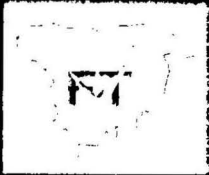


ফুলসাইন্দ পল্লীস্বাস্থ্য উন্নয়ন কেন্দ্র  
Fulshaind Pollishasthya Unnayan Kendro

Baseline Survey  
1997



 BRAC



Fulshaind Village Trust (UK)

# Fulshaind Pollishasthya Unnayan Kendro

## *Report of the Baseline Survey 1997*

Abdullahel Hadi *MA, DrPH*

Firoz M Kamal *MBBS, MPH*

Research and Evaluation Division  
BRAC, Dhaka, Bangladesh

---

Fulshaind Pollishasthya Unnayan Kendro (FPUK)

P.O. Fulshaind - 3108, P.S. Golapganj

Sylhet, Bangladesh

# EXECUTIVE SUMMARY

## 1. Introduction

### 1.1 Background

Although a considerable amount of resources has already been spent, Bangladesh has achieved very little in reducing mortality and improving health status of the population. No appreciable change in the socio-economic condition of Bangladesh has been observed since it achieved independence in 1971. Both the government and non-government organisations have been providing maternal and child health (MCH) and family planning programmes. Unlike health services, the family planning programme has achieved appreciable success in Bangladesh as a whole.

It is now widely recognised that an integrated health and development project, focusing on various dimensions of human life, might be an appropriate measure to improve overall health condition of a rural community in Bangladesh. Given this backdrop, Fulshaind Pollishasthya Unnayan Kendro (FPUK), a small independent voluntary development organisation, came forward with an ambitious project, although limited in scale, with an attempt to improve the health and socio-economic development of a rural community.

The *Fulshaind Pollishasthya Unnayan Kendro (FPUK)* is located at Fulshaind village under Lakshmanabond union of Golapganj Thana in Sylhet district. Its project area, at present, covers the whole of the Lakshmanabond Union and three other outlying villages of the neighbouring union covering approximately four thousand households.

### 1.2 Objectives

The baseline survey has generated estimates of various socio-economic, demographic and health status of the project area such as literacy, land ownership, economic condition, mortality, health practices, fertility, contraceptive prevalence rate, tetanus toxoid (TT) vaccines coverage during pregnancy, immunisation among children, and water and sanitation. The survey data will be compared with similar set of estimates to be collected again when this phase of the project closes. The differences of comparative estimates are expected to provide a clear picture of the impact of the development programmes of FPUK in the project villages.

### 1.3 Methodology

The survey was designed to be representative of the project population. The samples were selected from the sampling frame following systematic random sampling technique. The community information was collected from the relevant personnel working at the grassroots level in the project areas. The study was designed and implemented by the Research and Evaluation Division of BRAC in collaboration with FPUK during April-May of 1997.

## **2. Key Findings and Issues**

### **2.1 Most people in the project villages are living in poverty**

Despite improvement in literacy in recent decades in Bangladesh, socio-economic conditions still remain very low in the project area. More than half of the households are landless and an additional one-fifth have only a marginal amount of land. Most of the people live in poor houses. Only very few households possess consumer assets. Such nutritious foods as meat, egg and milk are rarely consumed by many people.

### **2.2 Opportunity to economic advancement is limited unless a major development intervention is initiated**

Despite a high out-migration of adult male population, a significant proportion of the population is unemployed or under-employed. As agriculture has remained the main economic activity in the area and as no shift of economic activities is visible except a few micro-credit schemes in a limited scale involving only women, it is unlikely that the economic condition will improve in the near future.

### **2.3 Although fertility has remained very high the possibility to reduce it is promising**

Total fertility rate has remained very high in the project area while fertility has been rapidly declining in other areas of the country. Attention must be given to acceptance of contraceptive method since the driving force behind the decline in fertility has been widely regarded as contraceptive use. The possibility to raise contraceptive use in the project villages is very high and promising.

### **2.4 Immunisation coverage is poor as a result of inaccessibility and lack of services**

Both the maternal and child immunisation in the project villages is very low although such health interventions as child immunisation, tetanus toxoid and safe delivery practices have been playing an important role in reducing mortality. Such low coverage indicates the inaccessibility or the lack of services in the project villages. Existing service delivery mechanisms should be strengthened through appropriate information, education and communication (IEC) activities.

### **2.5 Contraceptive acceptance is very low and the temporary methods are wrongly favoured and promoted**

The contraceptive prevalence is unusually low in the project area and is dominated by the use of pill and injectables while such other methods as IUDs and sterilisation are ignored. Reliance on spacing methods (pills and injectables) will be expensive and, therefore, may not be sustainable in the long run.

## **2.6 Improving sanitation system deserves special attention as the defecation behaviour has remained very unhygienic**

Only 27 percent of the households have access to either sanitary or slab latrines. A third of the adult population defecates in such unhygienic places as hole latrines or open places. Most of the defecating places are located within the compound close to the house. Unhygienic defecation by so many households indicates the poor sense of the need of cleanliness. While it would be very difficult, if not impossible, to change the culturally acceptable defecation practices in near future, providing low cost latrines to the poor families may be a good start.

## **2.7 Mortality rates are unacceptable by any standard**

Mortality estimates in the project areas are undesirably high as the neonatal mortality rate is 25.4 and infant mortality rate is 84.1 per 1,000 livebirths. This picture is clearly undesirable and unacceptable by any standard. A major health intervention in the project area was long overdue.

## **2.8 Traditional practices of child care should be replaced by safe childhood programme**

Only 43 percent of children are given colostrum during their birth and only 35 percent mothers practice exclusive breastfeeding indicating that the need for maternal and child health in the project is very high. Nearly two-third of the <5 year old children are malnourished. This situation can be improved by promoting breastfeeding practices and reducing morbidity among children by preventive measures.

## **2.9 Health care services are grossly inadequate**

The provision of safe delivery practice is grossly inadequate in the project area. Trained TBAs have assisted only 14.8 percent women. Nearly 30 percent of the sick persons receive treatment from a qualified physician while an other 42 percent can go to paramedics if needed. A well-tailored MCH programme targeting the problems at the grassroots can significantly reduce maternal and child mortality.

## **3. Concluding Remarks**

The socio-economic, demographic and health condition of FPUK project area, as discussed in this survey report, reflects that existing governmental development programmes have achieved very little in reducing mortality and improving socio-economic well-being in the project villages. Mortality, health practices, fertility, contraceptive practices and immunisation coverage seem to be worse than other areas of the country. The findings and interpretations, presented in the report, may not be comprehensive enough to understand the project communities. Nonetheless, the issued presented and discussed here would help understand the prospect and constraints in achieving the project goals.

## CHAPTER 10. SUMMARY AND IMPLICATIONS

This section of the report summarises the key findings of the baseline survey. The purpose here is to provide a picture of the socio-demographic, economic and health condition of the population living in the FPUK project villages. No attempt has been made to discuss the causes and consequences of a condition, event or characteristics. However, policy implications of the proposed FPUK health programmes in the area are provided where necessary.

Overall, the socio-economic condition of the study villages is not significantly different from the situation of the rest of the country. In some respects, the situation is better than expected. For example, literacy is higher in the project villages than the national average. The proportion of secondary and higher education, however, is very small indicating that emphasis should be given to secondary and higher education. Enrollment rate in the study area is also reasonably high although it could be even higher *if the community and gender variation in school enrollment is reduced by undertaking appropriate measures.*

Agriculture has remained the major occupation among adult men while virtually all adult women are involved in household activities. The dependency ratio in the FPUK project area is very high as a result of high fertility rate in the project villages. Sex ratio is also skewed to female probably because of high out-migration among male population. Unemployment in the project villages is also found very high although significant village level variation is reported. However, *this scenario of employment situation is no worse than the other parts of the country.*

*Poverty is widespread in the area.* This is reflected in the standard of living. Most of the houses where they live are poorly built. The concrete structure is rarely found indicating the poor economic condition of people. Poverty is also reflected in the distribution of cultivable land as more than half of the households are landless and additional one-fifth have only marginal amount of land. Only a small proportion of households has such assets as television, radio, boat, cycle, etc. The staple food is rice for almost all households. Such nutritious food as meat, egg, milk, etc. are poorly consumed. The food consumption pattern, however, varies widely by village. As the scarcity of cultivable land exists in the project area, nearly half of the households depend on selling manual labour for their livelihood. The overall socio-economic condition in the project villages also differs significantly.

The total number of the households in the project villages is 4,075 distributed in 10 villages. No government clinic or hospital is found in the communities. FPUK has been planning to build a community hospital in one of the project villages. NGOs like Grameen Bank, BRAC and CARE are found active in the project area. But none of these NGOs has major health programmes in the area. This suggests that *the institution-based services in the communities are inadequate.*

The population growth in the area was much faster in recent decades than before. The crude birth rate is higher than the national average. The general fertility rate is also very high. The total fertility rate (TFR) is estimated as 6.44 for the project villages. This growth rate is alarming. *It is, therefore, suggested that adequate measures should be taken to reduce such population growth rate.*

While fertility has been rapidly declining in other areas of the country, the TFR has remained very high in FPUK project areas. *Attention, therefore, must now be given to whether conditions are conducive to raise contraceptive use since the driving force behind the decline in fertility has been widely regarded as*

*the rapid rise of contraceptive methods* (Mitra et al., 1994). The national surveys have indicated that rural couple in Bangladesh wants to reduce fertility and the demand of family planning services are growing. But the corresponding contraceptive use rates are very low in the project areas. *This suggest that the possibility to raise contraceptive use in the NGO project areas is very high and promising.*

Like the national scenario, the contraceptive use in the project areas is dominated by the use of pills and injectables while such other methods as IUD and male sterilisation are ignored. Reliance on spacing methods (pills and injectables) will be expensive and, therefore, may not be sustainable in the long run. *Therefore, the FPUK should provide emphasis on much more desirable alternatives such permanent and semi-permanent methods (ligations, IUD, etc.).*

The crude death rate in the project area is higher than the national average. Mortality estimates in the project areas are undesirably high as the neonatal mortality rate is 35.4 and infant mortality rate is 84.1 per 1,000 livebirths. The prevalence of disease is also very high. Nearly 30 percent of the sick persons receive treatment from a qualified physician while other 42 percent can go to paramedics if needed. This picture is clearly undesirable and unacceptable by any standard. *A major health intervention in the project area was long overdue.*

Maternal and child mortality along with complication during delivery has remained a serious health problem in Bangladesh. This report also shows that the provision of safe delivery practice is grossly inadequate in the area. Trained TBAs have assisted 14.8 percent women. *A well-tailored MCH programme targeting the problems at the grassroots is expected to have significant role in the reduction of maternal and child mortality.*

Both the maternal immunisation during pregnancy and child immunisation coverage in the project villages are found be very low compared to any national rural estimates available. Programmatic factors such as child immunisation, tetanus toxoid and safe delivery practices have already playing important role in reducing mortality. But the service coverage in the study area is still below the national level. Only 54.2 percent of women are completely immunised from tetanus at the time of delivery of children. Such low immunisation coverage indicates that the heavy dropout or discontinuation from the programme in the project villages. *Existing service delivery mechanisms can be strengthen through appropriate information, education and communication (IEC) activities where FPUK health workers can play an effective role.*

Only 43 percent of children are given colostrum during their birth and only 35 percent mothers practice exclusive breastfeeding indicating that the need for maternal and child health in the project is very high. Nearly two-third of the <5 year old children are found malnourished. A significant proportion of them is severely malnourished. No significant sex variation is reported. *This situation can be improved by promoting breastfeeding practices and reducing morbidity among children by preventing measures.*

The use of safe drinking water is almost universal but only 17.5 percent of the households use safe water for other purposes. Only 27 percent of the households have access to either sanitary or slab latrines while a third of the adult population defecates in such unhygienic places as hole latrines or open places. Most of the defecating places are located within home. Unhygienic defecation by so many households indicates the poor sense of the need of cleanliness. *While it would be very difficult, if not impossible, to change the culturally acceptable defecation practices in near future, providing low cost latrines to the poor families may be a good start. In addition, health education, routine follow-up and close monitoring by the programme staff must be ensured.*

The socio-economic and health status of FPUK project areas, as estimated in this survey report, is no better than elsewhere in Bangladesh. Mortality, health practices, fertility, contraceptive practices and immunisation coverage, etc. seem to be worse than other areas of the country. The findings and interpretations, presented in the report, may not be comprehensive enough realise problems of the study communities. Nonetheless, it is expected that the issues presented and discussed here would help understand the prospect and constraints in achieving the project goals.