hospital units/departments. According to an article published in 2014, the project operated to provide services and helped avert long-term disability in over 17,500 children[vii].

Initially, the WFL project led by the Glencoe Foundation was operating in several district-based general hospitals and some tertiary hospitals with a mixed team with contributions as follows:

Contribution of the Government of Bangladesh (GoB)	Free services and supervision by the orthopedic surgeon, nursing staff, some MSR, and free hospital venues at the public hospitals, etc.
Contribution of INGO	Physiotherapist, counselor, brace support, training cost, etc.

At that time, the WFL program provided training to the orthopedic surgeon (on conducting tenotomy surgery as part of Ponseti-based treatment), nursing staff and some community clinic staff (for awareness and referral), and the Glencoe Foundation's physiotherapists on providing treatment using Ponseti method. A change in approach was planned by the Glencoe Foundation to increase its financial sustainabiliy by moving out of the Public Hospital facilities as of September 2019.

Glencoe Foundation's Walk For Life project decided to establish private clinics nearby their previous venue at the public hospitals, and to sustain the clinics they initiated a fee of TK. 26,500 (US$ 261.367) for clubfoot in one foot and TK. 30,500 (US$ 300.8186) in both feet, which was given at times free or

at a partial costing of different types only with foreign funding provided by organisations such as the Action on Poverty (AOP) over the September 2019 till June 2022 project period of WFL.

Purpose of evaluation

Action on Poverty (AOP) commissioned a final evaluation of the WFL project funded by them in order to assess the performance of the program and to identify key learning. The objectives of the end line evaluation were:

- What was the impact of the project over the lives of the children who were served through the project?
- What was the added value of AOP to the project?
- What was the key learning from the project?
- What are the risks associated with both demand and supply sides of services and the sustainability factor?
- What is the way forward in terms of expansion; existing strategy and dissemination of learning?

The key research questions are built around the following the OECD DAC evaluation criteria:

Cohesion, Effectiveness, Efficiency, Impact, Sustainability, Criteria, and also Project management

As the purpose of the evaluation had a focus on contributing to future strategy and program design and implementation, the evaluation was mainly formative, although with summative elements. The evaluation was designed to be participatory, offering significant opportunities for key program stakeholders, particularly past, and current service recipients i.e. guardians, representatives of OPDs, technical and strategic stakeholders in the public and non-government sectors and local community leaders to influence findings and recommendations.

The evaluation covered the full period of implementation of the program. The evaluation used an adapted set of OECD/DAC criteria of coherence, effectiveness, efficiency, impact, sustainability, scalability, project management, and safeguarding and inclusion.

Note: Following the project cycle, AOP originally circulated a Terms of Reference (ToR)[viii] in May 2022 for the End of Project Evaluation. In the process, a team of consultants were selected and contract was signed. The overall purpose of the evaluation was designed to assess the extent to which the project has succeeded or failed, in terms of its intended results, and find reasons why this happened. Conclusion to be drawn on the relevance and effectiveness of the project's approach in the broader WFL program, and highlight good practices and lessons learned. At the end, recommendations are to be presented for continuity and change which would provide a basis for future programming and approach. After discussion with the representatives of AOP during their Dhaka visit in August 2022, the revised evaluation objectives were provided as above, based on which the evaluation plan was revised and initiated.

Scope of Work: WFL 2019-2020 in Bangladesh

The evaluation objectives, key research questions (in Table 1 below) and the project stakeholders constituted the scope of work, based on which the team of consultants designed the detailed workplan for the WFL end of project evaluation.

The scope of the evaluation included the four WFL clinics stationed in the districts of Jashore, Rajshahi and Dhaka. The study team also visited the government hospitals, where WFL projects were running before the year 2019. In order to address the research questions and objectives, other stakeholders including key people from the district-level government health and social welfare departments, relevant

service providers for clubfoot treatment, a host of community people/leaders were brought under the scope.

Program description

From Sept. 2019 to June 2022, Glencoe Foundation Bangladesh implemented the Walk For Life project with the assistance from AOP and other donors aiming to make the Ponseti technique available for children needing clubfoot correction in selected areas, which are some of the remote and poverty-stricken areas of three districts namely Jashore, Rajshahi and Dhaka, as well as the peripheral districts. The effort was made to address two streams of people as target groups: service takers and service providers, including the following:

- children under the age of three born with clubfoot, especially those from families living in poverty or extreme poverty
- doctors, medical practitioners, physiotherapists, health professionals and NGO workers

Over these 3 years, the project documented the following outcomes of its redesigned programme:

- Mass awareness raised about the health impact, protection and treatment options, of both clubfoot and COVID-19 (when it appeared in Bangladesh from 2020) socio-economically vulnerable clubfoot patients and their families are protected from COVID-19 infection
- Socio-economically vulnerable clubfoot patients and their families maintaining continuity of clubfoot treatment
- Socio-economically vulnerable clubfoot patients and their families (taking the treatment under the project) are not becoming economically disadvantaged by the cost of treating clubfoot disability
- Covid-19 risk management promoted within and through the project, protecting frontline health workers, patient families, and children

METHODOLOGY

Evaluation Approach and Design: The evaluation was designed to be participatory in nature using a democratic evaluation approach (MacDonald and Kushnar, 2005). In this approach, the evaluators have taken up the role of a facilitator rather than of a referee. The evaluation has used qualitative design, blending various tools and methods to address the research questions.

Desk Review: A desk review of project documents made available and studies done in various countries including Bangladesh also contributed to the analysis. The issues of access, affordability, sustainability, planning and management of project, and associate quality were taken into consideration. A desk review of relevant documents and project data were conducted which were shared with the evaluation team. These included

- WFL project proposal, Project reports, Monitoring data, National Clubfoot strategy, Rights and Protection of Persons with Disabilities Act-2013, National Education Policy -2016, Previous evaluation reports on the project, National Clubfoot Project of Bangladesh: The four-year outcomes of 150 congenital clubfoot cases following Ponseti method[ix]. The Bangladesh clubfoot project: the first 5000 feet. (Journal publication), The Bangladesh clubfoot project: audit of 2-year outcomes of Ponseti treatment in 400 children. (Journal Publications).
- Evaluation report commissioned by CBM and Australian NGO Cooperation Program (ANCP)

Field visit: Five out of 6 WFL clinics in Dhaka, Rajshahi and Jashore, the sole brace centre in Jashore were visited. Visits to several public hospital facilities were also made. The team have collected two brief case stories which allowed the program stakeholders to identify what changes they value from the intervention of Walk for Life (WFL).

Participatory nature was followed, and participants in FGD and KIIs were given the opportunity to talk in absence of project personnel with some periodic presence (during the FGD).

The evaluators have been tasked with ensuring that all stakeholders, particularly those with 'less power', have the opportunity to participate and meaningfully impact the evaluation. This included utilisation of a number of qualitative tools with

- Groups of parents of the children who have undergone the clubfoot treatment through WFL. They include children who have received services (i) free, (ii) with payment, (iii) children who are currently undergoing services, (iv) children who have dropped out of services (v) children with relapse, (vi) children with fully cured clubfoot.
- Community stakeholders who include parents, representatives of Organisation of persons with disabilities (OPD), representatives of NGOs and NGO networks, teachers, representative of faith-based institutes and local government representative.

The methodology involved detailed data collection through conducting discussion with the relevant people. Qualitative data was collected using focus group discussions (FGDs), key informant interviews (KIIs) and in-depth interviews (IDIs). The qualitative methods in particular ensured input from intended beneficiaries is at the centre of the evaluation. These tools included:

- Focus Group Discussions: 5 Focus Group Discussion (FGDs) covering over parents of over 27 children, and over least 12 other community stakeholders. (list in Annexure). Parents brought their children in the FGD sessions.
- Key Informant Interviews: 22 Key Informant Interviews (KIIs). (list in Annexure)
- In-depth Interviews: 25 In-depth Interview (IDIs). (list in Annexure)
- Brief case story of the Brace centre, cured clubfoot child, drop out child (see Annexure)

Key Informant Interview: Another group of people, with who the project is supposed to coordinate according to the NGO Affairs Bureau instruction were reached at by the evaluation team who included the offices of the Deputy Commissioner, Civil Surgeon, Tertiary Hospital Directors, Hospital Superintendent, Orthopedic Surgeon, Child Development Centre, Physiotherapist at a Tertiary Hospital, Department of Social Services, One Stop Service Centre of the Jatitya Protibondhi Unnayan Foundation, Ward Commissioner of the Local Government Institute, Community Clinic, to conduct interviews. Moreover, WFL clinic staff as well as GF/SWF representatives and AOP representatives were consulted for KII.

In-depth Interview and Focus Group Discussion: Parents of 14 boys and 11 girls with clubfoot participated in the IDIs in the 5 clinics visited. Over 52 children and their parents (at times both the parents) were interviewed/consulted utilising pre-approved IDI (25 parents, 27 children) and FGD guidelines (over 27 parents, with their children). A 48% of the 52 IDI (parent and children) commenced the services at the WFL clinics during the project period under evaluation (September 2019 to June 2022).

Observation made by the team of WFL clinics during tour of clinics with and without staff members also contributed to the evaluation findings. Many of the children, particularly the cured cases of children were seen walking, and running during the interview. Casting and bracing of new cases, and follow-up cases were observed; also at least 4 to 6 cases of children with relapsed clubfoot were met to understand the situation and possible reasons for relapse and the interactions between the clients and the service providers. A wide range of both internal and external project personnel and professions were reached at through KII, (list in annex), and findings of which are analysed for the report.

A total of 5 FGDs were arranged of which three were held with parents of children with clubfoot, and two were held with other stakeholders. No FGD were arranged in the Trauma Centre WFL clinic, and the WFL clinic in the SMC clinic at Matuail, Dhaka arranged FGD with children only.

Over 12 participants representing school, Organisations of Persons with Disabilities, religious institute (mosque), NGO network, community-based institute etc. and other stakeholders were met during two FGDs arranged by the WFL clinics in Jashore and Rajshahi.

DAC Criteria: An agreed adaptive set of DAC criteria with pre-set questions per criteria as according to the ToR was used to collect responses/qualitative data. The five adaptive DAC criteria included that of Coherence, Effectiveness, Efficiency, Impact and Sustainability which were assessed through a scale of 5: excellent, good, satisfactory, attention and caution, with excellent having a score of 5 and caution having a score of 1. In addition, the issue of 'Project Management' was also given a score based on the requirement of the Evaluation Terms of Reference.

An inception report was submitted with the revised objectives, methodology and details tools, which were pre-approved by AOP.

Table 1 - Key evaluation questions

	Primary Tools	Data Source
Relevance/ Cohesion		
Were the project activities aligned with the plans and commitments of national level plans/policies on children, health and disability? How was the programme able to respond to the changes due to COVID-19 pandemic? Was the project consistent with the interventions of other actors such as the government and other relevant health service providers?	KIIs Document review	Government, non-government/ other stakeholders Project documents
Effectiveness		
Were the objectives and implementation plan of the programme aligned with the needs of the targeted populations and marginalised groups? Were the objectives achieved? What has worked and what did not work? What is the learning? What were the challenges faced and how was it mitigated?	KIIs FGDs MSC Stories	Project implementers Project partners
Efficiency		
Has the costing slab considered the purchase power of potential clients? Were there any local fund-raising attempts made to support poor children? To what extent, the project activity implementation was cost-efficient, and did not compromise quality? What was value for money achieved by the project in context of the lives of children? What was the added value of AOP?	KII	Government, non-government/ other stakeholders
Impact		
What were the impacts of the project observed? What is the satisfaction level of children and their families with the interventions and results? How was the Patient Satisfaction measured, and what is the key learning? How was the learning utilised? How well have the projects' activities and outputs contributed towards achieving the overall outcome of the project?	KIIs FGDs Document review MSC	Project implementers Project recipients Project Partners Government & other stakeholders Project documents
Sustainability		

How did the project collaborate with government stakeholders e.g., health, social welfare, education, local government etc. to sustain the services and impact of the project? What, if any advocacy done with other stakeholders? Were there any policy level changes observed as a result of the project? To what extent did the programme build the capacity of national institutions or strengthened an enabling environment to ensure sustainability of the programme outcomes? What is the level of ownership among government stakeholders? Which project activities and impact would continue beyond the project? Did the project create any linkages with any disability Organisations, OPDs and health providers contribute to sustainability? What is the level of ownership the project clinics? Has there been any sustainability plan put in place by the project? Was it done in context of the socio-economic status of all potential clients, existing policy? What learning can we take forward in future project design, scaling up and replication? Any suggestions for improvements?	KIIs FGDs Document review	Project implementers Project recipients Project Partners Government & other stakeholders Project documents

Ethical considerations

The evaluation followed WFL ethical guidelines outlined in the evaluation terms of reference (TOR). None of the evaluation team had any past involvement with the program, nor do they have any personal relationships with any of the program team or staff of the program partners. All members of the evaluation team signed WFL Code of Conduct and taking consent before taking interview and discussion[1].

The evaluation also ensured informed consent from all participants. A verbal explanation of the purpose and process of the evaluation and the data collection session was given at the start of every FGD, KII, IDI, and discussion. Informed verbal, and where possible, written consents were obtained from all participants before starting the data collection sessions and/ or interview. Where permission for recording was obtained – the interviews were also recorded.

Participation in the evaluation was voluntary and the process for obtaining consent included reassuring participants that their responses would not impact any future assistance they may receive from WFL program partners and donors, and that responses would be anonym zed to ensure confidentiality.

Risks to participants

Risks to participants of the evaluation were considered low. The main risk was potential concern (perceived or real) over future access to services from SWF/WFL Clinics as a result of any negative comments made during the evaluation. The informed consent process and assurances of confidentiality hopefully will help mitigate this concern partially. A list of FGD participating and IDI participating parents are however, kept at the concerned clinics. For FGD participants, there was an additional concern of the confidentiality of responses being damaged by other participants in the FGD sharing a participant's response. The introduction to the FGDs included a strong request for maintaining confidentiality, and WFL clinics were asked to reinforce this when inviting participants to the FGDs and for IDI. The Evaluation team requests WFL project to ensure that no beneficiaries who may have suggested availability of services in alternate free facilities are subject to any repercussions from the privately run WFL clinic authority.

COVID-19 protocol

In-person data collection activities adhered to WHO and the country-specific Ministry of Health COVID-19 guidelines and preventive measures as appropriate/possible. The data collection team was trained to ensure that they have a comprehensive awareness of COVID-19 prevention strategies.

[1] Please see Annex 5 for signed code of conduct for the evaluation project by the evaluation team members

FINDINGS

This evaluation focused mainly on the social aspects according to the revised terms communicated through email, hence our findings will also focus on the social impacts instead of technical quality of services, which were dropped from the objective of this evaluation by AOP during following the briefing meeting held at the former Glencoe Foundation country office (currently Sancred Welfare Foundation) in Mohammadpur, Dhaka.

The project was evaluated with the following five OECD DAC criteria with a scale of satisfaction as indicated below:

	Scaling explanation	Numeric rating
Excellent	There is strong evidence that the project fully meets all or almost meets all aspects of the evaluation criterion under consideration. The findings indicate excellent and exemplary achievement/progress/attainment. This is a reference to the set of questions selected for the adaptive DAC criteria.	5
Good	There is strong evidence that the project mostly meets the aspects of the evaluation criterion under consideration. The situation is considered reasonably good, but there is room for improvements. There is need for a management response to address the issues which are not met. An Action Plan for adjustments should be formulated to address any issues. Evaluation findings are potentially a reference for effective practice.	4
Satisfactory	There is strong evidence that the project only partially meets the aspects of the evaluation criterion under consideration. There are issues which need to be addressed and improvements are necessary under this criterion. Adaptation or redesign may be required, and a clear Action Plan needs to be formulated.	3
Attention	There is strong evidence that the project does not meet the main aspects of the evaluation criterion under review. There are significant issues which need to be addressed under this criterion. Adaptation or redesign is required, and a strong and clear Action Plan needs to be formulated. Evaluation findings are a reference for learning from failure.	2
Caution	There is strong evidence that the project does not meet the evaluation criterion under consideration and is performing very poorly. There are serious deficiencies in the project under this criterion. There is need for a strong and clear management response to address these issues. Evaluation findings are a reference for learning from failure	1

Report against the OECD DAC Criteria

Glencoe Foundation's Walk For Life project during the 2019 to 2022 operated in privatized modalities led by Clinic managers under the direct supervision of the GF country office lead in Bangladesh amidst COVID 19 pandemic. With assistances of partners including AOP, the WFL project has extended contribution to a number of their child beneficiaries' families during the pandemic. During the period the project also managed transferring of GF operation in Bangladesh to Sancred Welfare Foundation (SWF). The project lead at GF Country office and SWF for WFL remains the same.

Five DAC criteria i.e. Coherence, Effectiveness, Efficiency, Impact and Sustainability were assessed through a scale of 5: excellent, good, satisfactory, attention and caution, with excellent having a score of 5 and caution having a score of 1. In addition, Project Management was also given a score based on the requirement of the Evaluation Terms of Reference.

Coherence and Relevance Rating: Good

The project under evaluation was operated by private clinics, and these were assessed to be working in alignment with some of the activities indicated in the National Clubfoot Management Strategy (June 2019). These activities mainly concern provision of services, use of Ponseti method to treat clubfoot of children, some of who now come to clinics as young as several weeks old – thanks to the operation of the project over more than a decade now since 2009.

Due to inadequacy of quality and timely services, excessive cost of services at private clinics, closure of WFL clinics at the public facilities (apart from those continuing services at their own currently), continuous referral from the previous public facilities, orthopaedic surgeons, pediatricians, community clinics and referral made by satisfied clients – parents of new patients with clubfoot are regularly coming to the WFL clinics. This is certainly a good achievement. WFL service providers also reached out to some community clinics, and taken up initiative to raise awareness in the vicinity of the WFL clinics in operation.

The program was initially affected by COVID-19, thus, it could not operate during April to June 2020. The response of the WFL clinics in adopting COVID-19 mitigation strategies was effective as it included making provision of humanitarian assistance including food services for a selected group of parents of children with clubfoot, ensuring services maintaining necessary hygiene and wearing of masks etc. with assistance of organisations such as AOP. Despite the pandemic, WFL clinics ensured free services delivery to 480 clubfoot patients (including 79 new children, and the rest are follow-up patients). These children were also provided COVID 19 related assistance by the project with funds provided by AOP, DFAT and other organisations in these 3 project districts. The project was assessed as 'Good' under the criteria of coherence.

Effectiveness Rating: Good

The program effectiveness was good. Effectiveness was assessed at the outcome level of children, as well as the project's capacity to stand the shock of the COVID 19 pandemic. Children with successful clubfoot treatment utilising the Ponseti method were seen standing, walking, running, and their parents immensely happy and satisfied at the development of their children. Parents were happy with services provided by WFL clinics. Some of these children are now going to schools. However, a few of the children may still face issues of stigma in their community due to their past with clubfoot deformity.

Though the WFL project has utilised various tools including 'local cable TV channel' to raise awareness. The clinics mentioned disseminating awareness raising leaflets funded by AOP in the community. In some of the public facilities the WFL still kept a billboard for which they were not charged by the public hospital. Information shown in the billboard has also guided parents to the WFL clinics. The parents participating in the IDI and or FGD could not give examples of awareness raising activities implemented

by the WFL project. This may be due to various reasons including the inadequate coverage of the e.g. 'cable TV channel', the lack of affordability of parents in FGD to access such channels etc. Most of these participating parents came to the Government hospitals (i.e. at RMCH or the 250 bedded hospital in Jashore and Ma-o-Shishu Hospital of Matuail, Dhaka) and were referred to the WFL clinics to get clubfoot services. Many of the children who came to the clinics were born in the Rajshahi Medical College and Hospital (RMCH) or the Ma-O-Shishu Hospital or the 250-bedded hospital in Jashore – many of the children referred to by RMCH are infants who were lucky to be brought to the clinics the moment they were suspected to have clubfoot. Doctors and other staff at those hospitals continue to refer children to WFL clinics regularly.

One of the common types of referrals was from satisfied parents who continue to refer children with clubfoot. It is necessary to raise community level awareness to ensure more children can benefit from services early on. One way to reduce drop out of children is by increasing the level of awareness.

Efficiency Rating: Satisfactory

The program has utilised its resources reasonably efficiently to include services and COVID 19 assistance during the period under evaluation. The project had a budget of BDT. 9,547,726.00 as of June 2022. Most of the budget had been utilised for service delivery and only 7.54% of the budget remained unutilised as awareness raising activities could not be conducted due to limitations caused by the COVID-19 pandemic.

Currently, Glencoe Foundation/Sancred Welfare Foundation run WFL clinics provide services at the costs of TK. 26,500 (equivalent to US$ 261.367) for clubfoot in one foot and TK. 30,500 (equivalent to US$ 300.88) for both foot, which however, can be paid in suitable installments over a period of 5 years2. This cost/charge is usually much less than that charged at other private hospitals, but it is way above the cost required to spend at public hospitals for the same services. However, it is worth to note that there was only a limited number of public facilities providing this non-surgery service.

Free service option is available only for a limited number of poor people, and that too are made available only with assistance of foreign funders such as the AOP, Miracle Feet, etc. No cross-subsidy mechanism was however, made available by GF/SWF from paid patients or profits made by the WFL private clinics to assist poor patients.

The flexibility to pay in installment over a period of 1 to 5 years at the private WFL clinics is a positive step particularly for patients belonging to lower middle class to middle class economic strata. Some parents participating in the interviews have mentioned that they were struggling to pay as many of them earn very little, and do not get opportunity to access to low cost or free services as before from public hospital.

There was no documented analysis based on which this costing was fixed other than that 'the cost is much less than other private facilities' (as stated by WFL project staff and representative of GF/SFW). As such it will be appropriate for the WFL project to work out a standard costing slab, introduce cross subsidy mechanism from profit made by the respective clinics, and a business model is developed as long as this is considered a developmental initiative that also involves development organisations such as AOP. The costing slabs should be in context of the purchase power of many potential clients. Despite request made the evaluator had no access to accounts, financial documents indicating income and expenditure, profit made, monthly target/plan at the clinics, therefore, a detail analysis on this cannot be provided. At least 4 to 6 children with relapse were seen with their worried and disheartened parents, at least some of these cases of relapse occurred as parents were unable to pay for services in the privatised WFL clinics.

[2] Exchange rate of 101.39 conversion to USD is quoted dated November 12, 2022, https://www.google.com/search?q=us%24+vs+bangladesh+taka+in+nov+2022&rlz=1C1UEAD_enBD1032BD1032&oq=us%24+vs+bangladesh+taka+in+nov+2022&aqs=chrome..69i57j0i546l5.24335j0j7&sourceid=chrome&ie=UTF-8

An infant belonging to a very poor family supported by their grandmother, who is a daily wage-based worker was demanded full payment of TK. 30,500 at a WFL clinic. The criteria for poor appears to be applied by the clinics only for a limited number of poor people depending completely on the grants of international donors. In these clinics the options for free and subsidised services subject to authenticity check is not widely publicised.

Some criteria were set by the project to provide free treatment, but in reality, free treatment was given only based on the availability of funding. It was often given on a 'first come first serve basis' or from reference of local authorities or public hospitals, which means poorer patients coming late or without reference could not access to the free service. Some have chosen to delay treatment of the child because of their financial status. It is necessary to review the selection process to ensure that the information is well-known and appreciated by the communities as well as to enhance the community's supervision to reduce biases if any during the reference and approval process.

A parent (who falls under the WFL criteria of poor) claimed of being demanded to pay TK. 70,000 for clubfoot treatment of the child by a WFL clinic during the phase under evaluation. When she reached out to the nearby public facility, this fee was completely waved.

The issue of autoclaving: Though this evaluation had no responsibility to focus on the quality aspect of the Ponseti treatment, but still during visits of the WFL clinics, the team came across certain issues regarding autoclaving. As some clinics tend to use the central autoclaving of their 'host' hospitals, autoclave machine provided by other WFL donors was found unutilised at least in one clinic, which may have also reduced the scope of using autoclaved instruments for every tenotomy surgery. This practice potentially puts each child in danger of contracting other diseases. One autoclaved set was used for 3 to 4 children's tenotomy surgery sometimes at that clinic. Though the tenotomy operation is minor, but there is high possibility to get infected which may be harming the children unknowingly. Therefore, it is an immediate and important necessity to set-up standard procedure/protocol to conduct tenotomy, and establish robust mechanism and improve ethics in this area. Moreover, autoclave machine, unused shoes are kept in one place in a manner as if it's a dumping store.

Despite the difficulties due to COVID 19 pandemic, the WFL project operated well, and was prompt to initiate online based services. The WFL project mentioned that they've supported some clubfoot patients using online services by demonstrating physiotherapy, process of wearing shoes etc. during the COVID 19 lockdown and other restrictions. As soon as the lockdown was over, service delivery at clinics commenced on a roaster basis. The number of patients reached online was not made available.

Despite attempts made by the project, a number of children could not benefit from this online support due to unavailability of internet service, lack of smart phone, and poverty etc. during lockdown. Moreover, as a result of price hike in transportation, loss of income as a result of the pandemic, some parents could not continue to bring their children for follow-up.

All WFL clinics except for the one in Rajshahi offer treatment in specific day of the week for which they pay rent to their venue lending organisation/club/clinic (e.g. RADAS in Rajshahi, Rotary Club in Jashore, Trauma Centre and SMC clinics in Shyamoli and Matuail in Dhaka, respectively). Sometimes parents bringing their babies for treatment have to go back home as they came to the clinic in the wrong day – i.e. when the clinic was closed, which is why messages delivered need to be comprehensive by all sides. Sometimes poor parents cannot immediately bring back their child immediately for a second time, which too can delay the child getting early interventions.

Added value of AOP: As no initiative was taken locally to arrange free of cost or partially costed service delivery for those who are poor, it was only thank to the assistances provided by AOP and other international development agencies that 480 (including 79 new) poor child patients with clubfoot, were able to receive initial and/or follow-up services from this WFL project (July 2019 to June 2022). Their assistance also supported 480 families to sustain during the COVID 19 pandemic. The WFL clinics were prompt to transform some of the services e.g. technical counseling online. Regular follow-up over phone also started to tackle the patients' inability to come to clinics due to lockdown. COVID 19 protocols e.g., wearing masks, sanitisers were made available by the clinics. Moreover 150 service deliverers (including health workers, health inspectors, doctors and others) were brought under awareness session on clubfoot to increase referrals during (July 2019 to September 2022) according to data made available to the evaluators by GF/SWF. Nevertheless, parents are often not aware about the organisations behind these services (e.g. for both clubfoot treatment and COVID 19 assistances). Thus, it is recommended that the acknowledgements of the organisations should be made more visible and mentioned more frequently to parents and the public.

Impact Rating: Good

At the service user level, the project has had encouraging impacts as children with cured clubfoot following the services are not just able to avoid difficulties in stepping and walking, but they are better accepted at their extended family and community. Considerable degree of satisfaction was shown by parents of children with cured clubfoot; moreover, parents who came with new cases of clubfoot in their children were anticipating encouraging change as they have found service options. Individuals interviewed for the evaluation said the WFL program had caused a mind-set change at the family and community levels over the last several years. Overall, the WFL program has achieved its mission of providing treatment for children with clubfoot in Bangladesh.

The WFL project could however, initiate regular client satisfaction surveys as long as these surveys are conducted objectively the parents would feel encouraged. Overall, the project performance was ranked as 'good' under the impact criterion. But not all children had equal access to follow-up services and procedure as some of their parents had stopped coming to the clinics due to the costs. Many relapses of the deformity in the child's feet were attributed to this reason. Therefore, it is necessary to improve the level of awareness and counseling protocol to prevent drop out further as well as generate resources and/or work to ensure alternate facilities providing free or low-cost ensuring high-quality Ponseti treatment.

Sustainability: Satisfactory

The project was rated as satisfactory on the sustainability criterion.

The program has made significant shift in sustaining the WFL program in private clinics during the phase under evaluation.Those clinics are providing services to a good number of children whose parents are willing to do everything and/can afford the services offered by these clinics.

At the institutional level, the knowledge and awareness of the staff of clinic hospitals should be sustainable. The project has trained a total of 150 community health worker, health inspectors, doctors and others, which should strengthen community knowledge of on clubfoot. However, the community workers need continued support on awareness to ensure the gains of the program are retained. Thus, refresh training is necessary to ensure the practitioners maintain standard service quality and share their knowledge to others.

Funding support of NGOs such as AOP and like-minded other foreign donors have contributed hugely to make services available for poor patients. Though the private WFL clinics can sustain financially given the patient flow, it will be difficult to sustain the program for all, unless given strategies to cross subsidise the poor or ensuring existence of parallel services at the public facilities in the same districts

to cater the poor. Advocacy initiatives to promote the implementation of the NCMS 2019 are needed, to ensure that the WFL activities for example at RMCH and Ma O Shishu Hospital can continue.

A child with relapse was met during the evaluation who dropped out from follow-up as the father (who is a wage-based worker) could not afford to pay TK. 3,000 (equivalent to US$ 29.59) for a specific service option in the middle of treatment at that particular WFL clinic visited as part of evaluation.

Lack of initiatives was observed by GF or SWF or the clinics to connect poor patients (who cannot be provided free services through limited foreign fund) with e.g., the assistances provided by local philanthropist or from WFL clinic income during the project period. The WFL clinics operating under the project also did not share any business model/plan available or perform activities related to CSR (corporate social responsibilities) to assist poor patients from their earned profit when donor support for free gets exhausted. Though it was not possible for GF to take fund locally, they could easily follow the well-established practice of connecting patients with philanthropist (individual and/or organisations).

Project Management and Lessons Learned:

The organisations that host these WFL private clinics (e.g., RADAS, Rotary hospital) have no supervisory role in context of quality treatment. Though the NGO Bureau approval instructs the WFL project to maintain coordination with local offices e.g., the Deputy Commissioner, the Civil Surgeon, but no such meaningful attempts were observed.

Most of the KII and FGD participants suggested for similar services within the public sector hospitals, which offer a 'one-stop service point' giving them access to other treatment facilities for people who usually come from far-flung including rural areas. The WFL project management needs to consult their clients, as they have accountability to all service recipients. Many parents and OPD representatives participating in the evaluation strongly feel that the location of such centers at the government hospital enables them to avail of the service with ease, access and at a low cost. However, a few evaluation stakeholders e.g., in Dhaka shared that the overload of service recipients, and the long queue of service recipients at the government hospitals was one of the reasons for them to come to the private WFL clinic, as they had purchasing power. Thus, there is a need to have both options – services at public and private facilities for which strong advocacy is needed for a 'nationally available clubfoot service'.

In-person monitoring was done once a year by former GF/SWF for the project under evaluation, which is extremely inadequate to ensure proper quality of the services. Discussion with clinics indicated top-down approaches to planning e.g., clinic managers had no knowledge based on which their clinics are getting specific quantity of free service provisions.

It will be necessary to improve the counseling capacities of clinic managers and counselors to avoid such situations further. The finding is in alignment with the response of a clinic manager who during the interview said earlier while delivering services within the public facilities there was a lot more supervision and quality control, which they no longer have to endure under the present mechanism (2019 to 2022). Inadequate coordination was observed among different clubfoot providers. A sense of no-trust, and competitiveness was observed, which should be avoided. A regular channel of network preferably led by OPDs and disability organisations should be promoted. OPDs or disability-related networking organisations can take part in raising awareness in the community for clubfoot treatment. WFL can increase collaboration with the OPDs and disability-related networks.

Top-down project approach in practice: During the designing phase of the field project activities, some clinic staff mentioned there was no meaningful engagement of them in project/program designing and

planning. Therefore, their engagement has been mostly passive as the clinic managers received some documents to fill in for patient treatment information and send to GF/SWF. The clinic staff did not know how the target for free service is being calculated as this is handed down completely by the GF/SWF office in Dhaka.

Safeguarding and Inclusion:

Child safeguarding is one of the core components of program implementation that involves children. Interviews with clinic staff including managers indicate that they did not uniformly receive training on safeguarding. Training sesions were arranged by donors such as AOP but only WFL program staff can access. There should be new initiatives to disseminate the knowledge to the partnered clinics as well. Similarly, parents participating in the IDI and FGDs were mainly uninformed on the issue of safeguarding.

During the Covid-19 pandemic the clinic provided services utilising online service. Moreover, Clinic staff maintained a roaster and communicated over the phone to follow-up with the on-going patients, maintained social distancing provided masks and sanitiser.

Research shows that in Bangladesh club foot ratio between girls and boys is 1:2. The project has kept the balance while selecting children to provide cost subsidies and free-treatment. Still the project can consider to increase the number of girls to ensure no children including no girl children are left without services as the social prejudice on girls are still significant and can prevent them from getting treatment.

Cross referral

Quite a few children met (including those with clubfoot and their siblings without clubfoot but visiting WFL clinics as accompanying family members) at either IDI or FGD were suspected to have other forms of impairments (both physical including those requiring surgical intervention available at some tertiary public facilities, and other forms of impairment as well as with other forms of impairment requiring early interventions). None of them were referred to concerned services by the WFL clinics which were found more concentrated on the (club-foot) services they provided only. Two or more children with clubfoot in Jashore whose parents had participated in the FGD had other serious forms of physical deformities in both their feet and hands – these children need appropriate and early referrals and intervention at the earliest or may develop serious disabling conditions for life. WFL clinics tend to focus only on clubfoot treatment and overlook their responsibility in the context of the development and social inclusion of the child, some of which can be contributed through cross-referrals. Referral to services in areas of disability inclusion, health, education, and social inclusion would add value to the project.

Interestingly all the WFL clinics visited continue to benefit from referrals made by the government hospitals and health workers from their past lives, but there appeared to be a lack in referring back children for other services by the clinics. Many of the parents of children with multiple impairments and/or disabilities were found unaware of services for the associated impairment/deformities as well. Without getting early intervention through referral to an appropriate facility these children belonging to poor families may have their clubfoot cured, but will still grow to develop some other serious disabling conditions.

Moreover, findings from IDIs and KII conducted with the one-stop service center for persons with disabilities in Rajshahi revealed that there were no or limited cross-referrals taking place between the Rajshahi Diabetic Associated (RADAS) WFL clubfoot clinic and the One Stop Service Centre of the Jatyia Protibandhi Unnayan Foundation- JPUF (National Disability Development Foundation) for rehabilitation or physiotherapy.

Policy level Advocacy

While the Walk for Life project operated in the government facilities, all patients were receiving free services though WFL had to bear cost of certain materials including high quality plaster, and position

of physiotherapists etc. which were/and still are not part of the Government system with a few exception e.g. physiotherapists in Child Development Centre and physical Medicine departments at some tertiary hospitals.

The WFL project wanted to charge all patients Taka 600 for services, as part of cost recovery measures which was once agreed but then revoked by the government authorities, leading to the NGO-led operation decided to come out of the government health facility venue altogether. Under the government system, some medico-surgical requirements (MSR) which are still not funded under the general health system are usually purchased by the patients, the cost of which may have different range subject to the type of service needs per se cost of high-quality plaster. A study indicates 59% of parents mentioned that they could not bear the material costs of Taka 3,000 ($US 38.48) for their child to receive this treatment (Evans, A.M., Chowdhury, M.M.H., Kabir, M.H. et al. 2016). However, it is always possible to advocate (and sometimes successfully) with the government to review and include new MSR which may take some time – but not completely impossible. Public facilities such as in Dhaka, Rangpur, Mymensingh and Sylhet are still offering clubfoot treatment. During KII, RMCH has shown keen interest to re-initiate the services, and is even willing to review and make provisions for materials even brace at the hospital as this was for the improvement of the lives of children. Unfortunately, the Evaluation team did not notice any advocacy initiative made by the WFL representatives at national or local levels directed at system change, instead, they had decided to walk out and set-up a private center of business of a certain auxiliary health cadre.

Choice of Options for Services to Patients

Given limited resources for health care lower middle-income countries (LMIC) such as Bangladesh has a tendency to focus more on primary health care, improving immunisation, and mother and child health care rather than the fields of non-communicable diseases control. Walk For Life program unlike many other programs had a spectacular start as from the very beginning it was allowed to operate within several public hospitals at various tiers including several tertiary-level hospitals. With appropriate strategic interventions the project could be integrated well within the service delivery mechanisms in the public health system. A change in approach by WFL project was planned by the Glencoe Foundation to move out of the Public Hospital facilities as of August 2019 when the Government receded to allow the program to collect a fee of TK. 600 per foot correction from patients, which is contradictory to usual public health service practices in Bangladesh. Thus, the WFL program walked out altogether from all public facilities may limit the options of families with children born with clubfoot as they no longer access to services from public hospitals as before. It is necessary to reconsider the decision and start new initiatives to rebond with the government and public hospitals in order to extend service options for the patients.

CONCLUSION

Overall, the program has achieved significant success in improving the quality of life of children with clubfoot, who now stand the chance to avoid disabling conditions. Despite operating during one of the most significant global public health crisis of modern times, the program has managed to reach an impressive number of service users, maintained the WFL clinics running in profit despite the hard economic time created due to the COVID 19 pandemic. The key shortcoming of the program is that it has not managed to engage with the government systems including getting approval/affiliation to run the WFL clinics with local and national health administration.

There are a number of lessons that can be learned and some areas for improvement e.g. establishing standard protocol on autoclaving, establishing monitoring, evaluation and learning framework in alignment with a theory of change. The challenge for WFL program now is to work with the host government, and public health facilities, where possible, take support of the Organisations of Persons with Disabilities (OPDs) to ensure they implement the National Clubfoot Management Strategy (June 2019).

In most low and middle income settings, clubfoot treatments suffer from low level awareness, absence or inadequate implementation of the national clubfoot strategy by both the public and private sector players, absence of consensus on agreed treatment guidelines that include the Ponseti method, inadequate coordination and partnership between government and NGOs/other private sectors, reluctance of private WFL clinics to share or submit reports and avoid accreditation by health administration, lack of interest in working with the public facilities among NGOs, absence of strong monitoring on the quality of treatment by the central health administration, lack of adequate national capacity, inadequate options to get services utilising Ponseti method in the public hospitals, inability of existing public system to purchase treatment materials and absence of necessary auxiliary health cadres in many public facilities, as well as the interest in profit-making by certain group of auxiliary technical cadres etc.

Notably in many high-income settings, clubfoot treatments are embedded in the primary and tertiary health services (AT2030) (Clinton Health Access Initiative, July 2021), which needs to be re-explored and advocated by the WFL program in Bangladesh for clubfoot.

RECOMMENDATIONS

	Priority	Addressed To:
1. Strengthen engagement and advocate with government secondary or tertiary hospitals to make club foot treatment in Ponseti method available at RMCH, 250 bedded hospitals in Jashore and Ma-o-Shishu Hospital.	High	WFL clinics, SWF, AOP and others
2. Strengthen project monitoring both by number and to check quality, and accountability, as well as transparency of services and finance. And ensure systems are in place to avoid any serious health related complicacy (e.g. autoclaving) of unaware patients' families.	High	SWF, AOP
3. Develop and then strictly follow standard treatment protocols while doing any invasive procedure including tenotomy to avoid using the same instrument for surgery of more than one child without autoclaving	High	WFL Clinics, SWF, AOP and other donors
4. Strengthen engagement with Non-Communicable Diseases Control, Directorate General of Health Services (DGHS) and the Ministry of Health and Family Welfare (MoHFW)	High	WFL Clinics, SWF and AOP
5. The project's engagement to contribute to achieve the SDG-3 'health and wellbeing" must be monitored, validated and represented as such. A clear pathway to meaningful engagement of clinics is necessary during the redesigning, development of project TOC, log-frame, implementation, monitoring process and plans of the project. Vendor/event base activity will not bring impactful change completely.	High	WFL Clinics, SWF, AOP
6. Investigate public-private partnerships to sponsor free treatment support to the poor and marginalized people in the community to ensure sustainability of the services.	High	WFL Clinics, SWF, AOP
7. A percentage of the WFL clinic income/profits from paid and partially paid services must be diverted to support free services to poor patients. Processes need to be built to strictly monitor this both at programmatic and financial levels.	High	WFL Clinics, SWF, AOP
8. GF/SWF/AOP need to develop a comprehensive advocacy strategy and plan to work with Ministry of health to successful include clubfoot treatment in government facilities.	High	WFL Clinics, SWF, AOP
9. Establish relationships with district level government departments,and community clinics to raise mass awareness and strengthen the referral mechanism so that patients (service users) can receive different types of services as per their needs.	High	WFL Clinics, SWF, AOP
10. Ensure engagement with community structures such as OPDs/SHGs begins earlier in the programme to ensure longer term sustainability. Train OPDs/SHGs on inclusion and utilise them to ensure they can refer the clubfoot patients to the right place to access the service.	High	WFL Clinics, SWF, AOP

11. Advocate with the governments to develop the Master trainer on clubfoot using Ponseti at the public level to support the patients all through Bangladesh. Utilise the Maymenshing, Sylhet, and NITOR experience with the government. This will help to address capacity gaps that exist in the public sector.	High	AOP
12. Advocate with the Government to give equal importance to clubfoot treatment, monitor the allocation of budget, and properly utilise the budget for the treatment of clubfoot patients.	High	WFL Clinics, SWF, AOP
13. Use the evidence generated by the research conducted by the WFL to advocate with the government and other development partners to strengthen the implementation of national clubfoot guidelines.	High	AOP
14. To sustain the clinic modalities of the work GF/AOP should support the comprehensive organisational development plan and business plan for the clinics.	Medium	SWF

Annex 1: List of IDI Participants

The list includes 25 parents and 25 children, 48% of whom had commenced the services at the WFL clinics during the project period under evaluation.

Sl #	Gender	Participating parent occupation	Participating Children in IDI (name and age)	District	Service Started	Service ended/ Continuing	Paid	Free	Dropped out	Service completed
1	F	Housewife	F (2 years 2 months old)	Jessore	July 2020	Continuing		Free		
2	M	Businessman	M (20 months old)	Jessore	November 2020	Continuing		Free		
3	F	Housewife	F (6+ yrs old)	Jessore	January 2016	July 2021		Free		✓
4	F	Teacher	F (6 year)	Jessore	September 2016	September 2019		Free		✓
5	F	Sewing Work	M (6 years old)	Rajshahi	December 2016	August 2022		Frepe		✓
6	F	Service holder	F (3 years old)	Rajshahi	October 2019		paid		Dropped out	
7	F	Housewife	F (5 years 14 days old)	Rajshahi	September 2017	September 2022		Free		✓
8	F	Housewife	F (23 Days old)	Dhaka	October 2022	Continuing	paid			
9	F	Day laborer	F (2+yrs old)	Dhaka	July 2021			Free	Dropped out	
10	F	Housewife	M (4 years 3 months old)	Rajshahi	June 2018	Continuing	paid			
11	F	Housewife	M (10 Years old)	Rajshahi	January 2013	3 August 2018		Free		✓
12	F	Housewife	F (3 years 2 months 12 days old)	Rajshahi	July,2019			Free	Dropped out	
13	M	Businessman	M (4 years 8 months old)	Jessore	6 August 2018			Free	Dropped out	
14	F	Sewing Work	M (2 years old)	Jessore	2020	Continuing		Free		
15	F	Housewife	M (5 years old)	Jessore	January 2018	September 2022		Free		✓
16	M	Businessman	M (9 years old)	Dhaka	December 2013	2017		Free		✓
17	M	Businessman	F (9 years old)	Dhaka	2014	2018		Free		✓
18	M	Businessman	F (4+ yrs old)	Dhaka	2020		partial paid		Dropped out	▪

19	F	Housewife	F (5 years 4 months old)	Rajshahi	May 2017	2022	partial paid			✓
20	F	Housewife	M (5 years 11 months old)	Rajshahi	2017	March, 2020	paid			✓
21	F	Housewife	F (4 years 5 months old)	Rajshahi	2018		paid		Dropped out	
22	M	Farmer	M (14 years old)	Rajshahi	2014	2017	paid			✓
23	F	Housewife	M (5 years 6 months old)	Jessore	March 2017	July, 2022	paid			✓
24	F	Housewife	M (3 years 4 months old)	Jessore	October 2019	Continuing		Free		
25	F	Housewife	M (3 years 7 months old)	Jessore	April 2019		partial paid		Dropped out	

Annex 2: List of Key Informant Interview

Key Informant, Rajshahi:

SL.	Date	Name	Designation	Institution
1	03.09.2022	Roksana Akter (01717136780)	Child Development Therapist, Shishu Bikash Kendro	Rajshahi Medical College Hospital (RMCH)
2	03.09.2022	M.Md. Anwarul Islam (01723006716)	Senior Physiotherapist, Department of Physical Medicine	RMCH
3	03.09.2022	Md. Mehedi Hassan	WFL Clinic Manager	RADAS, Rajshahi
4	03.09.2022	Md. Mutakabbir Hossen (01783010616)	WFL Clinic Counsellor	RADAS, Rajshahi
5	04.09.2022	Bri. Gen. Md. Shamim Yazdani	Hospital Director	Rajshahi Medical College Hospital (RMCH)
6	04.09.2022	Dr. Obaidul Haque (01556303198)	Assistant Professor, Department of Orthopaedics	RMCH
7	04.09.2022	Dr. SM. Bayezid Ul-Islam (01749994000)	Medical Officer at Civil Surgeon's Office	CS, RMCH
8	04.09.2022	Mir Shamim Ali	District In-charge, Protibondhi Sheba-o- Sahajjo Kendro	Rajshahi
9	04.09.2022	Kalayan Chowdhury	Assistant Deputy Commissioner (General)	Deputy Commissioners Office, Rajshahi

Key Informant, Jessore:

SL.	Date	Name	Designation	Institution
1	07.09.2022	Dr. Md. Nazmus Sadique	Deputy Civil Surgeon	Jashore
2	07.09.2022	Quazi Munemul Huda (01711011136)	WFL Clinic Manager	Club Foot office, Rotary
3	07.09.2022	Md. Miaraz Hossain	WFL Clinic Counsellor	Club Foot office, Rotary
4	08.09.2022	Muna Afrin	District In-charge, Protibondhi Sheba -o- Sahajjo Kendro	Jashore
5	08.09.2022	Nasima Akter Jolly	Woman Counsellor (Reserved)	Jashore
6	08.09.2022	Ashit Kumer Saha	Deputy Director, District Social Service Office	Jashore

7	08.09.2022	Dr. Md. Akteruzzaman	Hospital Director	250 bedded Government Hospital, Jashore
8	08.09.2022	Dr. A.H.M.Abdur Rouf (01716833815)	Asso. Prof. Head of Department, Orthopaedics	250 bedded Government Hospital, Jashore
9	08.09.2022	Alamgir Hossain	Brace Centre-In charge	Jashore

Key Informant, Dhaka:

SL.	Date	Name	Designation	Institution
1.	09.11.2022	Kazi Nimeri	Social Welfare Officer	Department of Social Service.
2	03.11.2022	Most. Mojida Akhter	Education Officer	Directorate of Primary Education.
3	25.11.2022	Khondoker Jahurul Alam	Executive Director	Centre for Services and Information on Disability.
4	15.11.2022	Samia Ahmed	Campaign Lead	Safeback 2 school campaign.

Participants at the Focus Group Discussion (FGD) with Community People: Rajshahi

SL	Name	Designation	Phone number
1	Dr. Imama Iqbal	TO-Serive, APOSH	01758085980
2	Mst. Parvin Sultana	Teacher, MashishBathan Adarsha Balika Biddaloy	01770206707
3	Md. Aminul Islam	Khatib, Tarash Jame Mosjid	01737499274
4	Md. Mamunul Rahman	Manager, RHSTEP, RMCH	01718817203
5	Mst. Fatema Khatun	Kalpana Pritibondhi Unnayan Shangtha (OPD)	01775234771
6	Md. Sohel Rana	Kalpana Pritibondhi Unnayan Shangtha (OPD)	01736937167

Participants at the Focus Group Discussion (FGD) with Community People: Jessore

Sl #	Name of Participants	Designation	Name of Organisation
01	Mousumi Roy Chowdhury	Teacher	Moumachi kindergarten
02	Umme Kulsum Ronjona	Finance Executive	Aalor Sandhan Protibondhi Unnyon Sonshta
03	Hafijur Rahman	Member	Aalor Sandhan Protibondhi Unnyon Songsshta
04	Md. Nazrul Islam	Teacher & Religious Leader	Islamic Faoundation
05	Md. Shahjalal	District NGO Coordinator	
06	Meghna Islam	Executive Director	Somobay Somittee

List of FGD with Parents is available with respective clinics/GF/SWF

Reference

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[iv] https://globalclubfoot.com/clubfoot/

[v] https://www.hss.edu/conditions_the-ponseti-method-for-clubfoot-correction.asp

[vi] Ford-Powell VA, Barker S, Khan MSI, Evans AM, Deitz FR. The bangladesh clubfoot project: the first 5000 feet. J Pediatr Orthop. 2013;33:e40–4

[vii] Perveen R, Evans AM, Ford-Powell V, Dietz FR, Barker S, Wade PW, et al. The Bangladesh clubfoot project: audit of 2-year outcomes of Ponseti treatment in 400 children. J Pediatr Orthop. 2014;34:720–5

[viii] Annex 5 presents the Evaluation ToR, May 2022

[ix] Journal publication https://doi.org/10.1186/s13047-016-0175