

**BRAC Health Programme Evaluation: A Case Study of Labour Colony
PannaTextile, Khagan, Savar, Dhaka**

**Dissertation submitted in partial fulfillment of the Requirements for the Degree of MA in
Governance and Development (MAGD).**

SUBMITTED

By

NAY LIN

ID No. 14272022

MA in Governance and Development Programme 2014-2015



BRAC INSTITUTE OF GOVERNANCE AND DEVELOPMENT (BIGD)

BRAC UNIVERSITY, DHAKA, BANGLADESH

JULY 2015

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JULY 2015

CERTIFICATE

I hereby recommend and certify that this dissertation entitled “BRAC Health Programme Evaluation: A case of Labour Colony Panna Textile, Khagan, Savar, Dhaka” is a research work conducted by NAY LIN, MAGD-6, ID-14272022, under my supervision for partial fulfillment of the requirements for the Degree of MA in Governance and Development, BRAC University, Dhaka, Bangladesh.

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DECLARATION

I do hereby declare that I am the sole author of this dissertation.

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MAGD 6th Batch

DEDICATED TO

My Beloved Wife

DAW MAW MAW AYE

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I am grateful for the all out support provided by the BRAC University library for finding different publications on the BRAC Health Programme.

I respectfully express my sincere gratitude to my supervisor and reserved Course Coordinator, MAGE batch # 6, for his sincere support, inspiration, thoughtful supervision, and the candid discussions that I had during the course. I thank him for his kind allocation of valuable time for me.

It has to be noted with thanks that I have used the BRAC website extensively for statistics and information.

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Finally, I express my gratefulness to BRAC University authorities for supporting me to accomplish this study program.

Nay Lin

July 2015

ABSTRACT

Health is the level of functional or metabolic efficiency of a living organism. In humans it is the ability of individuals or communities to adapt and self-manage when facing physical, mental or social challenges. The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This definition has been subject to controversy, in particular as lacking operational value and because of the problem created by use of the word "complete" Other definitions have been proposed, among which a recent definition that correlates health and personal satisfaction. Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Diseases (ICD), are commonly used to define and measure the components of health.

The purpose of this study is to examine health condition providing by BRAC Health Programme and to identify what kinds of diseases suffered by the employee or worker of Panna Textile, Khagan in the last three months. Both the primary and the secondary data have been used in this study. The primary data has been collected through questionnaire survey method. The secondary data has been collected from various published documents in the forms of books, and the internet. In this study, the obtained data has been analyzed through quantitative method by using statistical tools and other arithmetic methods of data analysis that are available and variable. In some case, to present key finding of the data, graphics manner have been used with the aid if charts and tablature presentation.

The essence of this study is to convert large quantities of data into condensed forms to facilitate an easy interpretation and understanding for the readers. The study found that Khagan villagers are suffered from fever, the people suffer from cold and asthma respectively. Skin, diarrhea and diabetes are the most. Also found vomiting, cough and worm respectively. Others diseases are weakness, blood pressure, accident, kidney, allergy, headache, constipation, ophthalmological problems, and skin problem in scalp respectively.

BRAC Health Programme provides health service to the maximum people of Khagan area which is 43% of the respondents. The payments for health service provided by the BRAC Health Programme are subsidized. Dependence of traditional medicine is still remarkable. 34% respondents take health service from traditional health service providers. 20% respondents take health service from private sector by their own cost. 3% respondents receive health service from their own organization.

TABLE OF CONTENTS

CERTIFICATE.....	i
DECLARATION+.....	ii
DEDICATED.....	iii
ABSTRACT.....	v
TABLE OF CONTENTS.....	vii
LIST OF TABLES.....	x
LIST OF FIGURES.....	xi
LIST OF ABBREVIATIONS.....	xii
CHAPTER-ONE	1
INTRODUCTION	1
1.0 Background of the Study.....	1
1.1 Problem Statement.....	2
1.2 Objectives of the research.....	2
1.3 Research Questions.....	3
1.4 Scope of study.....	3
1.5 Outline of the Study.....	4
CHAPTER-TWO	5
BRAC Health Programme Literature	5
2.0 Health Programme: An overview.....	5
2.1 BRAC Health Programme for Women.....	8
2.2 Public Health Care System.....	11
2.3 Improving Maternal, Neonatal & Child Survival (IMNCS).....	18
2.3.1 District Profile.....	20
2.3.2 Population.....	21
2.4 Maternal Health.....	21
2.4.1 Identification of pregnancy.....	21
2.4.2 Antenatal Care.....	22
2.4.3 Maternal Danger Signs.....	22
2.4.4 Birth Plan.....	23
2.4.5 Protection of Mothers with Tetanus Toxoid (TT) Vaccine.....	23
2.4.6 Delivery attended by skilled Birth Attendant.....	23

2.4.7 Emergency Obstetric Care Service in Four intervention districts	23
2.4.8 Misoprostol.....	24
2.4.9 Maternal Complications	24
2.5 Neonatal Health	24
2.5.1 Early initiation of Breast Feeding.....	24
2.5.2 Low Birth Weight.....	25
2.5.3 Management of LBW Baby.....	25
2.5.4 Birth Asphyxia.....	25
2.5.5 Neonatal Sepsis.....	25
2.5.6 Neonatal Danger Signs	26
2.6 Child Health	26
2.6.1 Immunization.....	26
2.6.2 Acute Respiratory Tract Infection (ARI).....	26
2.6.3 Diarrhoea	27
CHAPTER – THREE	28
RESEARCH METHODOLOGY	28
3.0 Introduction.....	28
3.1 Research Method	28
3.2 Sources of Data.....	28
3.3 Research Instruments	28
3.4 Questionnaire Administer	29
3.5 Survey Respondents.....	29
3.6 Data Analysis and Presentation	29
3.7 Limitation of the study.....	29
CHAPTER – FOUR	30
RESULTS AND DISCUSSION	30
4.0 Introduction.....	30
4.1 Respondents’ Particulars.....	30
4.2 Demographic Information of Respondents	30
CHAPTER-FIVE	36
CONCLUSION AND RECOMMENDATIONS	36
5.0 Conclusion	36

5.1 Recommendations.....	37
References:.....	39
SURVEY QUESTIONNAIRES	40

LIST OF TABLES

Table-1	Districts Profile	19
Table-2	Distribution of People by Districts	20

LIST OF FIGURES

FIGURE-1	Kinds of diseases that suffered in Panna Textile in the last three months	30
FIGURE-2	Kinds of diseases that suffered by male above 18 years	31
FIGURE-3	Kinds of diseases that suffered by the 5-18 years children	31
FIGURE-4	Kinds of diseases that suffered by children under 5 years	32
FIGURE-5	Kinds of diseases that suffered by male above 18 years	32
FIGURE-6	Health service providers in Panna Textile	33
FIGURE-7	Traditional health service in Panna Textile	34

LIST OF ABBREVIATIONS

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
AWP	Annual Work Plan
BDHS	Bangladesh Demographic Health Survey
BEmOC	Basic Emergency Obstetric Care
CHW	Community Health worker
CPR	Contraceptive Prevalence Rate
CSBA	Community Skilled Birth Attendant
IMNCS	Improving Maternal, Neonatal and Child Survival
LBW	Low Birth Weight
LQAS	Lot Quality Assurance Sampling
SK	Shasthya Kormi
SS	Shasthya Shebika
UHC	Upazila Health Complex

CHAPTER-ONE

INTRODUCTION

1.0 Background of the Study

Essential health care (EHC) is the foundation of BRAC's health programmed, combining primitive, preventive and basic curative services. EHC has revolutionized the primary healthcare approach in Bangladesh, reaching millions with low cost basic health services through BRAC's frontline community health workers. EHC aims to improve reproductive, maternal, and neonatal and child health along with the nutritional status of women and children. The programme further aims to reduce vulnerability to infectious, communicable diseases and non-communicable diseases. The programmed provides primary healthcare services including maternal and child healthcare, basic treatment for acute respiratory infections (ARIs) and promotes family planning methods and safe delivery practices. Use of proper sanitation, safe drinking water, and hygiene-specific messages is also disseminated among communities. The EHC programme has partnered with different government agencies under the Ministry of Health and Family Welfare to observe national health-specific days and events of instruction across the country. Collaboration with the government to promote family planning, immunization of children and distribution of vitamin A capsules within communities are a few of the many successes of the programme. Currently the programme is operating in all 64 districts of the country and delivering healthcare services to over 120 million people, in turn serving as a platform for other health interventions.

In Bangladesh, 8 per cent of the population is suffering from extreme poverty. Their health status lags far behind that of the general population. Essential Health Care (EHC) services for the ultra-poor under challenging the frontiers of poverty reduction – Targeting the ultra poor programme (CFPR-TUP) is specially designed to meet the needs of extremely poor households unable to access or benefit from traditional development interventions. The goal of the programme is to reduce the vulnerability of the poor and ultra-poor to sudden health problems and to prevent them from sliding back into the vicious cycle of extreme poverty. The programme aims to increase access to health

services, through demand-based strategies and by providing a package of basic health services which meets the needs of the ultra-poor. The financial constraint of the ultra-poor is a major impediment in accessing available health services. To address this problem BRAC has introduced the provision of financial assistance to the ultra-poor so that they can access medical care from government or other health facilities. Community participation is ensured in the programme through community forums (Gram Daridro Bimochon Committee) which form an organized network for the improvement of health and the social status of the rural poor in each village. Committee members actively provide motivation and financial support to the ultra-poor for accessing different health services.

1.1 Problem Statement

According to the villagers the Khagan village has approximately 400 to 450 households. It is also found that the number of the households of the village is growing. As it is an industrial area, lot of people come from other parts of the country for works. For that reason, the population is growing. The village has several institutions like BRAC University, City University, BRAC CDM, Amico pharmaceutical industry, GQ Ball pen industry, Panna Textile Mills, a primary school and five mosques. Muslim, Hindu, Buddha and Christians are living in the village. Other than these, there is no ethnic group found.

I have collected data by taking interviews of 30 individuals. We tried to find out i) what type of diseases the villagers are frequently suffering from and ii) what kind of health services they get from government, NGOs, private and other sources. We also tried to find out what are the available health services they usually receive. According to our study I have found that most likely diseases they suffer from are fever, cold, asthma, weakness, diarrhea, skin disease, pain, headache, allergy, cough, worm etc.

1.2 Objectives of the research

This research is aimed at fulfilling the following objectives:

1. To examine health condition by BRAC Health Programme for the employee of Panna Textile, Khagan.

2. To identify what kinds of diseases suffered by the employee or worker of Panna Textile, Khagan in the last three months.

1.3 Research Questions

1. Does Panna Textile workers are getting health services by BRAC Health Programme?
2. What kinds of diseases suffered in Panna Textile, Khagan in the last three months?

1.4 Scope of study

In Bangladesh, about one-third of the population lives in urban areas with worse health situation in slums and squatters in cities. To improve the health status of the slum population, particularly women and children, BRAC started Manoshi, a community based healthcare programme, in 2007 at urban slums of nine city corporations around Bangladesh through development and delivery of an integrated, community-based package of essential health services. Manoshi envisages improvement in the health status of poor urban mothers, newborns and children by bringing healthcare services to their doorstep through our frontline Community Health Workers (CHWs). The Shasthya Shebikas and Shasthya Kormis provide antenatal and postnatal care, essential newborn care (ENC) and child health care. Through behavior change communication interventions they motivate, educate and prepare expectant mothers for childbirth, highlighting an array of health issues including maternal and neonatal danger signs, maternal and neonatal nutrition and so on. BRAC Delivery Centers are established within slums to provide intra-natal care to mothers and immediate care to newborns. Emergency obstetric, neonatal and child health complications are referred to the hospital through an established referral system. The community is connected to health facilities via an innovative mobile phone based referral system. Manoshi is currently being implemented in eleven city corporations. Currently piloted in the urban slums as Manoshi (MNCH Urban) Programme, the initiative intends to digitize the health services by collecting, recording and preserving household information. Thus it creates real time virtual database. The database helps to speed up service delivery process to the target population.

1.5 Outline of the Study

Chapter One provides an introduction to the research study. It covers the background, research questions, problem statement, and the scope of the study. The structure of the research is also outlined at the end of this chapter.

Chapter Two gives an insight into the existing literature of the research topic. BRAC Health Programme for the country and rural areas.

Chapter Three presents the methodology of this research study. This chapter explains the research design, process, and limitations of this study.

Chapter Four shows the analysis of primary data collected through questionnaires survey. It presents the major findings of the study.

Chapter Five includes this research study along with a review of the research objectives and recommendations based on the findings in the study for the improvement of existing selection process.

CHAPTER-TWO

BRAC Health Programme Literature

2.0 Health Programme: An overview

Health is a basic requirement to improve the quality of life. A nation's economic and social development depends on the state of health. A large number of Bangladeshi people, particularly in rural areas, remained with no or little access to health care facilities. The lack of participation in health service is a problem that has many dimensions and complexities. It mainly emphasizes the construction of Thana Health Complexes (THCs) and Union Health and Family Welfare Centers (UHFWCs) and paying salaries and allowances to the officers and staffs without giving much attention to their utilization and delivery of services. That is why we have decided to study the present situation of healthcare of the rural area. The objectives of the study is to find out-

- i. What types of diseases villagers are frequently suffering from?
- ii. What are the available health services villagers get from government or Non-government Organizations/ Private sectors?

Bangladesh has made remarkable strides in healthcare in the four decades since independence. Since the 1990's maternal mortality has dropped from 574 to 194 deaths per 100,000 live births, and child mortality from 133 to less than 32 per 1,000 live births. Over four decades, the contraceptive prevalence rate has gone up seven to eightfold. In the 1980's, when immunization coverage was two per cent, the shared roles and activities of BRAC and the government improved the status to 70 per cent within the last four years. The current status of fully immunized children is at 86 per cent. Despite the achievements, Bangladesh still suffers a high burden of deaths and diseases. Over 70 per cent of people seek care from informal health care providers and 62 per cent of those health providers practicing modern medicine have little or no formal schooling. One thirds of births take place at home, mostly assisted by unsupervised, untrained birth attendants. Recognizing these problems, we have created a pool of frontline community health workers, the Shasthya Shebikas and Shasthya Kormis, who strive to address the crisis of human resources in the health sector by playing a substantial role in providing accessible and affordable services to the majority of the population. Initiated in 1991,

Essential Health Care (EHC) has revolutionized the primary healthcare approach in Bangladesh reaching millions with low cost basic primitive, preventive and curative services through our cadre of frontline community health workers. The goal of EHC is to improve access to essential health services through delivering community care and organizing a bridging network with public healthcare system. Shashthya Shebikas and Shashthya Kormis are mainly part of Essential Health Care (EHC) Programme. In fact, E interventions of BRAC are fundamentally based on the platform of EHC programme. To provide these services to the doorstep of millions of people would have required huge investment in the traditional system because of the large number of employees involved in the system. However, EHC developed a very innovative entrepreneurship model where the primary service deliverer (Shashthya Shebika) provides voluntary service. Although they do not receive any salary or monthly stipend, they are provided with financial incentives on the sale of basic medicines and selected health commodities to their community. This low cost innovative service delivery strategy has attracted various donors and partners in BRAC's health programme because BRAC can deliver the service very effectively with a much lower cost. It have started maternal, neonatal and child health (MNCH) programmes in 2005 as a pilot project and has been scaled up to 11 city corporations and 14 rural districts in partnership with the government, UKAID and Australian High Commission. We have demonstrated that with limited resources, it is possible to change behavior and practices to lower the incidences of maternal and neonatal deaths within a short period. With the active engagement of community health workers and birth attendants, we ensure high coverage of antenatal and postnatal care while supporting skilled birth attendance. More importantly, an innovative referral system is developed which facilitates transfer of acute emergency cases to hospitals. Within three to four years, we have observed a decline in maternal and neonatal deaths in both urban slums and rural districts. Bangladesh has made a remarkable progress toward tuberculosis control since the inception of the Directly Observed Treatment Short- course (DOTS) strategy in 1993. In 1994, BRAC became the first NGO in the country to sign a Memorandum of Understanding with the government and expanded DOTS services across the country through its diversified partners. The national TB control programme in Bangladesh has established effective partnership with the consortium of 43 NGOs led by BRAC to implement the programme throughout the countries. BRAC has been working

in 297 sub-districts of 42 districts with the coverage of 93 million populations. In BRAC supported areas, all forms of TB case notification rate has increased from 105 to 129 /100,000 population per year. From 2004 to 2013, more than 1.5 million TB patients have been treated; yielding present treatment success rate 93 per cent in BRAC supported areas which has exceeded the national target (85 per cent) and is the second highest treatment success rate in the world Bangladesh has also improved case notification for child TB, smear negative TB, extra-pulmonary TB and drug resistant TB. The contribution of Shasthya Shebika in detecting presumptive TB cases, collecting sputum for lab diagnosis and DOTS for TB is tremendous. The Global Fund plays important role to control TB programme in Bangladesh. Growing challenges like TB/HIV co-infection, TB/diabetes are also being prioritized. More initiatives will be taken to address vulnerable communities including people with high risk behavior and marginalized socially excluded people for TB care services. Urban TB programme is also given special attention for further strengthening of the programme. The malaria control programme is on track in terms of MDG targets and has shown considerable success among the people at risk from malaria. The National Malaria Control Programme (NMCP) established an effective partnership with the consortium of 21 NGOs led by BRAC to implement the programme in 70 sub-districts of 13 endemic districts. Through the funding of The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Health, Population and Nutrition Sector Development Program (HPNSDP) of government of Bangladesh, the malaria control activities were scaled up and the quality of preventive, diagnostic and treatment services have been improved. BRAC is directly implementing the programme in high endemic three Chittagong hill tracts districts and in 2 sub-districts of Moulvi bazaar. BRAC's community based models applied in malaria programme using a large workforce of local Shasthya Shebikas and Shasthya Kormis in managing malaria patients at doorstep, raising awareness on malaria prevention and health service utilization. Malaria cases were reduced by 68per cent in 2013 comparing to baseline year 2008 and whereas death was reduced by 90 per cent at the same time. A total of 3,735,905 long lasting insecticidal nets (LLIN) were distributed and 4,231,689 ordinary bed nets were treated with insecticide in the same period. Recent malaria prevalence survey conducted in 2013, documented the decreasing of point prevalence of malaria from 4 in 2007 to 1.41 in 2013 per 1,000 populations based on RDT in malaria endemic districts. A good

utilization rate (>85 percent) of insecticidal bed net was observed among pregnant women and children under 5 years of age. Malnutrition among children is one of the major problems of our country. To mitigate this problem, BRAC's nutrition programme has been working at household and community level for creating awareness on nutrition. BRAC's Shasthya Shebika and nutrition promoters visit households in their communities and provide counseling, coaching and demonstration. Moreover, they offer community-based management of acute malnutrition (CMAM) service to mother and child of 6 to 59 months who are affected by moderate accurate malnutrition by providing supplementary food. Nutrition programme creates awareness about adolescent girls' nutrition and encourages mothers and family members about many issues like intake of healthy and various types of food, early initiation of breast feeding, exclusive breast feeding till 6 months, breast feeding for at least two years and initiation of complementary feeding after six months. Moreover, to prevent child malnutrition and anemia, micro-nutrient powder sachets are distributed under maternal, infant and young child nutrition (MIYCN) home fortification programme. It helps to prevent anemia of 6 to 59 months old child by providing required iron, vitamin and mineral. In Bangladesh, around seven hundred thousand people suffer from cataract blindness. Moreover, around one fifty thousand people are becoming blind every year. BRAC started 'Vision Bangladesh' project with the aim to remove the backlog of cataract blindness. In this programme, cataracts are identified through local eye camp and patients are sent to various government and private hospitals for operation. Community health workers visit household in their community and aware people about eye problems. And if there is any complex case, they send the patients to nearby hospitals or health centers. Moreover, BRAC's 'Reading Glass for Improved Living' project has been providing reading glasses to the people whose vision has become blurred due to age.

2.1 BRAC Health Programme for Women

The nutritional status of pregnant women has significant influence on fetal, infant and maternal health outcomes. Nutrition education and counseling during pregnancy improve maternal nutrition and reduce the risk of poor health outcomes in both mothers and their children. Health, Nutrition and Population Programme of BRAC initiated an innovative approach of providing nutrition education to pregnant women under its Improving

Maternal, Neonatal and Child Survival (IMNCS) project. This project developed a daily meal plan with recommended dietary allowance of 2500 kcal for pregnant women and had piloted that in Nilphamari district. In this project, along with nutrition counseling the community health workers also demonstrated the pregnant women the quality of the diet and which foods and what quantities they need to consume in order to achieve optimal dietary intake.

Despite remarkable achievements in selected health indicators such as immunization, maternal and child health - current health services in Bangladesh are still fragmented and skewed towards health MDGs - lacking continuity across levels of care. Access to quality health services still remains inadequate and expensive for a large segment of the population, leading the poor not to access care when needed. Out-of-pocket health expenditure in Bangladesh is one of the highest in South Asia, often resulting in medical expenditure impoverishment.

In Bangladesh an estimated 5,000 children a year are born with clubfoot deformity. Access to standard care treatment using the appropriate method, (Poinsett Method) is limited in Bangladesh. Neglected clubfoot causes life-long disability, limits educational and earning opportunities, and is a major cause of the developmental challenges of ill health and poverty. Poinsett clubfoot treatment (serial casting, Achilles tenotomy – minor outpatient surgery under local anesthesia – and serial bracing) has high efficacy in correcting the deformity. Sustainable Clubfoot Care in Bangladesh (SCCB) is a Canadian International Development Agency (CIDA) fund partnership initiative between the University Of British Columbia (UBC), the Government of Bangladesh and BRAC. BRAC is the key partner in Bangladesh and will work with local stakeholders and collaborating organizations, including the Ministry of Health and Family Welfare (MoH&FW), International Centre for Diarrheal Disease Research, Bangladesh (icddr,b), National Institute for Traumatology and Orthopedic Rehabilitation (NITOR) and the Bangladesh Orthopedic Society (BOS) to improve access to and promote adherence for clubfoot care. The MIS and Quality Assurance Unit (MIS) provides support to improve the quality of the BRAC Health, Nutrition and Population programme (HNPP) . Aligned with the monitoring & evaluation (M&E) framework, the MIS unit was formed in 2006 by combining MIS units of different programmes, namely of HNPP and Quality

Assurance Cell of EHC. In 2007, a monitoring unit was formed for IMNCS, followed by WASH, Manoshi and Alive & Thrive programmes. In October 2014, the unit was renamed the 'MIS and Quality Assurance Unit'. This unit has two cells – the MIS cell and the Quality Assurance Cell. The MIS Cell looks after the data of all 14 Health Nutrition and Population programmes. The Shasthya Shebika (SS) monthly performance report (MPR) is generated at field level by Shasthya Shebika (SKs). The Programme Organizers (Pos) compile MPRs of SKs under their supervision. The next compilation is done by a Sub-district Manager/ Branch Manager. The Sub-district Managers send their MPR to District Managers (DMs) and the DMs send their reports to Regional Managers (RMs). In city corporations, Branch Managers (BMs) send their reports to RMs. RMs send their reports to the MIS Cell, based in Head Office (HO). Feedback given at HO level is transmitted to different levels based on the nature of feedback. This feedback can reach up to SK if needed. The main task of this cell is to compile data and generate MPR for each programme. This cell also generates quarterly, half-yearly and annual performance reports. In addition, special reports are also generated according to the programmes' demand. The Quality Assurance (QA) Cell comprises of five teams are responsible for maintaining internal quality of EHC, IMNCS, Manoshi, Nutrition and SHIKHA programmes. QA is usually done on process, input and output indicators; and financial issues. Besides, QA teams also conduct sample surveys on different issues as per programmes' need. Upon completion of survey, findings are shared at branch/sub-district, district/regional and HO levels. At HO level, findings are shared with programme personnel just upon compilation of data by QA teams. Reports/ are submitted to programmes after analyzing the data. Sub-district/Branch Managers take immediate actions upon receiving feedback from QA team. The action taken by Branch Managers for their respective districts/divisions/city corporations is good. HO managers provide directions to different layers of field management based on QA findings. Non-communicable diseases (NCDs) commonly occurring amongst the people of 35 years and above, require a large quantum of health and social care, irrespective of socio-economic status. Most NCDs are chronic debilitating disease associated with a range of severe complications. Bangladesh has a large number of people living with NCDs. BRAC is going to undertake NCD pilot initiatives in 3 sub-districts of two districts (Narayanganj and Narsingdi) under EHC and 8 sub-districts of 5 districts under Leeds University

COMDIS study project. Initially there will be screening, referral and follow up of hypertension and diabetes patients in the community. To reduce the burden of chronic NCDs by promoting healthy lifestyles and reducing the prevalence of common risk factors through community based health care approach. To provide an easy access for diagnostic, preventive and curative services of chronic diseases (especially diabetes, hypertension, chronic respiratory illness and cancer) by an integrated evidence-based suspicion with a referral backup support. The frontline community health workers (CSWs) –Shasthya Shebikas and Shasthya Kormis will perform screening of hypertension and diabetes in the community. The CSWs will inform and educate people through door-to-door health education. They will also educate about healthy ageing, nutritional requirements, and lifestyle and behavior changes during their regular household visit and follow-up. Malaria is a major public health problem in some parts of

There are 13 districts of Bangladesh in the north-east & south-east areas which border India and Myanmar. Among them are the Chittagong hill tracts (CHT) districts which highly endemic and Cox's Bazaar which is moderately endemic. The National Malaria Control Programme (NMCP) established an effective partnership with a consortium of 21 NGOs led by BRAC. This partnership has leveraged the programme and increased the access to malaria treatment, prevention and awareness raising activities within communities, including the hard-to-reach areas. In partnership with the National Malaria Control Programme (NMCP), BRAC successfully secured a grant from the GFATM to strengthen and expand national malaria control activities to all endemic districts working directly and through other NGOs. BRAC is directly implementing malaria control activities in all sub districts of CHT, two sub districts of Moulvi bazaar, and through 20 partner NGOs in other districts which are monitored and supervised by BRAC.

2.2 Public Health Care System

Initiated in 1991, Essential Health Care (EHC) has revolutionized the primary healthcare approach in Bangladesh reaching millions with low cost basic primitives, preventive and curative services through our cadre of frontline community health workers.

Goal is to improve access to essential health services through delivering community care and organizing a bridging network with public healthcare system.

Objectives are:

- Promote positive health, nutrition and hygiene behaviors and create demand for public and private health services
- Mobilizing children and women for preventable vaccination, deworming and vitamin A supplementation
- Improve domiciliary access to non-clinical contraception and referral for clinical ones
- Ensure early screening for pregnancy complications, appropriate referral in emergencies and facilitation of safe home
- Provide home based management with referral for common symptoms, including diarrhea and pneumonia
- Provide early recognition, diagnosis and supervised treatment for infectious and common non communicable diseases
- Provide screening support for presbyopia and cataract and arrange for correction

Shasthya Shebikas (SS) and Shasthya Kormis (SK), the frontline community health workers, are locally recruited women and trained as health providers to deliver door-step health service. They prevent diseases and promote health activities through health education and dissemination of health and nutrition messages through health forums, household visits and meetings with the wider community. In addition, basic curative services are provided at doorsteps of target populations. In collaboration with the government, BRAC is working in areas of immunization, family planning and basic pregnancy related care. More importantly, major interventions, such as, tuberculosis, malaria and maternal, neonatal and child health and nutrition programmes are founded on the basic structure of EHC.

In Bangladesh, 8 per cent of populations are suffering from extreme poverty. Their health status lags far behind than that of the general population. Essential Health Care (EHC) services for ultra-poor under challenging the frontiers of poverty reduction – targeting the ultra poor programme (CFPR-TUP) is a specially designed programme to meet the needs of extremely poor households, who are unable to access or benefit from traditional development interventions.

Goals are To reduce the vulnerability of the poor and ultra-poor to sudden health shocks and to prevent them from sliding back into the vicious cycle of extreme poverty The programme aims to increase access to health services, through demand-based strategies and by providing a package of basic health services with a special focus on meeting the needs of the ultra-poor. The strategy involves social mobilization, raising health awareness and provision of basic healthcare services for all, especially for the targeted ultra-poor. Financial constraints are major impediments to accessing the available health services by the ultra-poor. To address this problem of financial constraints to healthcare, BRAC has introduced the provision of providing financial assistance to the ultra-poor so that they can access medical care from government or other health facilities. Community participation is ensured in the programme through community forums (Gram Daridro Bimochon Committee) which forms an organized network for the improvement of health and social status of rural poor in each village. Committee members actively provide motivation and financial support to the ultra-poor for accessing different health services. Improving maternal, neonatal and child survival (IMNCS) project is a comprehensive community based health intervention focusing on preventive and curative care with a group of trained community health workers under structured supervision and monitoring system. This comprehensive undertaking is uniquely designed to address the bottlenecks of demand and supply side for ensuring continuum of care from home to hospital. We are reaching around 25 million people living in rural areas of 14 districts (Nilphamari, Rangpur, Gaibandha, Mymensingh, Kurigarm, Lalmonirhat, Faridpur, Rajbari, Madaripur, Magura, Pirojpur, Joypurhat, Shaerpur and Shariatpur) with maternal, neonatal and child health (MNCH) services. Goal is to reduce maternal, neonatal and child mortality and morbidity, particularly, among the poor and socially excluded population.

Objectives are:

- Increased knowledge, and improved MNCH practices in communities.
- Improved provision of quality MNCH services at household and community levels
- Increased participation, accountability and responsiveness to communities' voice in MNCH services.

Community health workers (CHW), namely, Shasthya Shebikas, newborn health workers, Shasthya Kormis and community skilled birth attendants (CSBA) are the frontline workers providing family planning, pregnancy related care, newborn and under five child care at door steps. Behaviour change towards healthy practices in terms of reproductive health, nutrition, hygiene and sanitation is the strategy to preventive and primitive care. CHWs offer basic care, e.g., antenatal care, delivery care, postnatal care, newborn care and management of birth asphyxia, diarrhea, ARI and some common ailments. CSBAs attend home deliveries to ensure safe maternal and neonatal outcome at birth. A well structured referral system is in place to reduce delays in accessing healthcare by bridge gaps between community and facility during emergencies. In essence, a continuum of care is provided to mothers, neonates and under-five children.

In Bangladesh, about one-third of the populations live in urban areas with worse health situation in slums and squatters of Bangladesh. To improve health status of slum population particularly women and children, BRAC started Manoshi, a community based health care programme in 2007 in urban slums of city corporations and gradually expanded to 11 city corporations in Bangladesh through the development and delivery of an integrated, community-based package of essential health services .

Goal is to decrease illness and death in mothers, newborns, and children in urban slums of Bangladesh.

Objectives are:

- Increase knowledge of individuals, households and community
- Increase skills and motivation of human resources to offer services at household and community levels
- Improve and strengthen referral system for management of complications
- Strengthen and sustain linkage with government, NGOs and private health facilities
- Develop a supportive network to support communities and individual households to sustain services
- Facilitate scaling up of successful approaches

In Bangladesh about 20 per cent people suffer from presbyopia and are deprived of contributing to household activities and in the national economy as well, so it has become a major public health problem. This project aims to combat presbyopia - a chronic eye

problem, which results in difficulty in near vision and reduces productivity of adults over the age of 35 years. It has been implemented in partnership between BRAC and Vision Spring which is a non-profit organization in the USA. The mission of Vision Spring is to reduce poverty and generate opportunity in the developing world through the sale of affordable eyeglasses is consistent with the mission of BRAC which is: bringing positive changes in the quality of life of poor. The activities on reading glasses have been incorporated in the normal work schedule of the Shasthya Shebika (SS). Before conducting vision screening in the community the SS mobilizes people who suffer from eye problems. She uses forums like village organization (VO) meeting, group health education meeting etc. For a broader coverage of the programme camps are also held in different project areas. After testing vision the SS offers reading glasses of proper magnification to the presbyopic clients at affordable cost. Patients with other eye complaints are referred to district eye hospitals. Shasthya Kormis and programme organizer support the SS in screening and referral. Sub-district manager and other supervisors provide periodic supervision and follow-up.

In Bangladesh, tuberculosis (TB) is a major public health problem and a leading cause of adult mortality. The WHO ranks Bangladesh 6th among 22 high burden TB countries. Every year around 70,000 people die of TB in Bangladesh. BRAC is the first NGO to sign a MoU with the Government of Bangladesh in 1994 to expand the directly observed treatment short course (DOTS) services nationwide. Along with the government, BRAC is the principal recipient of Global Fund to Fight AIDs, Tuberculosis and Malaria (GFATM) to strengthen health system and expand DOTS across Bangladesh. BRAC and 41 NGOs are implementing TB interventions in partnership with the government.

Goal is to reduce morbidity, mortality and transmission of TB until it is no longer a public health problem.

Objectives are to achieve and sustain at least 70 per cent case detection and 85 per cent treatment success among smear-positive TB cases under DOTS.

BRAC's approach for TB diagnosis and treatment focuses on community level education and engagement. BRAC conducts orientation with different stakeholders of the community to engage them in efforts to identify patients, ensure treatment adherence, and reduce stigma. The stakeholders include: cured TB patients, local opinion and religious

leaders, girls' guides and scouts, other NGO workers, village doctors, pharmacists and private practitioners. The Shasthya Shebika (SS), the first frontline community health worker, plays a pivotal role of connecting individuals with TB control services during household visits and health forums. They disseminate TB messages, identify presumptive, refer them for sputum examination to Upazila Health Complex (Government sub-district health complex) or BRAC laboratory services, ensure daily intake of medicine for identified TB patients through DOT and refer for proper management of the side effects during TB treatment.

Malaria is a major public health problem in 13 districts of Bangladesh, of which Chittagong Hill Tracts (CHTs), Cox's Bazaar and Chittagong are highly endemic. Sporadic incidence occurs in other parts of the country. In partnership with the National Malaria Control Programme (NMCP), BRAC successfully secured a grant from the Global Fund to Fight AIDs, Tuberculosis and Malaria (GFATM) to strengthen and expand national malaria control activities to all endemic districts working directly and through other NGOs.

Goal is to reduce overall burden of malaria (morbidity and mortality) by 60 per cent from baseline year 2008 in 10.9 million populations in 13 high endemic districts of Bangladesh by 2015.

Objectives are:

- Expanding use of LLIN, 2 nets per household, to achieve 100 per cent coverage in 3 high malaria endemic districts and maintain 80 per cent coverage with ITN/LLIN in the remaining districts
- Expanding and improving quality diagnosis and treatment to 90per cent of malaria cases
- To further strengthen programme management capacity, and coordination and partnership in malaria control

BRAC's main approach for malaria control is to inform and educate people at community level, promote use of insecticide treated bed nets and increase early diagnosis and prompt treatment of malaria. BRAC also enhances referral of symptomatic cases for diagnosis by RDT or BSE, ensure treatment, and reduce stigma. The Shasthya Shebikas and Shasthya Kormis (health workers) are responsible for providing diagnostic and treatment services

at community level. They also refer patients to the nearest government health facility and pay special attention to pregnant women, children under 5 kg of weight and severe malaria cases.

Non-communicable diseases (NCD) contribute to 60% of all deaths globally and 80% of these deaths occur in developing countries like Bangladesh. The burden of morbidity by NCD is enormous. Disabilities resulting from these NCDs are very frequent. Countries with large population has large number of people with NCDs but due to absence of effective community based programme, most cases could not be identified at early stage resulting large number of disabilities and death. Considering this, BRAC initiated a community based NCD education and screening programme in 2011 with following goal, objectives and strategy.

Goal is to reduce the burden of chronic NCDs by promoting healthy lifestyles and reducing the prevalence of common risk factors through community based health care approach.

Objectives are:

- To introduce life style modification education
- To provide screening services at the door steps of the clients
- To refer identified suspected cases for diagnosis and subsequent treatment

Strategy is BRAC community health workers (Shasthya Shebikas) receive training on NCD and its community-based approach where they learn to measure blood glucose using glucometer and measure blood pressure. They perform primary screening for diabetes and hypertension among people at risk and refer potential cases with positive result to partner clinics/hospitals. The referral centers confirm the diagnosis and recommend appropriate management plan. In the community, Shasthya Shebika has the responsibility to ensure compliance of the management by following patients on regular basis. Shasthya Shebikas are also involved in awareness building through community mobilization and education sessions on healthy lifestyle and risk factors for NCDs.

2.3 Improving Maternal, Neonatal & Child Survival (IMNCS)

Despite the availability of reasonable infrastructure for antenatal care (ANC) at the community level, only 52% of pregnant women seek ANC, and 18% of all births are

attended by skilled personnel. About 30% of women are reported to receive postnatal care. Caesarean section rate is 8% with an increase of four percentage points from 2004. This is also indicative of wide variations across wealth quintiles, education, geographic locations and public versus private sectors.

Maternal Health

- 90% of estimated pregnancies were captured in the three new districts. It is observed that 62% of pregnancies were identified in the first trimester.
- In three districts 77% of mothers received +4 antenatal visits which were 14% at baseline.
- Skilled delivery increased from 15% at baseline to 20-30% at the end of the year in three districts.
- The proportion of obstetric complications treated in facilities (met need) increased from 22.9% to 33%.

Neonatal Health

- Early initiation of breastfeeding was 80% in three districts, which has increased from 51% at baseline.
- The proportion of newborns protected with thermal care (drying and wrapping within 10 minutes) increased from 18.5% at the baseline to 84% in the three new districts.
- In the three new districts, proportion of the post-partum mothers who received first postnatal check up with 48 hours of delivery increased from 0.4% at baseline to 74%.
- In the three new districts, only 1.4% of neonates were diagnosed with sepsis. Of the diagnosed cases, 93% were referred which increased from 19% at baseline.

Child Health

- In three districts 14% were diagnosed with ARI; and almost 97% of under-five children were managed. This remarkable increase from baseline at 20% at baseline to 64%.

BRAC is using its decentralized staff at the district level for overall coordination and management of the IMNCS project. Partnership and coordination with healthcare

providers and community are executed through the project to enhance accountability of the local health system to ensure wider and improved access for disadvantaged women and children to quality health services at community and facility levels. At the village level, local MNCH Committees are formed with local government members, Village Organization (VO) members, and local people having representation of women and poor families. They are involved in ensuring referral of cases to hospitals, auditing of maternal and neonatal deaths, monitoring and facilitating community health services, discussing quality of services at hospitals and so on. At district, Upazila and union levels, BRAC works through the existing committees of the government to address the existing gaps and improve services quality at facilities. A strong supervision and monitoring system is developed at all levels to ensure quality services. The district managers coordinate, manage and supervise field activities of the all the upazilas from district level. Overall activities of the project are coordinated and managed by a team from the central office in Dhaka.

2.3.1 District Profile

Profile of the four districts where the IMNCS project is active are presented in the Table 1. Mymensingh is the largest of the four districts with 12 Upazilas and 164 unions as opposed to Nilphamari which has six Upazilas and 61 unions. In Nilphamari, village sizes are relatively bigger than other districts suggesting a much larger population size in each village.

Particulars	Nilphamari	Gaibandha	Rangpur	Mymensingh	Total
Upazila	6	7	8	12	33
Union	61	78	83	146	368
Village	363	1,249	1,339	2,787	5,738
Government Facilities	10	8	11	13	42
Medical College Hospital	-	-	1	1	2
District Hospital	1	1	-	-	2
MCWC (EmOC)	2	1	1	1	5
UHC (EmOC)	1	3	2	4	10
UHC (BEOC)	5	3	5	7	20
Private/NGO Hospital	12	9	66	67	154

Table 1: Districts Profile

2.3.2 Population

Table 2 details the population distribution in each district. This information was collected through household census done by BRAC to enlist all households in rural areas and assess populations. The target population excludes pourashava and char areas in Gaibandha.

	Nilphamari	Gaibandha	Rangpur	Mymensingh	Total
Total population	1,595,956	2,155,059	2,517,383	4,703,019	11,971,417
Total households	365,346	535,365	628,598	1,027,708	2,602,017
Family size	4.4	4.0	4.0	4.4	4.2
Children Under-5	178,766	204,468	298,135	654,576	1,335,945
Children Under-1	38,381	52,738	64,179	134,444	289,742
Newborns	2,824	4,893	4,855	9,678	22,250
Women aged 15-49 years	329,251	535,437	547,912	972,235	2,384,835
Adolescent girls	60,650	82,136	91,790	189,171	423,747

Table 2: Distribution of Population by Districts

2.4 Maternal Health

In the three new districts the rate of modern contraceptive method use increased from 55% at baseline to 64% during 2009. The majority of the people still depended on oral contraceptive pill (67%) followed by injectable (21%). In Nilphamari the use of modern method was 64%, which followed a similar pattern in method use as in other districts. Compared to the national data, modern method use is much higher in the four project districts. Counseling, motivation, incentives and, most importantly, the combined efforts of field level workers of the BRAC contributed to this high achievement. A major progress was observed with 18% using permanent methods (vasectomy and tubectomy) in Nilphamari, which is much lower in the other three districts and at the national level. During 2009, a huge impetus was driven towards organizing sterilization camps and motivation couples to accept permanent methods.

2.4.1 Identification of pregnancy

Every month through household visits the SS identifies suspected pregnancies and informs the SK who confirms the pregnancies by conducting urine tests. Through this process 90% of estimated pregnancies were captured in the three new districts. The data for the pregnancy identification in the first trimester was analyzed during 2009. It is

observed that 62% of pregnancies were identified in the first trimester by SKs, which was 25 % in baseline. On the other hand, in Nilphamari, 91% of the estimated pregnancies were identified in 2009 while identification in the first trimester was 69%. Introduction of incentives for pregnancy identification has proved to be an effective way of accelerating the achievement especially in the early trimester. In addition, frequent contact with CHWs and awareness of women and families also contributed to a higher identification of pregnancy. Increase in the number of identification in the first trimester is becoming challenging, as many new pregnant women come to their parental home in their late trimester.

2.4.2 Antenatal Care

During the last twelve months about 68% of the registered pregnant mothers received antenatal care from SKs in the three new districts and 90% in Nilphamari district. Among them, 6% and 10% of pregnant mothers received antenatal respectively in the three districts and Nilphamari. The number is quite low in all the districts due to irregular organization of satellite clinics in the community. Remarkable progress was achieved in case of continued service delivery in Nilphamari. About 92% of women were reported to have received +4 antenatal visits throughout the pregnancy period. It was found that 74% of mothers in the three new districts received +4 antenatal visits by SKs -a significant increase from 14% found in the baseline survey. This high achievement is attributed to the SKs providing antenatal check-up through home visits.

2.4.3 Maternal Danger Signs

The baseline survey indicated that the level of knowledge among mothers regarding pregnancy-related danger signs and its management (e.g. calling BRAC staff using given mobile numbers and going to a hospital without delay) was very poor (7%) in Mymensingh, Rangpur and Gaibandha. This situation has improved as a result of the project's continuous efforts and inputs. A very recent LQAS report showed that 69.2% women who had recently delivered knew at least two danger signs related to pregnancy, 40.2% were aware of seeking help from BRAC staff and 76.7% knew about seeking medical care from a hospital. In Nilphamari this rate is even higher-53% and 93.9% respectively.

2.4.4 Birth Plan

During visits in the antenatal period, especially in the last trimester, SKs helps families make a plan for the upcoming delivery. They usually concentrate on four major issues among others: 1) place of delivery 2) attendant of delivery 3) saving and 4) transport. To emphasize this further, Pos also visit once in the last trimester and meet with the husband and other family members to motivate them. Rangpur was ahead of the four districts in terms of birth planning, where around 62% of the delivered women's' families had a birth plan. In Nilphamari this rate was 49%, and the reason for this low rate was that a significant number of posts for the Pos were vacant due the transfer of skilled staff to new districts. It took time to fill up those gaps.

2.4.5 Protection of Mothers with Tetanus Toxoid (TT) Vaccine

In the district of Nilphamari 92% received protection with the Tetanus Toxoid vaccine. In the three new districts the Tetanus Toxoid (TT) vaccine was administered to 84% of delivered mothers.

2.4.6 Delivery attended by skilled Birth Attendant

In all four project districts majority of the deliveries have been occurring at home. If hospital delivery is used as proxy indicator for skilled birth attendance, data shows that hospital delivery in Nilphamari was 22% and three other districts it was 16%. In order three districts areas, skilled delivery was 43% and out of all skilled deliveries, hospital delivery was 13-21% and home delivery was 25-30%. In Gaibandha, hospital delivery was very high due to presence of demand side financing in Gobindogonj UHC. Skilled attendance is also quite high both at home and in hospital in Rangpur, which could be due to the presence of tertiary medical college hospital and availability of practicing providers at close proximity.

2.4.7 Emergency Obstetric Care Service in Four intervention districts

Strengthening Emergency Obstetrical Care (EmOC) services covered under the DGHS programme, with specific focus on eight selected facilities. In 2009, 12 comprehensive and 19 basic EmOC facilities provided services. For the first time, out of 250 newly recruited doctors trained in obstetrics and anesthesia through Government funding, 20 doctors were deployed in these four districts due to strong advocacy.

2.4.8 Misoprostol

Women are given Misoprostol tablets immediately after delivery of the baby to reduce postpartum blood loss. It is observed that in case of home delivery, Misoprostol intake was 48% in Nilphamari indicating satisfactory results. In the three other districts the intake increased from 0.5% at baseline to 31% within a short span of intervention. Although the percentage of Misoprostol use remains low due to late initiation, the rate of Misoprostol use is increasing with time.

2.4.9 Maternal Complications

From January-December 2009, 43,743 mothers in three districts were referred to different facilities for pregnancy related complications during pregnancy, child birth and postpartum period. It has been calculated that around 22% of the women at risk experienced some sort of physical problem that required medical attention. In Nilphamari the number of referrals was 12,187 and the percentage was 36%, which was quite high due the effective referral system. People are now seeking healthcare much earlier than before. This change has transpired due to the assistance of the BRAC staff in the community as well as in the facility level.

2.5 Neonatal Health

The SS and NHW are trained in providing immediate newborn care. The proportion of newborns protected with thermal care increased from 18.5% at baseline to 72% in the three new districts and 95% in Nilphamari. This significant achievement was possible due to the continuous awareness-raising among mothers and families, strengthened training of SS and NHW, improved attendance of SS/NHW during delivery and incentivizing them for their performance.

2.5.1 Early initiation of Breast Feeding

Breastfeeding was initiated in around 94% of newborn babies in Nilphamari within the first hour of birth. Early initiation of breastfeeding was 80% in the three districts, which has increased from 51% at baseline. A positive change in favor of breastfeeding practice has been observed as a result of the continuous motivation of mothers and care-givers, interactions with family and presence of SS/NHW during deliveries.

2.5.2 Low Birth Weight

Around 17% of the babies were reported to be low-birth weight (LBW) in the three districts. This rate is very low compared to the national average of 33-36%. All the LBW babies were managed at home with special care. At the end of the 28th day all were again checked for weight gained. Babies fewer than 300 gm were referred to a hospital for further care. In the project area over the reporting period 65% of the LBW babies gained >300 gm weight within 28 days. In Nilphamari 36,200 babies were delivered during the reporting period, of which 28,770 (79%) had been weighed by the SKs within 48 hours of delivery. Data showed that 24% of the babies were below the range of normal weight and 81% of these babies gained the desired weight within the first month of life.

2.5.3 Management of LBW Baby

The knowledge of caring for a baby weighing less than normal weight with some special care was surprisingly high in the baseline (44.8%). After approximately one year of intervention 69.4% mothers could cite at least one special care.

2.5.4 Birth Asphyxia

Birth asphyxia is one of the most common contributors of all neonatal deaths, which allows very little time to respond in saving life. In the district of Nilphamari 2% of birth asphyxia was diagnosed by SS/NHW during home deliveries. Among the identified asphyxiated neonates, 67% were clinically managed with mouth to mouth breathing by SS/NHW. Similarly in the three new intervention districts 2% of birth asphyxia was diagnosed by SS/NHWs of which 76% were managed. The rest of the neonates were referred to health facilities for treatment.

2.5.5 Neonatal Sepsis

In the project area the SS identifies neonatal sepsis symptomatically and informs BRAC staff for confirmation. BRAC staff refers the case to a hospital or, with parental consent, starts treatment in the community. In three new districts, only 1.4% of the total neonates were diagnosed with sepsis. Of the diagnosed cases, 93% were referred, which was 19% at baseline. In Nilphamari the identification of neonatal sepsis was 3% and referral was 98%. If compared to national estimation, identification of neonatal sepsis was quite low. This is because neonatal health intervention is very new in the community and will

require more time for the development of skills and confidence among health workers and for awareness-building among women and families.

2.5.6 Neonatal Danger Signs

Initially, 18% of the mothers were informed about neonatal danger signs and its management. Knowledge of at least two symptoms or signs of life-threatening complications in the newborn was 61.8% according to the LQAS result. The care-seeking knowledge for any kind of illness was also satisfactory. Around 36% of the mothers cited seeking care using BRAC's mobile number and 75% spoke of going to hospital to care.. In Nilphamari the responses were 37% and 91% respectively.

2.6 Child Health

In Nilphamari 64% of children were exclusively breast fed for six months, while in the three new districts 50% of the children were exclusively breast fed for six months. The percentage of exclusive breastfeeding was 46.6% and 21% at the baseline in Nilphamari and the three new districts respectively.

2.6.1 Immunization

Children aged 13 months must be protected with vaccines listed under Expanded Programme on Immunization (EPI). In Nilphamari, 94% of children aged 13 months were fully immunized with EPI vaccines and in the three new districts 92% of the children received full coverage. At baseline the percentage was 88.2% and 88.4% respectively in Nilphamari and the three new districts.

2.6.2 Acute Respiratory Tract Infection (ARI)

Under-five children receiving ARI care include all children aged 29 days to 5 years. Shasthya Shebikas received training on ARI diagnosis and community management using the IMCI protocol. They treat cases under the direct supervision of Shasthya and Kormis. During the initiating of the programme, around 5.9% of the mothers of under-five children were able to identify symptoms of ARI and were aware of the required courses of action e.g. seeking care from SS, calling numbers provided by BRAC or seeking care from hospital. The LQAS data showed that 65.3% mothers could state at least one of the above-mentioned ways to address the issue.

2.6.3 Diarrhoea

Children Under-5 receiving care for Diarrhoea includes all children aged 29 days to 5 years. Shasthya Shebikas received training on diagnosis and community management using the Oral Rehydration Saline (ORS). They treat cases under the direct supervision of Shasthya Kormis. Diagnosis of Diarrhoea was 2% in Nilphamari and 1.5% in the three districts out of which 98% and 95% respectively, were managed by SSSs and also referred to hospitals for better management. There was an increase from baseline at 88%. Shasthya Shebikas and Shasthya Kormis – the field level health workers- inform and educate the community about proper healthcare for pregnant and lactating mothers, neonates and under-five children through continuous person to person contact. Different folk music shows in line with the native culture and tradition have also been organized to depict and relay the same messages in an entertaining manner. These have been found to have a significant impact over the community. Additionally, to improve the knowledge of the mass population, messages calling attention to maternal signs and immediate response to emergencies have also been aired on the most popular television and radio channels in Bangladesh.

CHAPTER – THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the methodology of this research study. It explains the research design, process, categories of respondents, the way of questionnaire development, and data collection & analysis techniques used for this study. It also covers the limitations of this study.

3.1 Research Method

Research method is the functional action strategy to carry out the research in the light of the theoretical/analytical framework and guiding research questions and or the proposed hypotheses. There are three broad types of methodology to carry out any research: quantitative method, qualitative method, and mixed method. In the present study, data were collected using the quantitative method.

3.2 Sources of Data

Both primary and secondary data have been used in this study. However, this research is mainly dependent on the primary data collected through the questionnaire survey method. It is considered as an effective method to seek a large sample size for quantitative data analysis. Secondary data have been collected from published documents in the form of books, newspapers and the internet browsing.

3.3 Research Instruments

This piece of research has been performed through questionnaire survey method. This study mainly depends on the primary data collected through questionnaire survey. Therefore, the questionnaire prepared for the survey is the main research instrument of this empirical study.

3.4 Questionnaire Administer

Set of questionnaire have been prepared for collecting primary data through questionnaire survey to perform the stipulated research work. The researcher under the direct supervision of Dr. Zuhural Islam has administered the set of questionnaire.

3.5 Survey Respondents

The 30 respondents were participated to answer the questionnaires openly. I got much valuable information from them. I took much time for detail information about BRAC Health Programme in Panna Textile in Khagan.

3.6 Data Analysis and Presentation

Data analysis is where the researcher continually reflects on collected data, thus moving deeper for understanding and representing the data, deriving an interpretation of the larger meaning of data. The essence of this study is to convert large quantities of data into condensed forms to facilitate an easy interpretation and understanding for the readers. In this study, the obtained data has been analyzed through the quantitative method. After getting the data collected through Questionnaires Survey, they will be categorized and analyzed by using statistical tools and other arithmetic methods of data analysis available and viable. In some cases, to present the findings of data, graphic manner can be used with the aid of graphs and pie charts.

3.7 Limitation of the study

The study is expected to be based on empirical data from the existing from the people of Panna Textile. To collect data from Panna Textile, I faced several hurdles like time constraints. Most of respondents were females because of the time of survey that was working time for the males. Nevertheless, within the stipulated time this study has tried to cover the maximum number of respondents. Not time and not even resource allows covering the whole area for data collection for this particular study.

CHAPTER – FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents the survey data and analyses them in accordance with the research objectives and given appropriate arguments with findings. It also provides a comparative study between the findings of the present research and those of other relevant researchers under the title of discussion. The aim of this chapter is to convert large quantities of data into condensed forms to facilitate an easy interpretation and understanding for readers.

4.1 Respondents' Particulars

Respondents have been selected based on availability. Different particulars of the respondents, especially genders, educational qualification have been considered for this study.

4.2 Demographic Information of Respondents

According to the villagers the Khagan village has approximately 400 to 450 households. It is also found that the numbers of the households of the village are growing. As it is an industrial area, lot of people come from other parts of the country for works. For that reason, the population is growing. The village has several institutions like BRAC University, City University, BRAC CDM, Amico pharmaceutical industry, GQ Ball pen industry, Panna Textile Mills, a primary school and five mosques. Muslim, Hindu, Buddha and Christians are living in the village. Other than these, there is no ethnic group found. We have collected data by taking interviews of 20 individuals. I tried to find out:

- i) What type of diseases the villagers are frequently suffering from last three months? and
- ii) What kind of health services they get from government, NGOs, private and other sources?

I also tried to find out what are the available health services they usually receive. According to our study I have found that most likely diseases they suffer from are fever, cold, asthma, weakness, diarrhea, skin disease, pain, headache, allergy, cough, worm etc.?

Diseases people of the research area are suffering from shown in the pie chart below according to percentage:

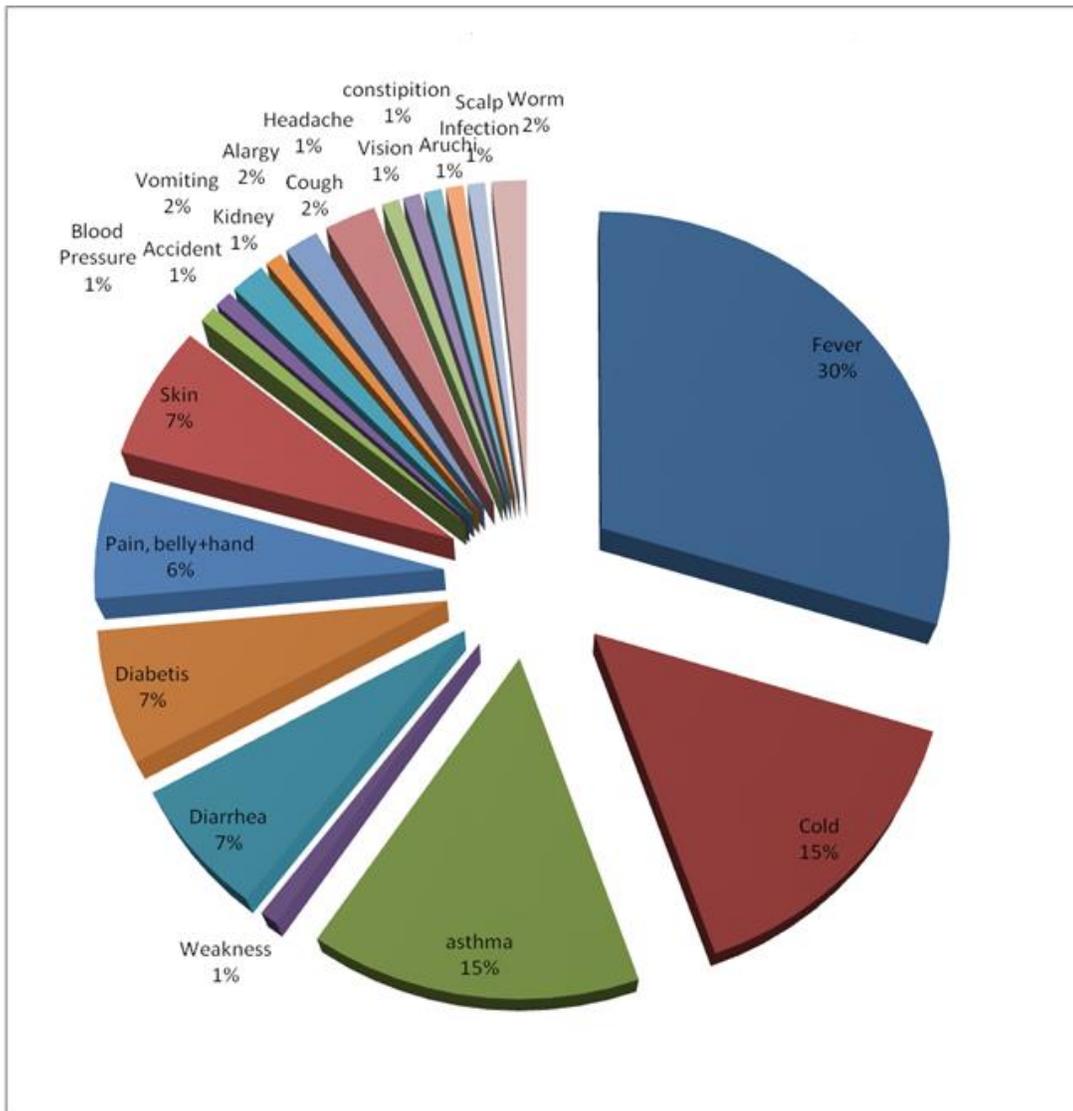


Figure No.1 Kinds of diseases that suffered in Panna Textile in the last three months

Above pie chart shows that 30% people suffer from fever, 15% people suffer from cold and asthma respectively. Skin, diarrhea and diabetes are 7% respectively. 6% people suffer from pain. Vomiting, cough and worms 2% respectively. Others diseases are weakness, blood pressure, accident, kidney, allergy, headache, constipation, ophthalmological problems, and skin problem in scalp are 1% respectively.

This graphical representation shows the different type of diseases suffered from by the male from above 18 years.

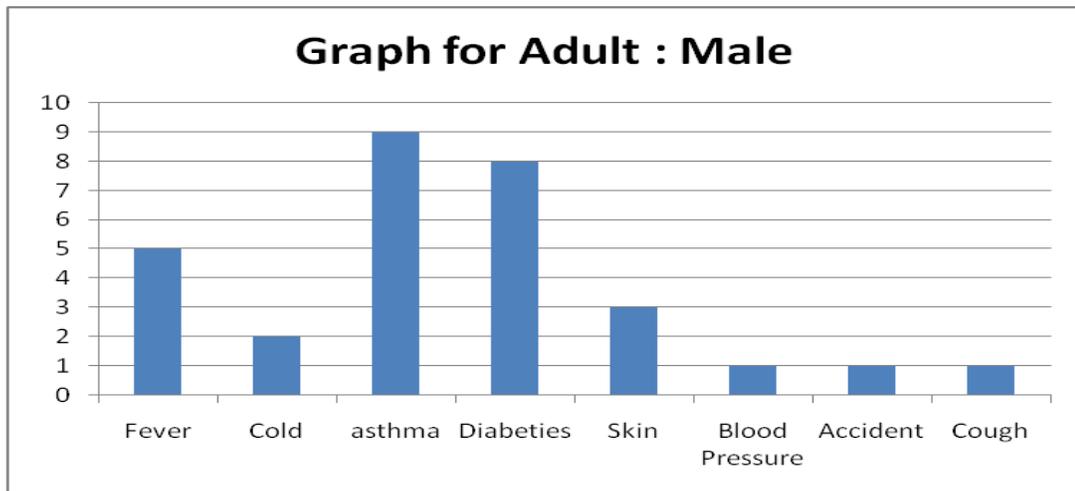


Figure No.2 Kinds of diseases that suffered by male above 18 years

Asthma is the highest ranking disease told by the respondents, second highest is the diabetes. Then gradually come fever, skin, cold, blood pressure, accident, and cough. Blood pressure, accident, cough are in the same rank.

For the 5-18 years children, the common diseases are shown in below:

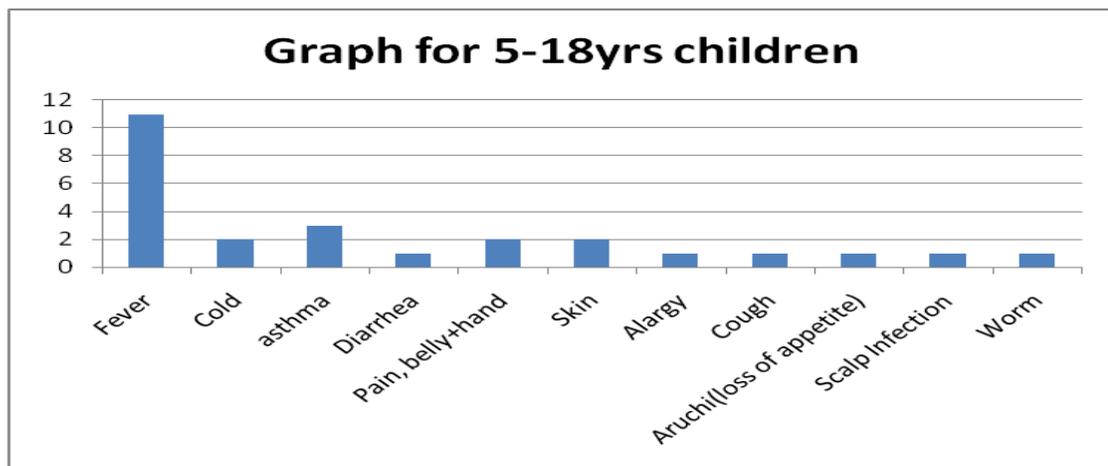


Figure No.3 Kinds of diseases that suffered by the 5-18 years children

Fever is the highest ranking disease told by the respondents, second highest is the asthma. Then gradually comes cold, pain, skin diarrhea, allergy cough, aruchi, scalp infection, worm. Dharrhea, allergy cough aruchi (loss of appetite), scalp infection, worm are in the same rank.

The common diseases of under 5 year's children are shown below:

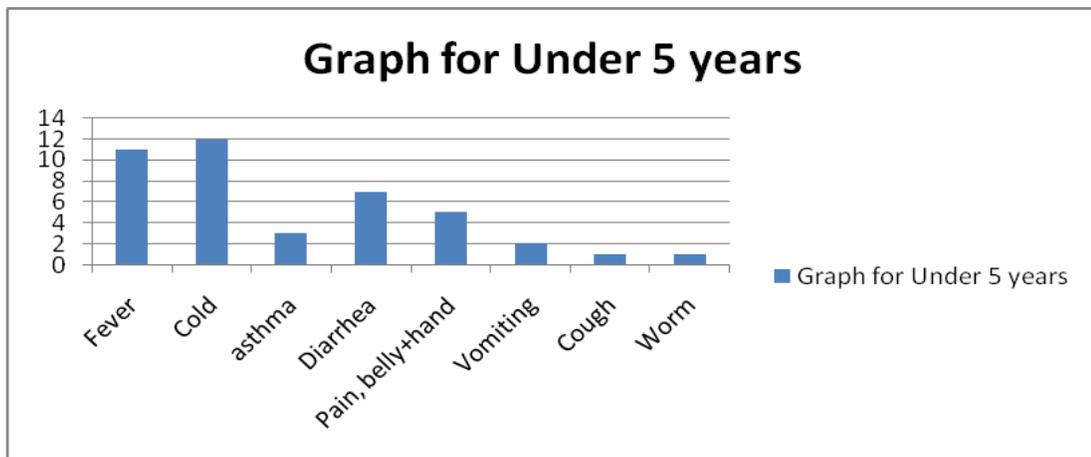


Figure No.4 Kinds of diseases that suffered by children under 5 years

Cold is the domination disease among the children of under 5 years. Then comes fever. Diarrhea, pain, asthma, vomiting, coughs and worm.

The common diseases of female are shown below:

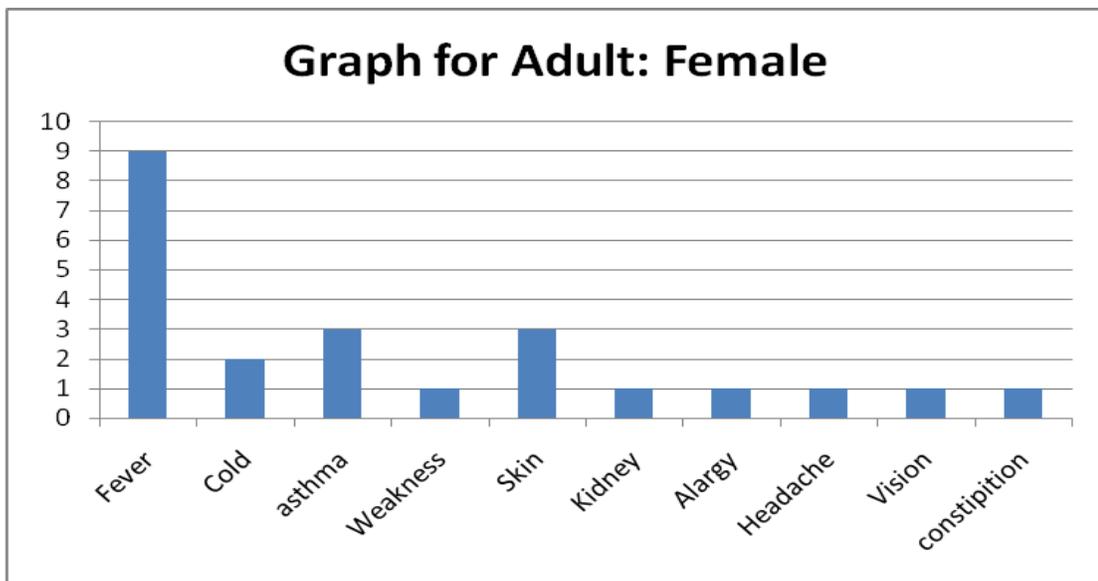


Figure No.5 Kinds of diseases that suffered by male above 18 years

Fever is the highest for woman of above 18 years. Then comes skin and asthma in same rank. Cold is third highest disease. Weakness, kidney allergy headache vision constipation is in lowest rank.

The villagers get all health services from BRAC Health Programme, private and traditional sources. Moreover some workers get their health service from their own organizations. None of the villagers received health services from government hospitals or clinic. Most of them thought that getting health services from the government institutions is troublesome and time consuming.

The graphical presentation of receiving health services are shown below:

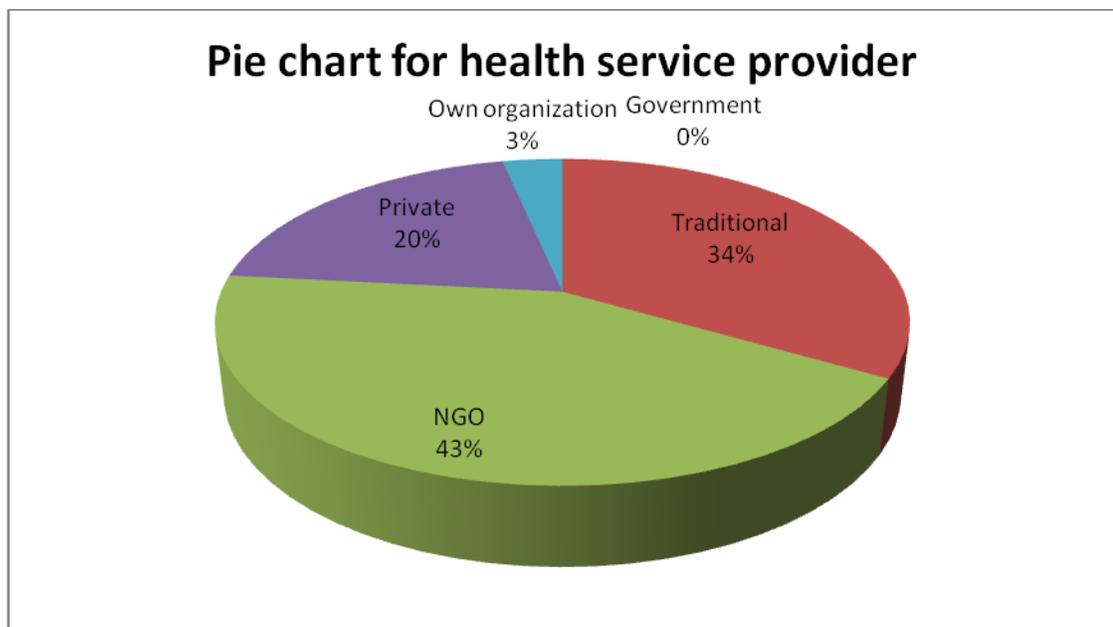


Figure No. 6 Health service providers in Panna Textile

No respondent told about receiving any kind of government health services. BRAC Health Programme (NGO) provides health service to the maximum people of that area which is 43% of the respondents. The payments for health service provided by the BRAC Health Programme are subsidized. Dependence of traditional medicine is still remarkable. 34% respondents take health service from traditional health service providers. 20% respondents take health service from private sector by their own cost. 3% respondents receive health service from their own organization.

All respondents are under the coverage of Expanded Program for Immunization (EPI) Due coverage of EPI, children do not suffer from diseases like tuberculosis, diphtheria, peruses tetanus, hepatitis-B, hip diseases, poliomyelitis, measles, night blindness.

From the BRAC Health Programme and private sources all of them, received treatment and medicine facilities. All of the cases they have to pay for the services. But people, who are getting health services from their own organizations, need not to pay. A significant part of the villagers also received traditional health services like kobirazi, quack doctor, tabiz, panipora, jharfuk etc.

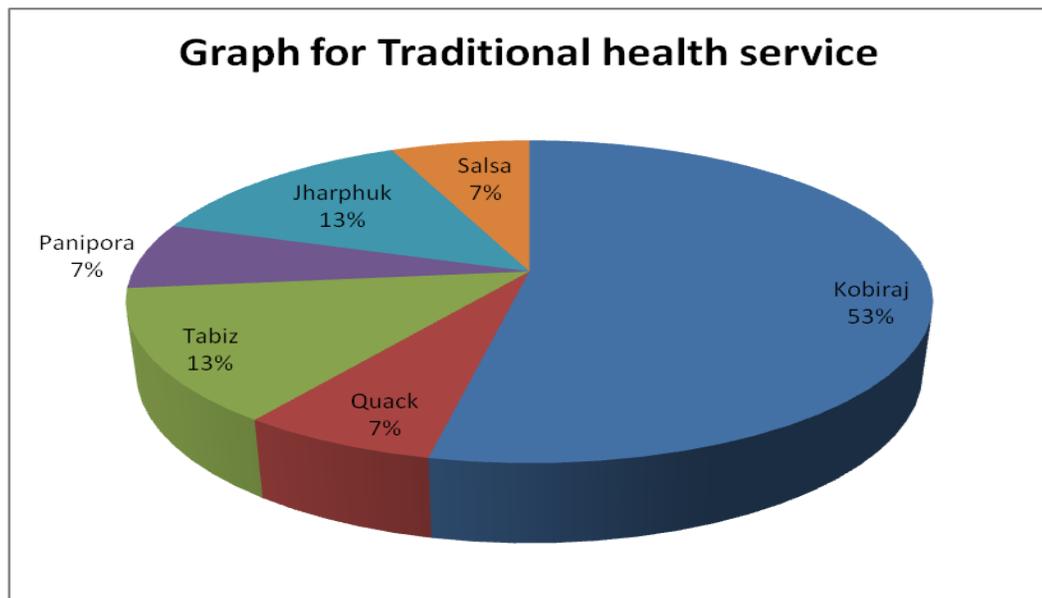


Figure No.7 Traditional health service in Panna Textile

CHAPTER-FIVE

CONCLUSION AND RECOMMENDATIONS

5.0 Conclusion

BRAC's health intervention is a combination of health, family planning and nutrition activities which covers prevention, curative, rehabilitative and promotional health services.

In Bangladesh, 8 per cent of the population is suffering from extreme poverty. Their health status lags far behind that of the general population. Essential Health Care (EHC) services for the ultra-poor under challenging the frontiers of poverty reduction – Targeting the ultra poor programme (CFPR-TUP) is specially designed to meet the needs of extremely poor households unable to access or benefit from traditional development interventions.

The goal of the programme is to reduce the vulnerability of the poor and ultra-poor to sudden health problems and to prevent them from sliding back into the vicious cycle of extreme poverty. The programme aims to increase access to health services, through demand-based strategies and by providing a package of basic health services which meets the needs of the ultra-poor. The financial constraint of the ultra poor is a major impediment in accessing available health services. To address this problem BRAC has introduced the provision of financial assistance to the ultra-poor so that they can access medical care from government or other health facilities. Community participation is ensured in the programme through community forums (Gram Daridro Bimochon Committee) which form an organized network for the improvement of health and the social status of the rural poor in each village. Committee members actively provide motivation and financial support to the ultra-poor for accessing different health services. BRAC facility based care started its journey in 1995. To meet the need of the community, the static health facilities have emerged to offer a package of curative, promotive and rehabilitative health services through a sustainable and comprehensive approach at a reasonable cost. Although more focus was given to offer services to vulnerable groups,

particularly women, adolescents and children, these health facilities offer a range of services to all groups of the population including males. BRAC Clinics are not just traditional clinics or hospitals but are emerged from the needs of the community and ensuring the availability of and accessibility to services. They utilize BRAC's existing community network, infrastructure and trained manpower. At present, BRAC runs 3 Clinics. BRAC Clinics provide both outdoor services and indoor services to patients. Major indoor services provided are caesarean section, normal deliveries, MR/ post-abortion care, major general surgery and major gynaecology surgery. To support the physically disabled population with rehabilitative aids and services, BRAC is operating BRAC Limb and Brace Centre (BLBC) which provides low-cost appropriate technology. At present, BRAC runs 2 BLBCs. Major Services provided are braces, physiotherapy, below knee prosthesis and above knee prosthesis.

5.1 Recommendations

1. In my study no life threatening and contagious diseases were found in the interviewees and their family members. Fever is the prominent disease in the area, Cold and asthma follows it. A few people told that they sometimes suffer from skin problem and diarrhea. Some also mentioned diabetes and pain. Vomiting, cough and worms cause some physical problem to a small number of children.
2. No respondent told about receiving any kind of government health services. BRAC Health Programme provides health service to the maximum people of the study area. They need to pay subsidized rate of expense for health service provided by the BRAC. Some people also take health service from private sector by their own cost. A small number of respondents receive health service from their own organization where they serve. Dependence on traditional medicine is still remarkable.
3. There are various industries like garment factories and textile industries located there. Due to some sort of unhealthy environment of factories, laborers become victim of tuberculosis (TB). That is why BRAC health workers visit garment factories in lunch break to give motivational lecture to the laborers to create

awareness of TB periodically. This is how awareness development about TB is done by NGOs and DOTs program implemented by the BRAC helps treat patients of TB of these area.

4. Respondents are neglected part of this area as they are the laborers of the ‘Panna Textile’ and they do not represent the mainstream population of the village. Seasonal map shows that they live in a labor barrack which is poorly arranged and shabby. They do not have any opportunity to go for homestead farming even. They are poorly paid laborer. They do not have any privilege to support them by any kind gardening for income support.
5. Lack of information about health services, absence of social and emotional support, inaccessibility to appropriate health facilities and inability to pay for treatments are still disturbance for that area.
6. The government spends about US\$ 5 per head on the Health, Nutrition, and Population sector programme (HNPPSP) while per-capita out of pocket expenditure is about US\$ 7 which is far short of the required level set by the World Health Organization (Financial Express, 2013). Government needs to allot more money for health care of the citizens. Present Health Services management is not also up to the mark.
7. Government health services cannot reach to the marginalized people. As BRAC Health Programme provide door to door health services peoples are now feel comfort to receive health care services for them. Either government needs to reach to poor and marginalized segment of the society or government should empower NGO’s to render better health services to this segment. Dependence on traditional medicine creates concern for us as it is not scientific. It may deteriorate poor health standard of this poor segment. Major life causing diseases are not mentioned by the respondents. That is a matter of satisfaction. But it may happen that they have some sort of problems like that which is not properly detected for the limitation of diagnosis. Access to Standard Health care service is still a far cry for the poor people of this country.

Expanded Programme for Immunization (EPI) helps reduce life threatening diseases like diphtheria, whooping cough, measles, tetanus etc. The study reveals that financial and technical support is very helpful to ensure health service among village people.

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SURVEY QUESTIONNAIRES
BRAC Health Programme Evaluation: A case of Labour Colony Panna
Textile, Khagan, Savar, Dhaka

Questionnaire:

(Dear respondent, this survey questionnaire has been designed in order to collect data for academic research only. Strict confidentiality about your identity will be maintained. Your sincere cooperation will add countless value to the research.)

Name: Mr. /Mrs. _____ **Age** _____ **Sex:** Male/ Female

Profession: _____ **Income:** _____

1. For the last 3 months what kind of diseases are you suffering from?

- a) Fever
- b) Diarrhea
- c) Cold
- d) Asthma
- e) Diabetic
- f) Others

2. Please mention some disease in the following age group.

- a) Children under 5 years:
- b) Children 5-18 years:
- c) People above 18 years:

3. Where from you get health services?

- a) Government
- b) NGO
- c) Traditional

d) Others

4. Do you usually pay for treatment?

YES

NO

5. Does your organization pay for health treatment?

YES

NO

6. Does BRAC Health Program provide you Health Treatment Service?

YES

NO

7. If EPI (Expanded Program for Immunization), do BRAC Health Service charges you for treatment?

YES

NO

8. What are the available health services you get from NGO's?

a) Treatment

b) Medicine

c) Both

d) None

9. What are the traditional medicines or treatment you accept?

a) traditional medicines

b) treatment

10. Others

Thank you for your cooperation.