



IMPACT ASSESSMENT OF SHEBA HEALTH PROGRAM

June 2020



বিস্তারিত Bangladesh Extension Education Services (BEES)



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Abbreviations and Acronyms

ANC:	Antenatal Care
BBS:	Bangladesh Bureau of Statistics
BCC:	Behavior Change Communication
BDHS:	Bangladesh Demographic and Health Survey
BMI:	Body Mass Index
BRAC:	Bangladesh Rural Advancement Committee
BRDP:	Bogura Rural Development Project
CC:	Community Clinic
CDC:	Communicable Disease Control
CF:	Complementary Feeding
CPR:	Contraceptive Prevalence Rate
CRWRC:	Christian Reformed World Relief Committee
C-section:	Caesarean Section
EBF:	Exclusive Breast Feeding
EPI:	Extended Program for Immunization
FGD:	Focus Group Discussion
FP:	Family Planning
FWV:	Family Welfare Visitor
FYP:	Five Year Plan
GMP:	Growth Monitoring and Promotion
GOB:	Government of Bangladesh
HH:	Household
HIV/AIDS:	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IUD:	Intrauterine contraceptive device
MCH-FP:	Maternal and Child Health, Family Planning
M&E:	Monitoring and Evaluation
MDG:	Millennium Development Goal
MNCH:	Maternal Neonatal and Child Health
MoH&FW:	Ministry of Health and Family Welfare
NGO:	Non-Government Organization
NID:	National Immunization Day
NSV:	Non-Scalpel Vasectomy
NVD:	Normal Vaginal Delivery
PNC:	Postnatal Care
PVT:	Private
R&D:	Research and Documentation
SBA:	Skilled Birth Attendant
SVRS:	Sample Vital Registration System
WB:	World Bank
WHO:	World Health Organization



BEES contribution to the development field is to alleviate poverty and empower the poor of rural and urban areas. It is registered as a national NGO which has been working for the last few decades for bringing about socio-economic changes in the lives of the poor, illiterate, neglected, unskilled and malnourished people, especially women and children of the society through empowerment. The development drive executed by BEES was initially started as Bogura Rural Development Project (BRDP) under Christian Reformed World Relief Committee (CRWRC) in 1975. The project along with assets and staffs was handed over to BEES in 1984. Since then, with a new mission and vision, BEES started its operation by refreshing the ongoing activities as per need and demand of the clients and extended its activities in other areas of Bangladesh. BEES has enhanced self-reliance efforts of more than 5.8 million people so far. BEES sets forth its activities with the objectives of accomplishing the factors that promote or boost development by giving emphasis on sustainability, behavioral change and women empowerment in terms of universal literacy, access to health care, including WatSan, promotion of personal hygiene and sanitation, nutrition education, rights and governance and income and employment generation for livelihood development.

A major emphasis is given specially on the access to health care. BEES initiated a self-funded development program 'SHEBA' which implements numerous development activities including health, education, agriculture and insurance for the target people. Among other development activities, Sheba Health program has been carried out since July 2002. The core activities of this health program are preventative and curative care with regard to Maternal and Child Health, Family Planning (MCH-FP), treatment of general diseases, nutrition education and referral services for complicated patients. Under this program, BEES introduced BCC (Behavior Change Communication) which provides intensive interpersonal communication, along with social mobilization and advocacy for building awareness among target groups about health, nutrition education and different social issues such as demerits of early marriage, dowry, child labor and women's rights. These development activities are being implemented in Narsingdi, Kishoreganj, Gopalganj, Bogura and Gaibandha districts of Bangladesh. The sheba program activities are financed by surplus generated from BEES microfinance program. The sheba program will be extended to all working areas of BEES as more surplus is expected to be generated in the coming years.

Due to some limitations and hurdles, BEES was not able to conduct studies on the program's activities for the past 17 years. Therefore, BEES decided to conduct an impact study on "Sheba Health Program" to assess the achievements and drawbacks of the program to come up with a better strategy to successfully continue the program ahead. Considering the indicators, Research and Documentation (R&D) cell of BEES had developed the questionnaires for conducting the study. Some secondary information on different indicators was also incorporated to make the report more reliable. The estimated figures may differ in comparison with the national estimates as the study population is limited to the above-mentioned districts.

The responsibility was given to the R&D cell of BEES for conducting the survey. The personnel of R&D cell carried out the study taking the assistance of relevant staffs of the cell, staffs of Sheba Health Program of BEES's central office and the unit offices of Bogura, Gaibandha and Narsingdi districts, who were directly connected with the activities from the beginning to date.

I extend my gratitude towards the members of our R&D cell of BEES, and special thanks to the staffs of Sheba Health program, the staffs of Bogura, Gaibandha and Narsingdi unit offices and Coordinator (M&E) for their dedication to carry out the study successfully.

I also extend my gratitude to Dr. Naushad Faiz to lead the research team as a Team Leader.

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Executive Summary

Introduction

Bangladesh is one of the most densely populated countries in the world with a population of roughly 157.9 million people living in an area of 147,570 square kilometers. Providing all the basic necessities to this large population is very challenging. The health services needed to fulfill the demand of the people are also quite limited. Considering these limitations, BEES has been implementing a health program since its inception and providing health services to the underprivileged population of the country. Among all the health programs of BEES, Sheba Health Program is a unique initiative that was started in July 2002. This program is run with the surplus from BEES's Microfinance Program. Thus it is a self-funded program of the organization. Currently, Sheba Health Program is providing health services to the targeted underprivileged people of Narsingdi, Kishoreganj, Gopalganj, Bogura and Gaibandha districts of the country in order to improve their health status.

The goal of the program is to improve the health status and develop the standard of living of the targeted families in the intervention areas of BEES, and also to strengthen preventive and curative health services and enhance knowledge on health, nutrition, sanitation and personal hygiene, HIV/AIDS prevention and other relevant issues. The target beneficiaries of this program are the family members of borrowers under BEES microfinance program and other community members, especially women of reproductive age and children under the age of five.

Objectives and Methodology of Study

After implementing the program for the last decade, BEES conducted a study during November 2018-January 2019 to assess the impact of the program. The major objectives of the study were to: (a) assess the impact of the health services received by the target beneficiaries of the program; (b) measure its effectiveness; and (c) take initiatives to improve the strategy of interventions and document the learning throughout the implementation of the program.

A total of 20,741 beneficiary families, consisting of around 84,208 members, were covered by the Sheba Health Program. In order to credibly assess the program impact, both quantitative and qualitative data were collected from various sources. The major sources of data included listed households, households from outside the list, local elites and program implementers. Structured questionnaires were used to facilitate the data collection process. The questionnaires were prepared for this survey along with the methods of data collection. Enumerators were given training before starting data collection and were closely supervised by the Research and

Documentation (R&D) team of BEES during the whole data collection process. This study is anticipated to serve as a source of information on the activities of Sheba Health Program, which extended its services to the target beneficiaries for the last 17 years. The information generated by the study is expected to be helpful for program implementers, policymakers and researchers.

Main Findings of Study

The major findings of the study are summarized below.

Children's health related findings

In the Sheba Health Program intervention areas, 91% children were fed colostrum immediately after exclusive breast feeding (EBF), and 88% were given complementary feeding after the completion of 6 months. On the other hand, initiation of complementary feeding before the appropriate age in the intervention area was less (12%). Majority of the children (91%) were fully immunized according to the EPI guideline. Neonatal and infant mortality rates are less in the intervention area when compared to other areas. For every 1,000 live births, neonatal (0 to 28 days) mortality was 26, infant (0 day to <1 year) mortality was 26, and the mortality rate for children under 5 years was 46. Also, 35% children below the age of 2 years in the intervention area were monitored using GMP cards. Of them, 26% had received services from BEES paramedics and 9% from government and other organizations. For children aged between above 2 years to below 5 years, 43.8% were monitored using GMP cards. Of them, 38.2% had received services from BEES paramedics and 5.0% from government and other organizations.

Mother's health related findings

Under the scope of Sheba Health Program, 44% pregnant mothers received delivery facility at home, where 6% delivery were facilitated by skilled birth attendants and 38% by unskilled birth attendants. For comparison with the national data, 62% pregnant mothers received delivery facility at home, according to the Bangladesh Demographic and Health Survey (BDHS) 2014. In the Sheba Health Program area, 56.3% pregnant women received delivery services from government and non-government hospitals. Among them, 37.5% underwent C-section, while 18.8% went for normal vaginal delivery (NVD). Besides, 57.5% pregnant women received delivery services from public and non-government hospitals in the program area. Among them, 40% had to go for C-section and 17.5% for NVD. BDHS 2014 shows that 37% women went to hospitals for delivery; among them 23% underwent C-section and 14% NVD.

Moreover, 33% pregnant mothers in Sheba Health Program area received delivery services from government health facilities, while 67% obtained the same from the private sector. In areas outside of the Sheba Health Program, the corresponding numbers were 35% and 65% respectively. In the program area, 93.8% pregnant mothers received antenatal care (ANC) services at least once. Among them, 37.5% received services from paramedics of BEES, 12.5% from public health facilities and

43.8% from other private health care providers. On the other hand, in the out-of-program area, 72.5% pregnant mothers received ANC services at least once. Among those mothers, 30% obtained services from the public sector and 42.5% from other private health facilities. In the out-of-program areas, there were no pregnant mothers who received ANC services from the BEES program. According to BDHS 2014 data, 64% pregnant mothers received ANC services at least once.

In the program area, 63.6% pregnant mothers received postnatal care (PNC) services at least once within 42 days of delivery. Among them, 18.2% received services from paramedics of BEES, 9.1% from public health facilities and 36.4% from other private health providers. On the other hand, in the out-of-Sheba Health Program area, 34.6% pregnant mothers received PNC services at least once. Of them, 15.4% obtained services from the public health sector and 19.2% from other private health facilities. There were no postnatal mothers who received PNC services from BEES. BDHS 2014 data shows that 36% pregnant mothers received PNC services at least once within 42 days of delivery.

Findings on BMI measurement

In the program implementing area, 35% adolescent girls were measured for Body Mass Index (BMI) with the full support of the paramedics of BEES. There was no other service provider in the area for providing this service. On the other hand, only 17% of adolescent girls were measured for BMI and only 2% were supported by BEES paramedics in the out-of-program area.

Status of health cards

In the program area, 3.6% households received health cards. Around 0.8% of the cards were distributed by BEES paramedics. In the out-of-program area, 3.8% households received health cards. However, there was no contribution of BEES paramedics in the distribution of cards in the out-of-program area.

Status of general treatment

In the program area, 70% households received general treatment. Among them, 20% received the service from program paramedics during 6 months prior to the survey. On the other hand, 58% households received general treatment in the out-of-program area, where there was no service rendered by the Sheba Health Program.

Status of Contraceptive Prevalence Rate

In the program area, 70.2% of eligible couples used modern contraceptive methods compared to 65.8% in the out-of-program area. Among all users of modern contraceptive methods, 29.8% received services from the public sector and 40.4% from private/NGO service providers in the program area. On the other hand, in the out-of-program area, 23.5% received contraceptives from public service providers and 42.3% from private/NGO sources. BDHS 2014 data shows that 54% eligible couples were modern method users.

In the area of Sheba Health Program, 57.5% of fertile married women, aged between

15 and 49 years, took pills compared to 59.9% in the out-of-program area. The rate of condom use in the program area was 7.5% compared to 8.9% in the out-of-program area. The rate of injectable use in the program area was 21.3% which was very closer to the out-of-program area. There was no fertile married woman who used intrauterine device (IUD). About 2.1% of the eligible men used non-scalpel vasectomy (NSV) in the program area, where as it was only 0.4% in the out-of-program area. The rates of implant and tubectomy were 5.4% and 5.8% respectively in the program intervention area, while the rates were 4.5% and 4.8% respectively in the out-of-program area. Thus, from the above discussion it is clear that the pill was the most preferred method of contraception in both program and out-of-program areas.

Status of Referrals

More than 7.4% of the patients in the program area were referred to government hospitals and clinics during six months prior to data collection. 0.55% of the cases was referred by the program's paramedics. In the out-of-program area, the proportion of referred patients was 6.5%.

Status of households' participation in demonstration sessions on supplementary feeding

In the program area, 19.2% of households participated in demonstration sessions on supplementary feeding for children. About 17.8% households participated in sessions organized by the BEES program. On the other hand, in the out-of-program area, the proportion of households participating in the demonstration sessions was insignificant, 0.8%. And only 0.3% households participated in demonstration sessions organized by BEES.

Use of Sanitary Latrines

In the area of Sheba Health Program, 71.8% households used sanitary latrines, 12.6% used latrines with broken water seal, and 15.6% used katcha/open latrines. In the out-of-program area, the proportion of households using these types of latrines was 75.8%, 14.5% and 9.8% respectively.

Conclusion

Overall, the impact of Sheba Health Program after seventeen years of implementation is quite satisfactory. Pregnant and lactating mothers, fertile couples, children from 0 to 5 years, and adolescent girls were the major target groups as beneficiaries of this program. Through the program, the beneficiaries received services on antenatal care, postnatal care, and family planning, etc. The paramedics of BEES provided services to the program beneficiaries through static and satellite clinics. They referred emergency or complicated cases to local government health facilities or clinics through collaboration with them. Significant achievement was seen in the intervention of colostrum feeding, complementary feeding, measurement of growth monitoring for children, ANC and PNC services, and BMI measurement of adolescent girls and pregnant mothers.

Major Recommendations

- Awareness sessions on the importance of colostrum feeding of newborns and exclusive breastfeeding of children up to the age of 6 months may be arranged for beneficiary pregnant mothers and their families. Different varieties of attractive BCC materials regarding these needs may be distributed to pregnant mothers at the time of ANC/PNC.
- Quality ANC may be ensured through incorporating most of the parameters of ANC for increasing the number of patients.
- Demonstration sessions on 'Health and Nutrition for Children and PNC/ANC Mothers' may be arranged to raise awareness of pregnant mothers and their family members.
- Sessions may be conducted through courtyard meetings to enhance awareness among fertile couples on the issue of maintaining proper birth spacing to keep up the sound health of mothers and children.
- Program implementers may create awareness among parents on the importance of immunization for children to increase the number of children under immunization program.
- Program implementers may create awareness among parents about the importance of GMP and provide colored GMP card for encouraging them to receive the service again.
- School program can be introduced in collaboration with the government's health program for including more adolescent girls under BMI measurement.
- For reducing home delivery by unskilled birth attendants, linkages may be established with appropriate service centers/persons whose list may be supplied to the beneficiaries.



Section 1: Introduction

BEES (Bangladesh Extension Education Services) initiated its Microfinance Program in 1988 to enhance the scope of socio-economic uplift and empower disadvantaged people, especially women. It was started in collaboration with Bangladesh Bank and later with Rajshahi Krishi Unnayan Bank (RAKUB). It is the major program of BEES and provides much needed capital to the beneficiaries to invest in various fields of developmental activities which help them generate income for their families. From the surplus income of the Microfinance Program, BEES has been contributing to several developmental activities through operating health, education and agricultural programs. Sheba Health Program is such a program by which BEES has been extending health support for its beneficiaries and other community people in its working areas. It was started in July 2002 as a Self Supported Development Program of BEES in Narsingdi, Kishoreganj, Gopalganj, Bogura and Gaibandha districts of Bangladesh (see map in Figure 1). These districts were selected for program implementation considering the vulnerability of the rural poor. Communication, economic opportunities, educational status and existing health services were taken into consideration while selecting the implementing area.

The goal of the Sheba Health Program is to “improve the health status and develop the standard of living among the target families in BEES intervention area.” Its objectives are to strengthen preventive and curative health services and enhance knowledge on health, nutrition, sanitation and personal hygiene, HIV/AIDS prevention, and other relevant issues. The target beneficiaries are the family members of the microfinance program and community people, especially women of reproductive age and children under five, in the intervention area.

The core activities of this program are preventative and curative services with regard to Maternal and Child Health, Family Planning (MCH-FP), treatment of general diseases, nutrition education and referral services for complicated patients. Under this program BEES also introduced Behavior Change Communication (BCC), which provides intensive interpersonal communication, along with social mobilization and advocacy for building awareness among target groups of health, nutrition education and different social issues such as demerits of early marriage, dowry, child labor and women’s rights, etc.

The BEES paramedics provide health services through static and satellite clinics under the supervision of a health supervisor and guidance of the head office. The emergency or complicated cases are regularly referred to the local government health facilities or clinics through collaboration with them.

The major services provided under Sheba Health Program are: antenatal and postnatal care; counseling of mothers on colostrum feeding, exclusive breastfeeding and complementary feeding; monthly growth monitoring for children under 5 years; promoting immunization for children under 2 years and women of reproductive age; nutrition education for pregnant mothers, lactating mothers and adolescent girls; and counseling newly-wed and fertile couples on family planning methods for improving their health status and standard of living.



Figure 1: Districts where SHEBA Health Program is implemented (indicated by red star)

After implementing the Sheba Health Program for the last decade, BEES conducted a study during November 2018-January 2019 to assess its impact. It was anticipated that the study would serve as a source of information based on the activities and success of the Sheba Health Program, which extended its services to the targeted beneficiaries for the last 17 years. This report provides details of the impact assessment study. It is organized in six sections. After the introductory remarks in Section 1, the objectives and methodology of the study are described in Section 2. Section 3 contains a brief review of findings of similar studies conducted in Bangladesh at the national level, while Section 4 presents the main findings of the study. Section 5 concludes the report and Section 6 makes a number of recommendations.



Section 2: Objectives and Methodology of Study

The major objectives of the study were to:

- a. Assess the impact of the health services received by the target beneficiaries of the program
- b. Measure effectiveness and take initiatives to improve the strategy of existing interventions
- c. Document the learning throughout the implementation of the project

In order to fulfil the above objectives, a sample survey was conducted through which the beneficiaries of Sheba Health Program area were compared to non-beneficiaries living outside the program area. The target respondents were the beneficiaries as well as non-beneficiaries of the Microfinance Program of BEES. The methodology of the survey is explained below.

2.1 Sampling Technique

The total number of listed beneficiaries up to December 2018 was considered as a sampling frame to draw the sample. During sampling, a total of 20,741 beneficiary families consisting of around 84,208 members were covered by the services of the Sheba Health Program. Systematic random sampling method was applied as it is more convenient for this type of population. To cover the entire population, a total number of 400 samples were drawn from the beneficiary list which was kept in the area offices. Formula of one sample proportion test was applied to compute the sample size considering the population parameter.

To assess the program impact credibly, both quantitative and qualitative data from different sources were collected. Listed households, households from out of the list, local elites and program implementers were the major sources of data.

Sample size determination

Formula of One Sample Proportion Test to determine the Sample Size:
The formula of one sample proportion test is:

Sample size calculation for one sample proportion test

$$n = \frac{p_a(1 - p_a) * (z_{\alpha/2} + z_{\beta})^2}{(p_a - p_0)^2}$$

Where,

$$z_{\alpha/2} = 1.96 \text{ for } 5\% \text{ level of significance}$$

$$z_{\beta} = z_{0.80} = 0.842 \text{ (from Z table) at } 80\% \text{ power}$$

p_a = Expected proportion after implementation of the program (considering 10% increase from national survey report) = 70.4%.

p_0 = A proportion expressed as a percentage.

Prevalence of any ANC service taken by mothers = 64% (BDHS-2014)

Example,

Z	1.90
z_{β}	0.842
p_0	0.64
p_a	0.704

Then n = 399

(Machin D, Campbell MJ, Tan SB, Tan SH (2009). Sample size table for clinical studies, 3rd ed.)

The sampling units were scattered all over the working areas of Narsingdi, Kishoreganj, Bogura and Gaibandha districts. According to the formula, a total of 399 beneficiary samples were required to be drawn. However, considering the number of enumerators and accuracy of data, a total of 400 samples were drawn from the beneficiary list and data was collected accordingly. In addition, further 400 representative samples from outside of the program area were selected randomly covering a wider area, where Sheba Health Program did not provide any service. Data from those samples acted as control by which impact of the program was measured. The geographical location and socio-economic status of the respondents in the out-of-program area were similar to those of the beneficiary respondents in the program area.

2.2 Data Collection

Data for the study was collected through in-depth interviews with individual respondents and focus group discussions (FGD) with groups of respondents. A total of 400 in-depth interviews were conducted and 18 FGDs held. The main objective of conducting FGDs was to collect background information on quantitative data and critically assess the impact of the project. Structured questionnaires were used to facilitate the data collection process. The types of respondents surveyed and the methods of data collection used are shown in Table 1 below. The questionnaires are contained in Annexes 1-6.

Table 1: Types of respondents and methods of data collection

Respondents	Data collection methods
1) Beneficiary (individual and association member)	In-depth interview
2) Beneficiary (group and association member)	FGD
3) Non-beneficiary (individual and outside of working area)	In-depth interview
4) Non-beneficiary (group and outside of working area)	FGD
5) Program implementers	FGD
6) Elite person of the project (teacher, union parishad member, chairman)	In-depth interview

2.3 Training and Field Work

It was decided to provide training on data collection to internal staff members of respective areas to be covered by the survey as they knew the program closely and the area as well. Therefore, 11 paramedics of Bogura and 6 paramedics of Narsingdi area were selected as enumerators for collecting data from the field. Concerned staffs of the R&D Cell developed the survey tools and conducted practical orientation sessions for the enumerators. After receiving orientation, the enumerators went to the program implementing area of BEES to pre-test the questionnaires under the guidance of the R&D Cell personnel. The questionnaires were finalized after necessary modifications, and the concerned enumerators started collecting data under very intensive supervision of R&D Cell staff members. It took four months to complete the survey. During the entire survey period, intensive supervision and monitoring were ensured by the R&D team to confirm the authenticity of the collected data.

2.4 Data Processing and Analysis

All the survey questionnaires along with the collected data were returned to the R&D Cell after which the processing of collected data started. Microsoft Excel was used as data template for data entry and analysis. Office editing and coding of open-ended questions were done before the data entry. Descriptive analysis in Excel was done to process the qualitative data.

If any inconsistency was detected during data processing, the concerned personnel from R&D Cell discussed the problem with the enumerators and advised them to collect data appropriately for ensuring their authenticity. Several figures were generated to make the analytical information more visible.

It should be mentioned that the research team took permission from the respondents before collecting data from them. The team maintained full confidentiality of the collected data.

2.5 Limitations

The limitations of the study methodology include the following:

- Considering the cost, time and experience, program staffs were involved as data enumerators for collecting data from both intervention and non-intervention groups. There was a chance of inappropriate data collection as this bias was not eliminated. However, this limitation was overcome with strong monitoring and supervision.
- The research team selected the respondents systematically for data collection from the intervention area. But there was no systematic order in the identification of the respondents for data collection in the control area.
- The team only selected the villages for control and the data enumerators selected the sample according to the instruction of the team.
- The data enumerators collected data from the field in addition to doing their regular job, so they could not give full concentration on the research activities. As a result, it took them more time to collect the data.



Section 3: Literature Review

Status of contraceptive method users

With reference to their awareness of specific family planning methods, it was observed that among the recipients, contraceptive pill, injectable and IUD were the most commonly known methods followed by tubectomy and condom. Among the non-recipients, the best known methods were the contraceptive pill and injectables followed by IUD, condom and tubectomy. For both the recipients and non-recipients, the least known methods were vasectomy and traditional methods.

Over 80% of the recipients knew the use of the pill, injectables, IUD and condom. Among the non-recipients, 61% knew how to use the pill. (Haque et al. 2001, October, Page 43, vol 47, No 2, Status of Satellite Clinics in Bangladesh). Contraceptive prevalence rate is 62.1% and 62.3% in Sample Vital Registration System (SVRS) 2015 and SVRS 2016 respectively. Child mortality rate in Bangladesh dropped 73% in 25 years, according to a UNICEF report (News Desk, bdnews24.com, published: 2015-09-09).

According to the most recent Demographic and Health Survey (DHS) (NIPORT, 2001), the proportion of currently married women using a family planning method increased from under 8% in 1975 to over 53% in 2000. About 43% of women reported use of modern methods while around 10% use traditional methods. The rural-urban divide shows that 60% of the urban women and 52% of the rural women use contraceptive methods.

Status of pregnant woman receiving delivery facilities

Since 75% of rural doctors are men, families put further pressure on the pregnant mother to give birth at home due to having conservative mindset. Midwives break that barrier and provide services for the growing demand of maternal care in rural areas.

However, in Bangladesh, skilled attendants assist only 12% of births (doctors 7% and nurses, midwives or family welfare visitors 5%). Furthermore, almost 92% births are delivered at home, often in unsafe and unhygienic conditions. Traditional birth attendants (TBAs, locally called dais) assist 64% births. Again, there are significant rural-urban differences, as professionally trained personnel attend 33% of births in urban areas, compared to only 8% in rural areas (NIPORT et al., 2001).

Considering the present population size and birth rates, about 2.9 million mothers are expected to give birth annually. The recent demographic and health survey shows that only 7.9% of the total deliveries are conducted in health facilities (NIPORT 2001).

One of the underlying factors leading to poor maternal situation in Bangladesh is that a very low percentage of women actually seek professional medical assistance for pregnancy related care, deliveries and complications. Only 7.9% deliveries take place in the health facilities and only 5% of the expected complications seek services of static health facilities (Azizur et al.).

Status of mortality rate of children under 5 years

Child deaths under the age of five have been reduced from 12.7 million to 6.3 million as of 2013 - an almost 50% decrease. Between 1990 and 2011, under 5 mortality decreased from 151/1000 to 53/1000 live births. According to SVRS 2017, it was 24 per 1000 live births.

Mortality declines are associated with improved coverage of effective interventions to prevent or treat the most important causes of child mortality and with improvements in socio-economic conditions. Programs to ensure high coverage of vaccine preventable diseases, treatment of diarrhea and ARIs, implementation of IMCI and to deliver newborn health interventions have been crucial to these reductions. Moreover, Bangladesh has seen reduced disparities in fewer than 5 mortalities between urban and rural areas and across different regions of the country.

Status of maternal mortality ratio and causes of mortality

The percentage of mothers in developing nations with access to skilled health personnel has increased from 56% to 68% in 2012; however, mortality rates have only dropped by 45%. (<http://scholarworks.bgsu.edu/irj/vol3/iss1/10>).

Of the total maternal deaths, 69% are due to direct obstetric causes, 14% are reported as due to injury and violence, leaving 17% due to indirect causes. The most common obstetric causes of maternal deaths are postpartum hemorrhage, eclampsia, and complications of abortion, obstructed labor, and postpartum sepsis. The high reported incidence of injuries and violence as causes of maternal mortality indicate social issues that must also be addressed to improve maternal health in Bangladesh (Azizur et al.).

One factor potentially influencing the high maternal mortality ratio (MMR) is that nearly two thirds (63%) of mothers do not receive antenatal care. Difference in the coverage by division is minimal although the rural-urban difference is very high. About 59% of urban mothers receive antenatal care, while in rural areas the rate is only 28% (NIPORT 2001).

It is widely agreed that one of the most important health interventions useful in reducing maternal mortality is to have mothers deliver with assistance from a skilled birth attendant.

Between 1990 and 2010, maternal mortality in Bangladesh decreased from 574/100,000 to 194/100,000 live births. The decline is associated with reduced total fertility rate (from 5 births per woman in 1990, to 2 in 2011) and with increased skilled delivery attendance (from 5% in 1991 to 32% in 2011). Programs such as the Maternal Health Voucher Scheme and Emergency Obstetrical Care Services (EmOCs), and the rapid development of the private sector, have also contributed to reducing maternal mortality.

Bangladesh has made significant progress towards achieving the Millennium Development Goal (MDG) 5 target of 75% reduction in the maternal mortality ratio (MMR) between 1990 and 2015. Starting at 570/100,000 livebirths in 1990, there has been a 44% decline by 2001 to an MMR of 322 maternal deaths per 100,000 livebirths (Malay et al).

Status of infant mortality rate

The national infant mortality rate (IMR) declined from 150 per 1000 live births in 1975 to 87 in 1999. The annual crude death rate has also fallen from 19 per 1000 in 1975 to just 5 in 2000. The annual birth rate declined from 43 per 1000 population in 1980 to 36 in 2000, giving a population growth rate of 1.7% in 2000, compared to 2.4% in 1980. This lowering of fertility is largely due to increases in the contraceptive prevalence rate, standing at 53.8% in 2000 (NIPORT, 2000). Although MMR did fall from 620 per 1000 live births in 1982 to 440 in 2000 (Azizur et al), this level is still considered unacceptably high, with around 20,000 Bangladeshi mothers dying each year due to causes related to pregnancy and child birth (Azizur et al) Official government reports, however, estimate a lower MMR, usually around 300 per 100,000 live births.

Status of mothers receiving ANC and PNC

Only 26.8% mothers prefer to receive antenatal services from a government facility. More than 58% mothers prefer to use the services of an untrained provider at home. A wide range of factors have been identified as influencing these decisions, including lack of information and education about services, superstitions, fear of losing family prestige, financial crisis, negligence of service providers, insufficient supplies (lack of adequate drugs or medicine), shortages of skilled doctors, and predominance of male doctors in the government hospitals (Haider et al, 2000). Success factors of women and children: Ministry of Health and Family Welfare, Bangladesh; coordinated and supported by WHO.

It was found that 21% pregnant mothers do not visit the doctors for receiving ANC services during their pregnancy period. About 22% pregnant mothers received consultation for 4 times. In case of PNC, it was found that 39% mothers do not visit the doctors to receive PNC services. Around 14% PNC mothers, who were under caesarean section, consulted with doctors for 4 times. About 8% mothers under normal delivery consulted with doctors for 4 times for receiving PNC services (BBS-

December 2013, Health and Morbidity Status Survey- 2012). ANC coverage (at least one visit by skilled health professional) is 63.9% (BDHS 2014).

The proportion of mothers seeking postnatal care from professionally trained personnel is very low, both in rural and urban areas of Bangladesh (Barkat et al., 1995). On the whole, only 7% of women who delivered at home sought postnatal care from medically trained personnel, despite the postnatal period being one of the riskiest periods for occurrence of life threatening complications.

Status of children's immunization

A total of 88% children aged 12-23 months were immunized by BCG vaccine, 79% by Measles vaccine and 70% by all vaccines (BBS-December 2013, Health and Morbidity Status Survey- 2012). Besides, full vaccination has been received by 86.8% children (Health bulletin 2018).

Status of C-section delivery and NVD

In case of maternal health care, about 83.6% deliveries were normal and 16.4% were caesarean among women aged 15-49 years who gave birth during the last one year of the survey. In rural areas, 87.4% deliveries were normal and 12.6% were caesarean. In urban areas, about one-third (30.7%) deliveries were caesarean. About 69% deliveries of ever married women aged 15-49 years during last 1 year of survey occurred at home. In the rural areas, home deliveries were about 74% and these were about 50% in urban areas. About 14% deliveries were in government hospitals, 15% in private hospitals and 2% in NGO health care centers. (Bangladesh Bureau of Statistics-December 2013, Health and Morbidity Status Survey-2012). According to BDHS 2014, C-section rate was 22.9% and home delivery rate was 62.2%.

About 21.2% deliveries of ever married women aged 15-49 years during the last one year of survey were attended by doctors, 10.3% by nurse, 36.2% by trained midwives, 3.3% by health workers, 14.0% by untrained midwives and 15.0% by others.

For more than 80% deliveries of ever married women aged 15-49 years during last one year of survey living in the lowest and 2nd lowest asset quintiles, were taking place at home. About 50% deliveries of the mothers of the same age living in highest asset quintile happened in health care institutes.

It is observed that there was a negative correlation between birth order and birth attendants as doctor or nurse. With the higher birth order there was a trend of more untrained birth attendants during deliveries (BBS-December 2013, Health and Morbidity Status Survey- 2012).

Size of population, its growth and age-sex structure have manifold socio-economic and demographic implications. Current age-sex structure observed in any population

is the result of past trends in fertility, mortality and migration. On the other hand, age-sex composition and socio-economic variables have significant effect on fertility, mortality and nuptiality. The current age structure of Bangladesh population is young as about 32.5% of population is under the age of 15.

Of those women not using family planning, an estimated 5 million couples are seen as not having their contraceptive needs met, either wanting to space births, or wishing to limit the number of their children. Therefore, in spite of achieving a high CPR, unplanned pregnancies are still common in Bangladesh.

Many of these barriers will lead to delays in seeking all forms of maternal care, even when life-threatening emergencies arise, which may be a major factor behind the high level of maternal mortality. In Bangladesh, a 2001 survey found only 61% of women who sought medical care decided to do so within 6 hours of recognizing the need, with delays of 3 days or more in some cases (NIPORT 2002).

Quality of care and patient-provider interaction greatly affects the overall maternal health situation in Bangladesh. It has been found that the quality of maternal health services provided by the government institutions is poorer than desired. Facilities suffer from a large number of problems, such as shortage of medical equipment, dearth of doctors, nurses, and technicians, an unhygienic physical environment, scarcity of power and water, pilferage of drugs and medicines and irregularities in the management system (Bangladesh Ministry of Health and Family Welfare, 2000).

A United Nations Children's Fund (UNICEF) report stated that the under-five mortality rate in Bangladesh in 1990 was 144 per 1,000, but in 2015 the rate was 38 per 1,000. The Levels and Trends in the Child Mortality Report 2015 also showed that the child mortality rates across the world have halved, 53 percent, over the same timeframe. Besides, according to the Health Bulletin 2018, under-5 mortality rate was 31 (SVRS 2017).

The number of under-five deaths has dropped to below 6 million for the first time in the reporting year, a figure that is in stark contrast to the 12.7 million deaths in 1990. UNICEF Deputy Executive Director, Geeta Rao Gupta, said the development was a great achievement (UNICEF Report 2015).



Section 4: Results and Discussion

In this section, the results of the study are presented, interpreted and discussed so that the readers can easily understand the research findings. Graphs have been used extensively to make the analytical information more visual.

4.1 Child Health

During the survey of the Sheba Health Program, data on children of 0 to 2 years in relation to the issue of colostrum feeding after birth were collected. It was found that 91% children of this age group, who were under the Sheba Health Program, received colostrum. In the case of children outside the program area, the proportion was 88%. This shows that 3% more children received colostrum in the program area (Figure2). When paramedics visited pregnant mothers they told them about the importance of colostrum feeding, as a result of which more children were under colostrum feeding in the program area.

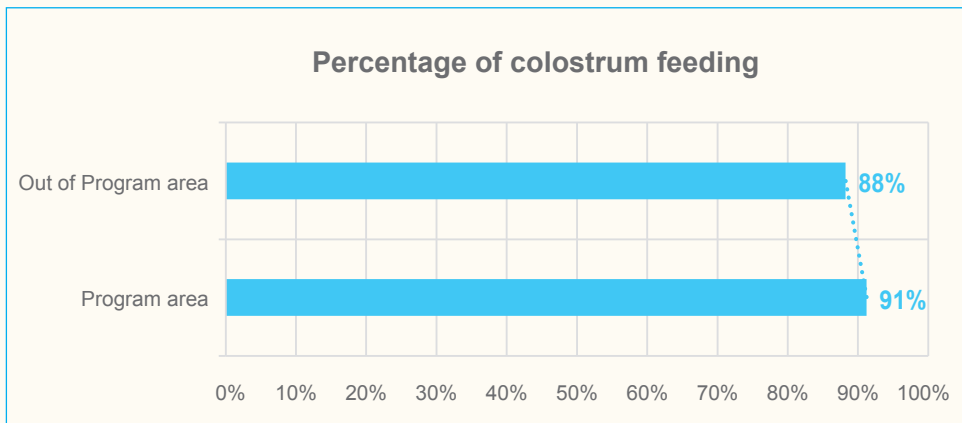


Figure 2: Percentage of newborns breastfed with colostrum

Through discussion with relevant staff members of BEES about the issue of children who did not receive colostrum, it was identified that a number of mothers who underwent caesarian section could not feed colostrum to their children due to their unsound physical condition after delivery.

To find out the status of children in regard to exclusive breastfeeding, children aged 6 months plus to 2 years were selected for data collection. It should be mentioned that these children were selected for data collection under the parameter 'Children under exclusive breastfeeding (EBF)' had never received honey, dairy milk, goat milk, mixed water or any type of complementary feeding. It was found that 50% of the children from that group residing in the Sheba Health Program area were exclusively breastfed until they completed 6 months of age. In the case of children in the out-of-program area, the proportion was 49%.

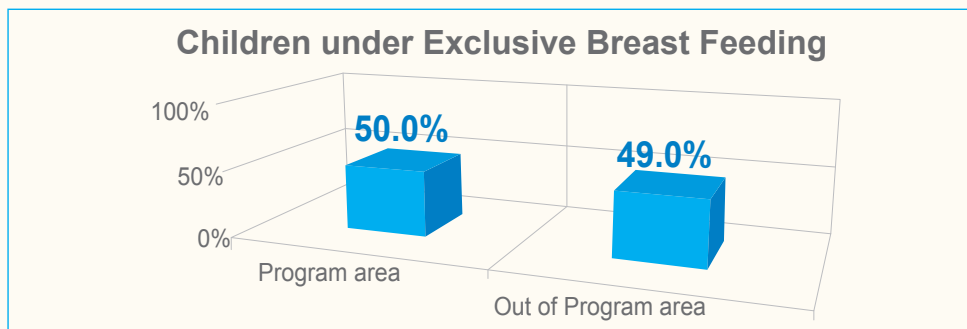


Figure 3: Exclusive breastfeeding pattern of children under 6 months

In all cases, the number of children under EBF was not satisfactory. The following are the main reasons for the low number of children under EBF:

- According to local tradition or social prejudice, mothers and family members started to serve rice and other food to their 5-month-old children. In some cases, parents served additional food to their 3-month-old children too.
- Children do not get sufficient milk from malnourished or teenage mothers. In such cases, parents have to serve additional food to their children at an early stage.
- Babysitters serve additional food to children in their early age in case of working mothers.
- Some mothers remain sick after caesarian, so they cannot provide breast milk to their children.

During the survey we tried to find out at what age complementary feeding was initiated for the infants. It was found that complementary feeding was started for 88% of the children when they were 6 months and older, while 12% received complementary feeding when they were from 3 to 6 months old in the program area. In the case of children in the out-of-program area, the proportions were 71% and 29% respectively (Figure 4).

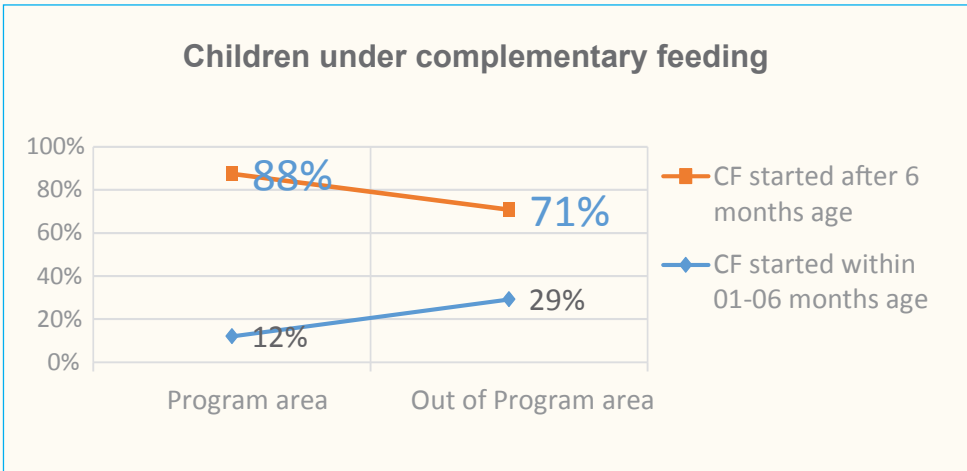


Figure 4: Percentage of children initiated with complementary feeding after and before 6 months of age

The above graph also shows that, in the program area, 17% more children started to receive complementary feeding right after crossing the age of 6 months and, apparently, 17% fewer children below the age of 6 months received complementary feeding compared to children in the out-of-program area. The major cause behind children getting complementary feeding prior to reaching the required age is short birth spacing. A mother generally has to provide complementary feeding to her newborn child when the elder child remains habituated to breastfeeding. The government encourages permanent methods of birth control for couples who have more than two children. Through discussion with the respondents it was found that fertile women generally buy contraceptives from the local pharmacy. The sales persons in local pharmacies often make mistakes in selling the appropriate contraceptive materials. As a result, contraception often does not work and fertile women become pregnant unexpectedly.

Figure 5 below shows that 91% of children in the program area were fully immunized, while the proportion was a percentage point higher (92.1%) in the out-of-program area.

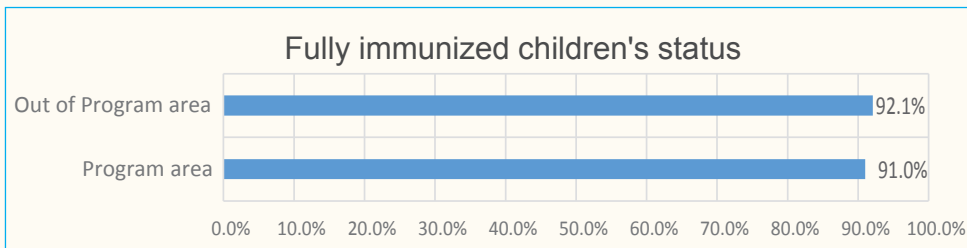


Figure 5: Status of fully immunized children according to EPI schedule (in %)

The Bangladesh government health department is directly involved with this program to implement its activities. Sheba Health Program personnel have only been counseling the community people to receive immunization services through the government. After being immunized for the first time, children suffer from fever. Although this fever is a common phenomenon, many parents do not show interest in giving their children the 2nd dose of vaccination in order to avoid fever. Although the number of immunized children is more than 90%, it is necessary to check the immunization cards and convince the parents to bring more children under the immunization program.

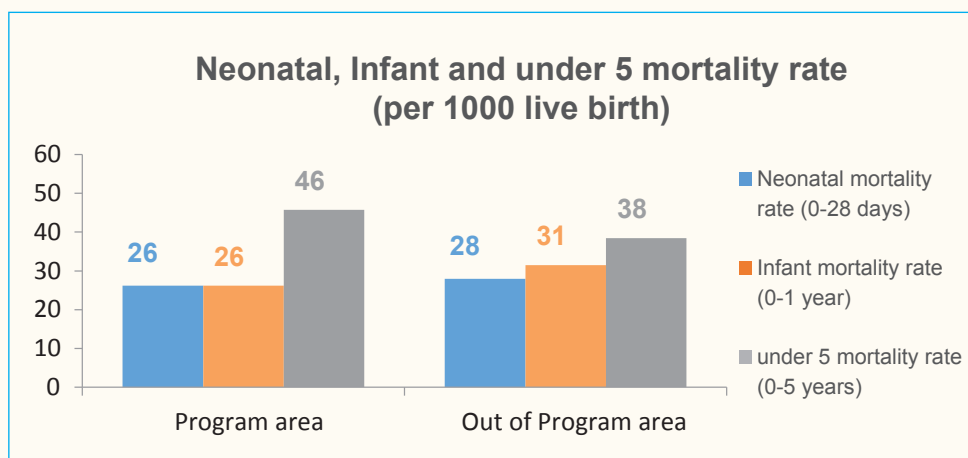


Figure 6: Neonatal, infant and under five mortality rates per 1,000 live births

Data on the incidence of children's death during the period January 2014-December 2018 have been collected for several categories of children from 0 to under 5 years old. The respective categories were neonatal (0 to 28 days), infant (0 day to <1 year) and children under 5 years. Figure 6 above shows that neonatal and infant mortality rates were lower in the Sheba Health Program area compared to those in the out-of-program area. Neonatal mortality rate was lower by 2 per 1,000 live births and infant mortality rate by 5 per 1,000 live births. However, the under-5 mortality rate was higher in the program area (46 per 1,000 live births) than in the out-of-program area (38 per 1,000 live births).

Under the Sheba Health Program, 35% of children below 2 years were monitored using a Growth Monitoring and Promotion (GMP) card. Among them 26% were measured by paramedics from BEES and 9% by service providers from the government and other organizations. This is a significant achievement for BEES. In the out-of-program area, on the other hand, only 9% children received this service (Figure 7). A total of 65% children below 2 years did not receive any GMP service. The main reasons for this are the following:

- Parents are not aware of the benefits of GMP measurement

- Limited number of paramedics in the program to cover the vast and distant area

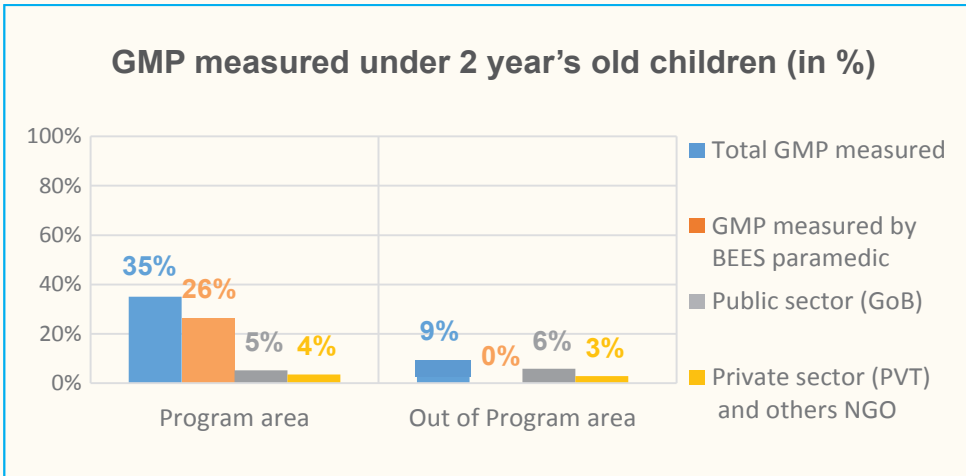


Figure 7: Status of Growth Monitoring and Promotion (GMP) of children below 2 years (in %)

Figure 8 shows the GMP status in and outside of Sheba Health Program areas, which were 80% and 20% respectively. The paramedics expect assistance from the Field Organizers of Microfinance program to create awareness among the beneficiaries about the benefits of GMP.

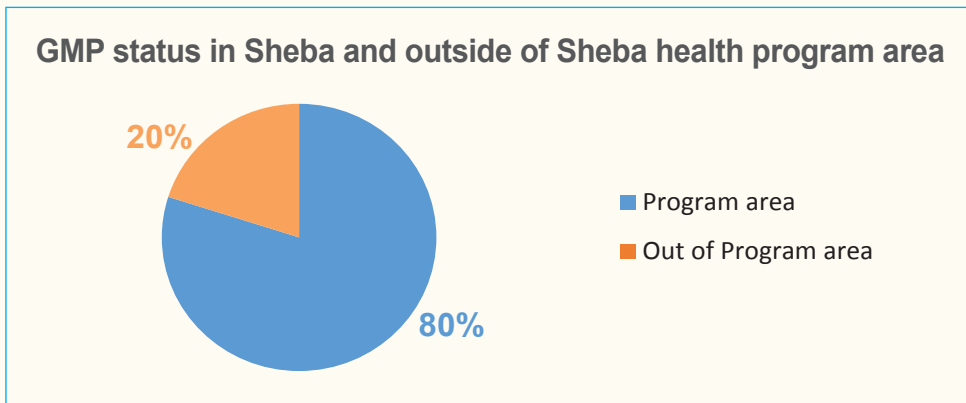


Figure 8: GMP status in and outside of Sheba Health Program areas (in %)

For children from the age of 2 to 5 years, a total of 43.8% children received the GMP measurement facilities in the program area. Among them, 38.2% were facilitated by BEES. In the out-of-program area, only 5.0% children were monitored using GMP cards facilitated by others (Figure 9).

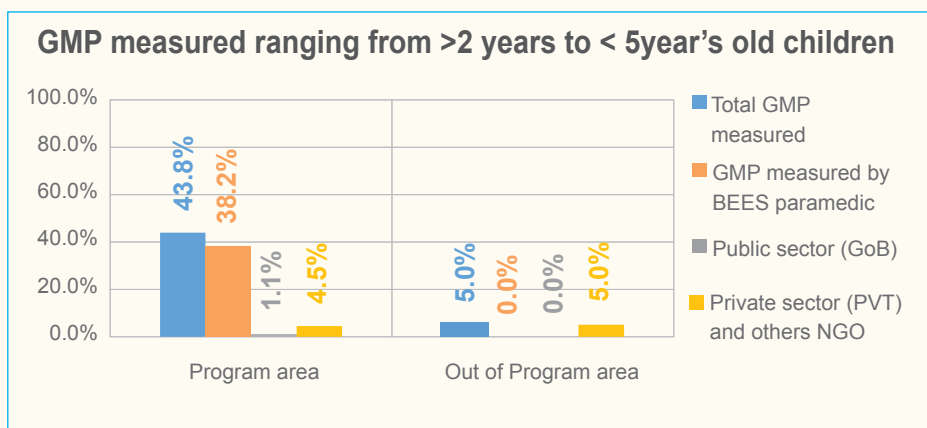


Figure 9: GMP status of children from 2 to 5 years (in %)

4.2 Maternal Health

Last six months' data on pregnant mothers were collected from both program and out-of-program areas in order to find out the status of deliveries at home. The data reveal that 44% pregnant mothers received delivery facilities at home in the Sheba Health Program area. Of these, 6% of the deliveries were facilitated by skilled birth attendants and 38% by unskilled birth attendants. Similarly, in the out-of-program area, 43% pregnant mothers delivered at home; 3% were facilitated by skilled birth attendants and 40% by unskilled birth attendants (Figure 10). The program implementers said that establishing linkages with appropriate service centers such as government health centers or relevant service providers might reduce the number of deliveries at home by unskilled birth attendants.

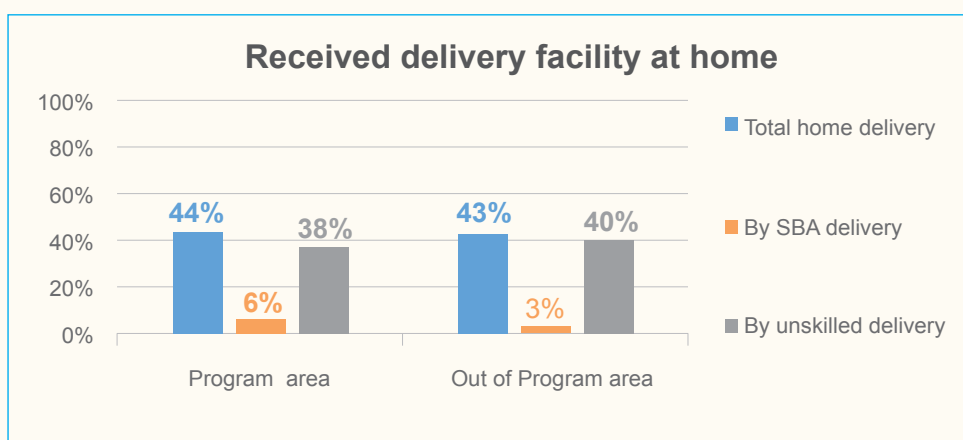


Figure 10: Status of pregnant mothers who received delivery facility at home (in %)

In the Sheba Health Program area, 56.3% pregnant women received delivery services from government and non-government hospitals. Among them, 37.5% had to go for C-section and 18.8% for normal vaginal delivery (NVD). Similarly, in the out-of-program area, 57.5% pregnant women received delivery services from government and non-government hospitals. Of them, 40% had to go for C-section and 17.5% for NVD (Figure 11).

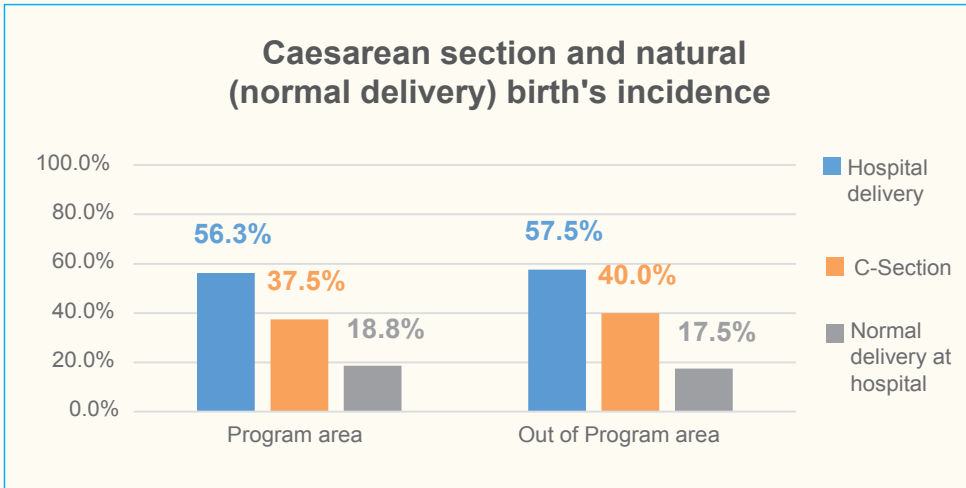


Figure 11: Incidence of Caesarean Section and Natural Birth (in %)

During the survey, data on delivery services provided by the government and private health sectors for a period up to the last six months were collected. After analyzing the data, it was found that, under the Sheba Health Program, 33% pregnant mothers received delivery services from government facilities and 67% from private service providers (Figure 12). In the out-of-program area the corresponding proportions were 35% and 65% respectively (Figure 13).

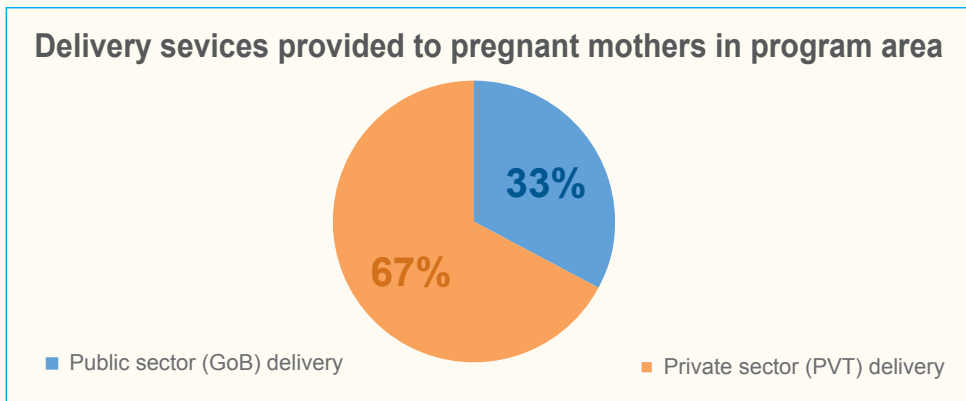


Figure 12: Sources of delivery services provided to pregnant mothers in program area (in %)

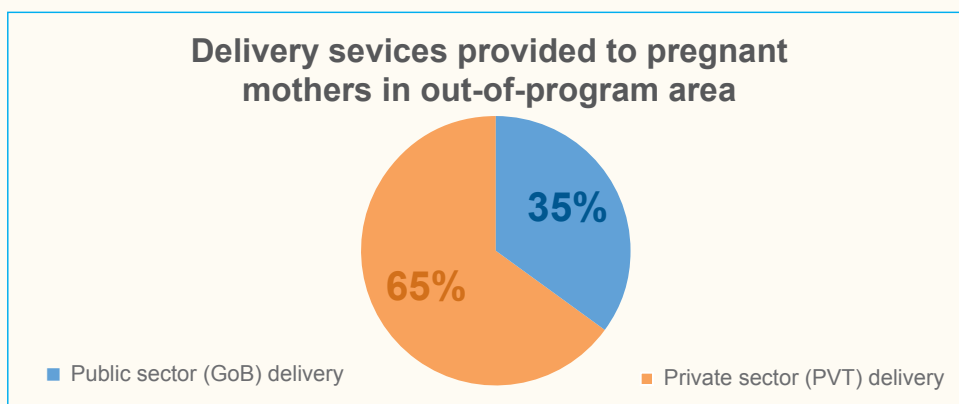


Figure 13: Sources of delivery services provided to pregnant mothers outside of program area (in %)

Discussions with the implementing staffs revealed that patients and their attendants generally preferred to go to private clinics or hospitals for getting better service. Lack of knowledge of public health care facilities is another reason for choosing the private sector. The facilities available in government health centers need to be properly introduced to the community people in order to change their perception of the public health sector.

In the area of Sheba Health Program, 93.8% pregnant mothers received antenatal care (ANC) services at least once. Among them, 37.5% received services from paramedics of BEES, 12.5% from public service providers and 43.8% from private facilities. On the other hand, in the out-of-program area, 72.5% pregnant mothers received ANC services at least once – 30% from the public sector and 42.5% from the private sector (Figure14). The figure shows that the Sheba Health Program of BEES had a significant role in providing ANC services to pregnant mothers. As a result of the intervention, 21.3% more pregnant mothers received services in the working area of BEES.

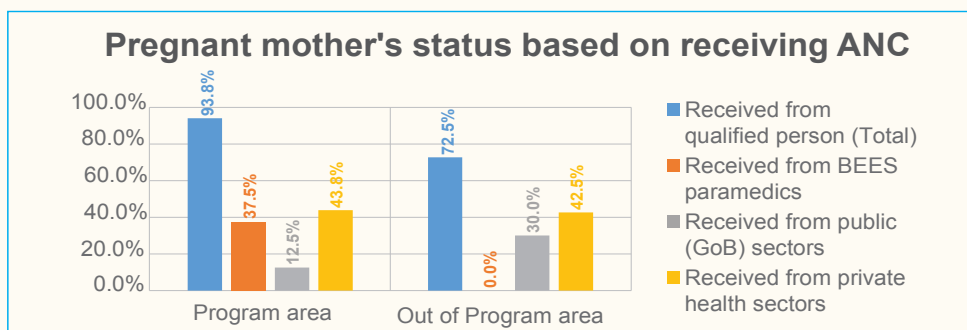


Figure 14: Status of pregnant mothers who received ANC services at least once (%)

During discussions the program implementers identified a number of challenges in providing adequate ANC services to pregnant mothers. These include the following:

- Number of paramedics is very limited considering the number of community people.
- Existing paramedics cannot manage to cover the whole of Sheba Health Program area; therefore, they cannot identify more pregnant mothers in advance.
- The frequency of holding satellite clinic is low due to the lack of paramedics.
- Due to lack of health cards for long time in the field the mothers cannot be convinced to obtain ANC services.
- Due to unavailability of different routine tests in the program, the pregnant mothers have to go to private clinics for services.

In case of services for postnatal mothers, Figure 15 shows that in the area of Sheba Health Program, 63.6% pregnant mothers received postnatal care (PNC) services at least once within 42 days of delivery. Among them, 18.2% received services from paramedics of BEES, 9.1% from public health facilities and 36.4% from other private service providers. On the other hand, in the out-of-program area, 34.6% pregnant mothers received PNC services at least once – 15.4% from the public sector and 19.2% from the private sector. There were no postnatal mothers who received PNC services from BEES in the out-of-program area (Figure15). Provision of PNC services by BEES paramedics to lactating mothers was limited.

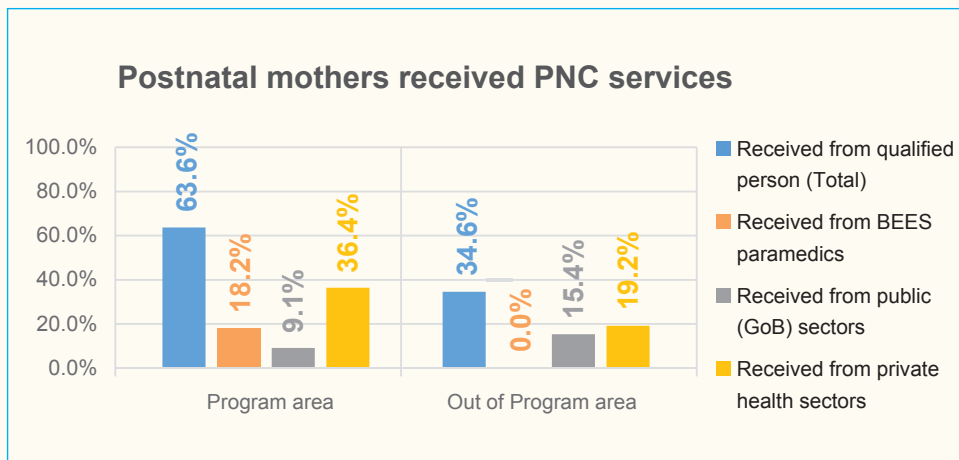


Figure 15: Status of postnatal mothers who received PNC services at least once within 42 days of delivery (in %)

In response to a question on what kind of services should be provided on maternal and child health, Ms. Parveen Begum, an assistant teacher of a primary school in Chhatragachha village of Chaderhat union, Sadullapur upazila, said: *“It is necessary to provide services to all pregnant women, lactating mothers and children at their doorsteps or in their villages because poor people do not have money. Besides, people in the villages should be made aware of the need to obtain necessary health care services.”*

4.3 Body Mass Index Measurement

Figure 16 below shows that, in the area of Sheba Health Program, 35% adolescent girls were measured for Body Mass Index (BMI) with the full support of the paramedics of BEES. There was no other service provider in that area for providing this service. On the other hand, in the out-of-Sheba Health Program area, only 17% girls were measured for BMI. Only 2% were supported by BEES paramedics, 3% by the government health service providers, and 12% by the private sector, including other NGOs. It should be mentioned that BEES does not provide BMI services outside its program area, but some people come to the static clinic for getting services at their own initiative.

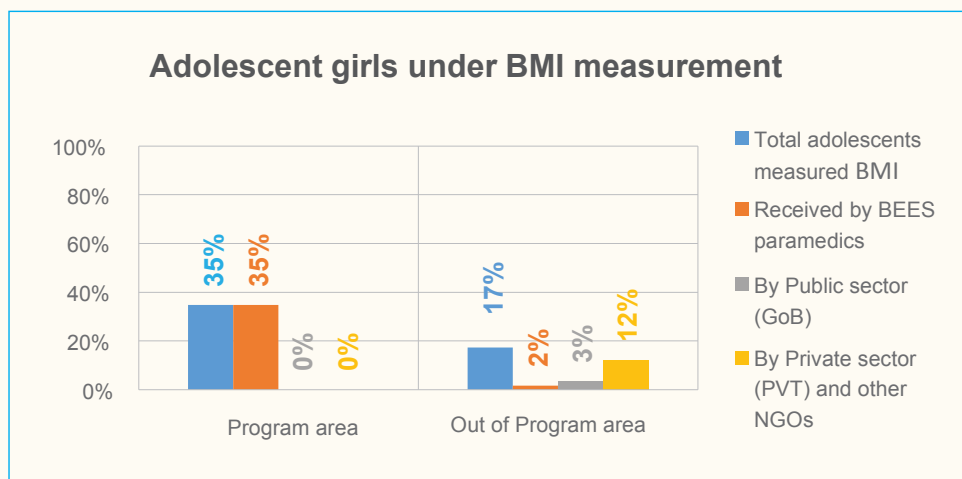


Figure16: Status of adolescent girls under BMI measurement (in %)

4.4 Health cards distribution

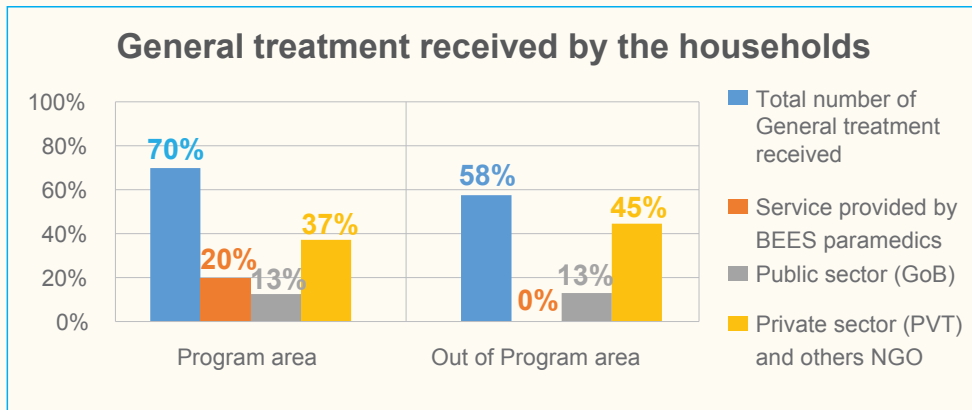
In the program area, 3.6% households received health cards. Around 0.8% of the cards were distributed by BEES paramedics. In the out-of-program area, 3.8% households received health cards. However, there was no contribution of BEES paramedics in the distribution of cards in the out-of-program area.

Table 2: Status of households based on receiving health cards (in %)

	Total household received health cards.	Health cards distributed by		
		BEES paramedics	Public sector (GoB)	Private sector (Pvt.)
Program area	3.6%	0.8%	0.0%	2.7%
Out of Program area	3.8%	0.0%	0.3%	3.5%

4.5 General Treatment

During the survey, previous six months' data were collected on general treatment of ailments (common cold, fever, cough, diarrhea, dysentery, acidity, worm infestation and skin diseases) received by the households in the program area. Analysis of the collected data shows that 70% of the households received general treatment – 20% obtained the services from the paramedics of Sheba Health Program, 13% from government service providers, and 37% from the private sector, including other NGOs. On the other hand, in the out-of-program area, 58% households received the services (13% from the public sector and 45% from private and NGO service providers). BEES paramedics did not provide any service in the out-of-program area (Figure 17). For increasing the intake of services on general treatment, the awareness of the beneficiaries needs to be raised through courtyard meetings.

**Figure 17: Household status based on receiving general treatment (in %)**

Md Shahidul Islam, a prominent person of Nizpara village of Bhabanipur union in Sadullapur upazila of Gaibandha district said: *“In addition to public health services, static, satellite clinics will have to identify diseases in the area and provide services through temporary camps. Because many poor people do not get proper services when they go to the hospital, or they do not go to the hospital on their own due to lack of awareness.”*

4.6 Contraceptive Prevalence Rate

In the area of Sheba Health Program, 70.2% eligible couples were found to be using modern contraceptive methods. Around 29.8% of the users received services from the public health sector and 40.4% obtained the contraceptives from private/NGO sources. In the out-of-program area, 65.8% of eligible couples were modern method users – 23.5% received contraceptive services from the public health sector and 42.3% from private and NGO service providers (Figure 18). The figure further shows that, in the program area, 6.3% more couples received services from government health centers and, on the contrary, 2.1% fewer couples obtained services from the private/NGO sector, and overall 4.4% more couples used modern contraceptive methods of birth control. To increase the contraceptive prevalence rate in the program area, the Sheba Health Program can sell birth control pills and condoms and increase the number of advocacy sessions on family planning as well.

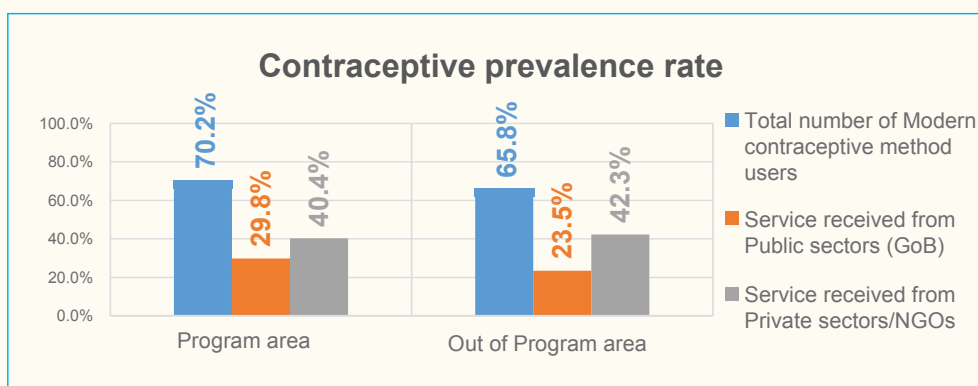


Figure 18: Status of Contraceptive Prevalence Rate (CPR) among fertile couples (in %)

In the area of Sheba Health Program, 57.5% of fertile married women, aged between 15 and 49 years, took pills compared to 59.9% in the out-of-program area. The rate of condom use in the program area was 7.5% compared to 8.9% in the out-of-program area. The rate of injectable use in the program area was 21.3%, which was very closer to the out-of-program area. In the program area, there was no fertile married woman who used intrauterine device (IUD). About 2.1% of the eligible men used non-scalpel vasectomy (NSV) in the program area, where as it was only 0.4% in the out-of-program area. The rates of implant and tubectomy were 5.4% and 5.8% respectively in the program intervention area, while the rates were 4.5% and 4.8% respectively in the out-of-program area (Figure 19). Thus, from the above discussion it is clear that the pill was the most preferred method of contraception in both program and out-of-program areas.

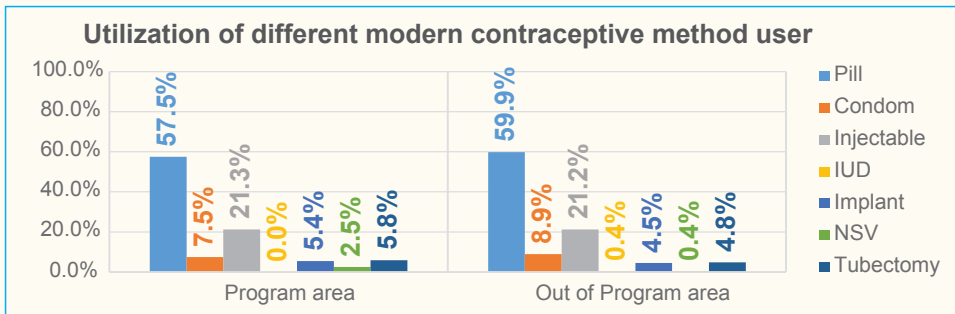


Figure19: Trend of CPR on different modern methods used (in %)

4.7 Status of Referrals

During the data collection period, it was observed that emergency patients were referred from the local level to government/private hospitals and clinics. Analysis of the collected data shows that, during six months prior to the survey, 7.4% of patients were referred to the government hospitals and clinics. Among those cases, 0.55% was referred by the paramedics of the Sheba Health Program. In the out-of-program area, 6.5% of the patients were referred (Figure 20).

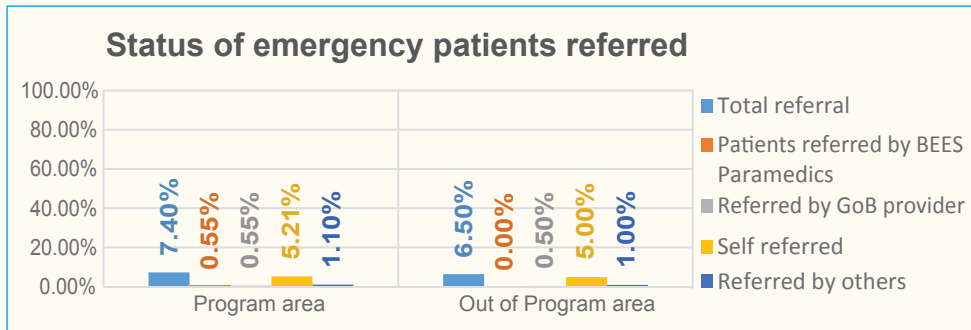


Figure 20: Emergency patients referred from different households (in %)

Figure 21 and Figure 22 below show the percentages of referred patients in program and out-of-program areas respectively. The program’s front line staff members commented that, if BEES had its own clinic/hospital or linkage/coordination with other hospitals, the number of referrals might have been more.

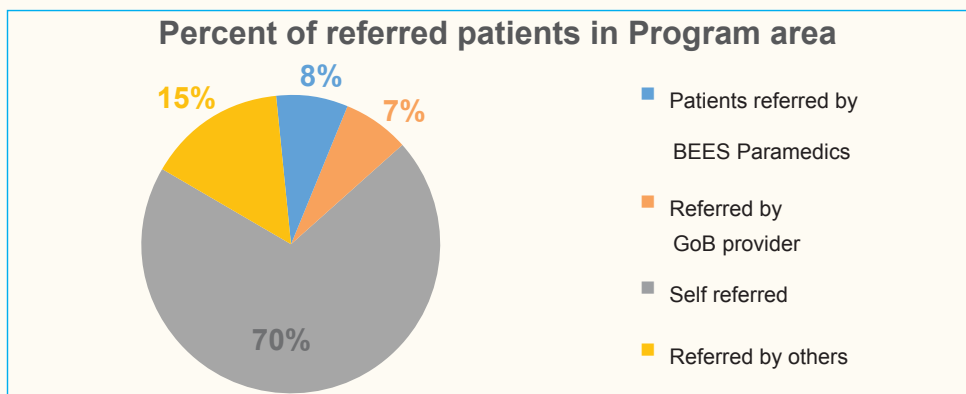


Figure 21: Status of referred patients in program area (in %)

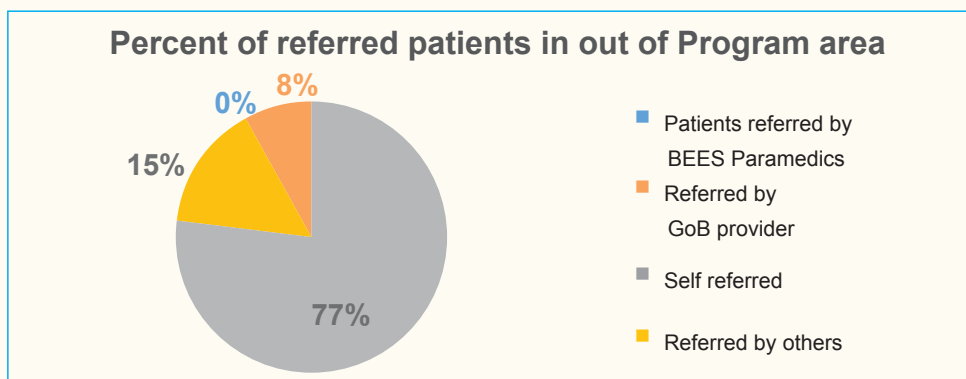


Figure 22: Status of referred patients in out-of-program area (in %)

4.8 Participation of Households in Feeding Demonstration Sessions

Mothers participate in food demonstration sessions to practically learn about supplementary feeding of their children. They learn, in particular, how to prepare safe and balanced food for their children. Figure 23 below shows that, in the program area, a total of 19.2% of the households took part in demonstration sessions on supplementary feeding of children above six months. About 17.8% households participated in sessions organized by BEES. In the out-of-program area, on the other hand, the rate of participation was very insignificant with 0.8% of the households attending. Only 0.3% of households participated in sessions organized by BEES.

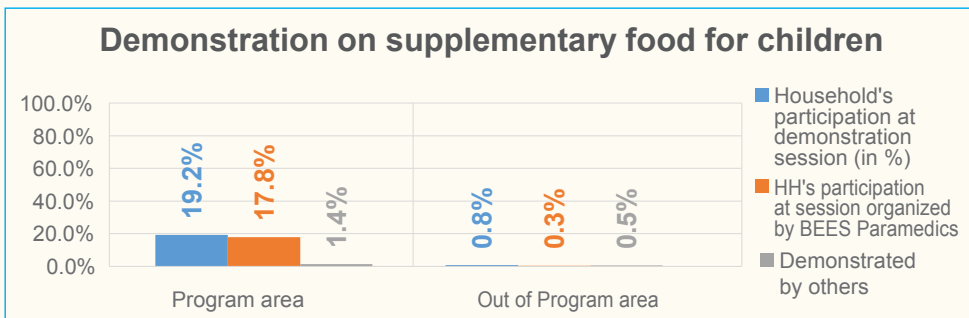


Figure 23: Status of households' participation in the demonstration session of supplementary feeding for children (in %)

During discussions, the program staff mentioned that the present allocation is inadequate to meet the requirements of ensuring quality of sessions and recommended that the budget should be increased according to the current market price allocation.

Regarding the opportunities for working on health issues in the area, Mr. Abdul Matin, a teacher of Ningaon Government Primary School, Shivpur upazila, Narsingdi district, said: *"The first requirement is to provide safe delivery. Besides, it is necessary to provide services on health check-up of pregnant and lactating mothers and make them and their families aware of various diseases of children."* Ms. Afroza Shoikat of Chorgolmamudpur village of the same upazila stated: *"We should give emphasis on birth control and arrange growth monitoring for children."* Ms. Farida Begum, Assistant Teacher of Mainuddin Bhuiyan Government Primary School of Monohordi upazila, Narsingdi district, declared: *"Health services need to be provided through at least 4 satellite clinics every month."*

4.9 Use of Sanitary Latrines

Three types of latrines were considered to categorize the households from whom the data were collected. It was identified that in the area of Sheba Health Program, 71.8% households used sanitary latrines, 12.6% used latrines with broken water seal, and 15.6% used katcha/open latrines. In the out-of-program area, the corresponding proportions were 75.8%, 14.5% and 9.8% respectively. The data shows that 4% more households used sanitary latrines in the out-of- program area (Table 2).

Table 3: Distribution of households by type of latrine (in %)

Area	Sanitary latrine	Latrine with broken water seal	Katcha/open latrine
In Program area	71.8%	12.6%	15.6%
In Out of Program area	75.8%	14.5%	9.8%
Average	73.9%	13.6%	12.5%

Discussion with the implementing staff members revealed that lack of knowledge and insufficient water to clean the latrines were the major reasons why a fourth (26%) of the households were not using sanitary latrines. BEES did not provide any service regarding installation or utilization of sanitary latrines. After analyzing the data in this regard, the respective program personnel and other stakeholders of BEES declared that it is essential to discuss the use of sanitary latrines with beneficiaries during courtyard meetings because the issue is very relevant to health and nutrition.

In regard to the existence of organizations or individuals that encourage people to ensure safe water, sanitary latrine use and healthy practices, Md. Ruhul Amin, Head Teacher of a primary school in Palashbari upazila, Gaibandha district, said: *“No individual or organization encourages people to use safe water and sanitary latrine and indulge in healthy practices in our area.”*

4.10 Gaps in Services

In order to learn details about the health status of the community people, the survey team interviewed local elites (e.g., school teachers, commissioners, ex-members of union parishad, local politicians, and religious leaders, etc.) of the community. Discussions with them revealed the following:

- There was no static or satellite clinic to serve the community people of many areas.
- In very limited areas, BRAC provided domiciliary health services to pregnant and lactating mothers but the services were not satisfactory in meeting their demands.
- In most of the areas, only government health services were available. But the services were very inadequate considering the size of the population and their needs.
- In a very few selected areas, BRAC conducted awareness programs for the community people on using safe water, sanitary latrines and hygiene.
- The members of the community demanded general health treatment, especially for children and mothers, and treatment for asthma, diabetes, and ENT-related problems. They also for the treatment of adolescents and others.
- Many fertile couples expected the availability of appropriate contraceptive methods in their areas.
- Sheba Health Program implementing staff expected to strengthen relationship and cooperation with the Microfinance team.



Section 5: Conclusion

Overall, the impact of Sheba Health Program after seventeen years of implementation is quite satisfactory. So far, many beneficiaries have received much-needed health services from this program. Pregnant and lactating mothers, fertile couples, children from 0 to 5 years, and adolescent girls were the major target groups as beneficiaries of this program. Through the program, the beneficiaries received services on antenatal care, postnatal care, family planning, counseling on colostrum feeding and weaning food, exclusive breastfeeding, immunization, treatment of general diseases, supplementary food demonstration, and referral facilitation. As frontline project implementers, the paramedics of BEES provided services to the program beneficiaries through static and satellite clinics. They referred emergency or complicated cases to local government health facilities or clinics through collaboration with them. Significant achievement was seen in the intervention of colostrum feeding, complementary feeding, measurement of growth monitoring for children, ANC and PNC services, and BMI measurement of adolescent girls and pregnant mothers. A significant number of households also received general treatment for common cold, fever, cough, diarrhea, dysentery, acidity, worm infestation and skin diseases from the program's assigned paramedics.

Despite having some limitations, the program turned out to be successful, although there are a lot of areas to improve, such as dissemination of program activities and other information through attractive BCC materials, introduction of school program for adolescent girls for BMI measurement, preparation of a list of appropriate service centers and skilled birth attendants for the beneficiaries and others, and working for providing need-based services to the beneficiaries of the program. Improvement of monitoring and evaluation tools is required to measure the changes over time and to observe the impact of the program effectively. Strengthening collaboration among the staff members of the Microfinance Program and the Sheba Health Program is also required in order to implement the program smoothly.



Section 6: Recommendations

The recommendation part of a report is very important because it directs the stakeholders to the solution of their specific problems. The following are the main recommendations of the study which may help to further improve this program:

- Awareness sessions on the importance of colostrum feeding of newborns and exclusive breastfeeding of children up to the age of 6 months may be arranged for beneficiary pregnant mothers and their families. Different varieties of attractive BCC materials regarding these needs may be distributed to pregnant mothers at the time of ANC/PNC.
- Quality ANC may be ensured through incorporating most of the parameters of ANC for increasing the number of patients.
- Demonstration sessions on 'Health and Nutrition for Children and PNC/ANC Mothers' may be arranged to raise awareness of pregnant mothers and their family members.
- Sessions may be conducted through courtyard meetings to enhance awareness among fertile couples on the issue of maintaining proper birth spacing to keep up the sound health of mothers and children.
- Program implementers may create awareness among parents on the importance of immunization for children to increase the number of children under immunization program.
- Program implementers may create awareness among parents about the importance of GMP and provide colored GMP card for encouraging them to receive the service again.
- School program can be introduced in collaboration with the government's health program for including more adolescent girls under BMI measurement.
- For reducing home delivery by unskilled birth attendants, linkages may be established with appropriate service centers/persons whose list may be supplied to the beneficiaries.
- List of skilled birth attendants can be prepared and displayed to the pregnant mothers and their families through static clinic, satellite clinic and during home visits
- Formal and non-formal training may be arranged to enhance the expertise of program's paramedics.
- The public and private health sectors' facilities may be disseminated to the community people as they can choose the facilities according to their needs.
- Number of paramedics and satellite clinics can be increased for expanding the program area and increasing the number of beneficiaries.
- Contraceptive pills and condoms can be sold through Sheba Health Program at subsidized rate to increase CPR.

- Monitoring tools with a concrete set of indicators can be developed to measure changes over time and conduct further evaluation after certain interval to observe the impact of the program.
- The importance of GMP measurement can be enhanced through increasing the awareness of beneficiary families about the benefits of GMP and increasing the number of paramedics.
- Goal, objectives and importance of the Sheba Health Program can be explained to the field level staffs of the Microfinance Program as they can contribute to the proper implementation of the program.

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Annex 1: Data collection tool for treatment sample

Impact Evaluation Survey Questionnaire 2018 SHEBA Health Programme Bangladesh Extension Education Services (BEES)

Data collection method: Through Individual Interview

Respondent's Name (Association member): _____

Respondent's contact number: _____ Personal/On request (Mark ✓)

Husband/Father's Name _____

Village: _____ Union: _____ District _____

Branch Office: _____ Area Office: _____

1. Mother and Child health related information:

Child health related information	Number	Causes/ Comments
1. Current number of children of your family (0 to 6 months)	Number: Age:	
2. Current number of children of your family (6 months to 2 years)	Number: Age:	
3. Current number of children of your family (2 to 5 years)	Number: Age:	
4. Total children who received colostrum (0 to 2 years)		
5. In case of 6 months plus to 2 years children: Children (0 to 6 months) who received exclusive breast feeding	Number: Age:	
6. In case of 0 to 6 months old children, in which age each child started to receive supplementary feeding?	Number:	
	Age:	
7. In case of 6 months plus to 2 years children, in which age each child started to receive supplementary feeding?	Number:	
	Age:	

Child health related information		Number	Causes/ Comments
8. Status of children (2 years plus to 5 years) who received all vaccines according to EPI schedule			
9. Stillbirth (Status based on last 6 month's delivery)			
Child health related information	How many children died during the last 6 months		
	Number	Data source	Cause/ Remarks
10. Up to 28 days			
11. 29 days to 1 year			
12. 1 year to 5 years			
13. Current status of the children (0-2 years) who are under growth monitoring		BEES: Government: Non-government:	

Delivery service related information	In case of all deliveries during the last 6 months		
	Number	Birth attendant	
14. Delivery with the assistance of trained birth attendant at home (Paramedic, nurse, midwife, FWV, doctor)			
15. Delivery with the assistance of unskilled birth attendant at home			
16. Delivery at Govt./Non-Govt./Clinic	Caesarian: Govt./Non-Govt.		
	NVD: Govt./Non-Govt.:		

2. Health related knowledge and practices:

Water source	Purpose of use (Put tick)					Service provider (Person or organization)
	Drinking water	Washing kitchen utensils	Cooking water	Water for hand wash	Others (e.g. bath, after defecation etc.)	
1. Tube well (Arsenic free)						
2. Tube well (Arsenic)						
3. Pond						
Type of used toilet (Mark tick)						
Subject		Yes/No	Service provider (Person or organization)		Remarks	
Hygienic (With ring/slab and unbroken water seal)						
Kancha (pit toilet without ring/slab)						
Toilet with broken water seal						

3. Preventive and remedy related services**ANC health service related information**

Number of deliveries at home during last 6 months (In case of all delivery e.g. living, stillbirth & dead):

	Have you received ANC service?	Measure blood pressure of pregnant women	Test albumin/sugar in urine	Measure weight	Test haemoglobin in blood	Discuss about breast feeding within 1 hour of birth	Discuss about exclusive breast feeding up to 6 months of birth	If yes, from where h/ she received services (Doctor, nurse, midwife, paramedic, FWV or others)	Number of total ANC
In case of one delivery	Yes/No								
	If yes how many								
In case of two delivery	Yes/No								
	If yes how many								
In case of three delivery	Yes/No								
	If yes how many								

PNC health service related information (for mothers)

Number of all deliveries within the range from 43rd day to 6 months (In case of all delivery including living, stillbirth and dead)

	Have you received PNC service?	Measure Blood pressure of PNC mother	Test albumin/sugar in urine	Measure weight	Test haemoglobin in blood	If yes, from where h/ she received services (Doctor, nurse, midwife, paramedic, FWV or others)	Number of total PNC
In case of one delivery	Yes/No						
	If yes how many						
In case of two delivery	Yes/No						
	If yes how many						
In case of three delivery	Yes/No						
	If yes how many						

Services	Yes / No	How many (put tick)			Service provider's/ organization's name	Causes/Remarks
		1	2	3		
Existence of growth monitoring service for the children >2-5 years old					Govt.: Non-Govt.:	
					Govt.: Non-Govt.:	
Existence of BMI service for adolescent girls in the family					Govt.: Non-Govt.:	
					Govt.: Non-Govt.:	
Existence of BMI service for pregnant women in the family					Govt.: Non-Govt.:	
					Govt.: Non-Govt.:	

4. Was there any initiative taken to reduce the risk during pregnancy in past 6 months? Yes/No.

If yes, what was that and who took that initiative?

5. Have you received health card for your family from any institution to receive health services?

Yes/No

If yes, from which institution you have received it?

Have you been benefited by receiving the health card? How?

6. Information on services regarding Static and Satellite Clinic: (Received health services from government and other services centres)

Services	Yes/No	Organization's name	Remarks
Have you received general health services in past 6 months? (fever, cold, cough, diarrhoea etc.)		Govt.: Non-Govt. Others:	
Number of Married fertile couple in the family	Number:		
Fertile couple who receiving birth control method	Number:		Type of birth control method:
Critical pregnant mothers or other critical patients were referred to govt. hospital/clinic in the last 6 months	Number: Type of Patient:	Govt.: Non-Govt. Own:	
		Govt.: Non-Govt. Own:	

7. Was there any demonstration session organized for pregnant mothers and children on supplementary food intake? If yes, who organized it and when it was organized?

Have you been benefited after participating in the demonstration session? How?

8. What is your concept about balanced diet?

9. Have you introduced any changes in your family regarding food habit? Why?

Interviewer's Name:

Designation:

Date: 2018

Annex 2: Data collection tool for control

THIS FORMAT IS APPLICABLE FOR THE OUTSIDE OF SHEBA PROGRAM AREAS OF BEES

**Impact Evaluation Survey Questionnaire 2018
SHEBA Health Programme
Bangladesh Extension Education Services (BEES)**

Data collection method: Through Individual Interview

Respondent's Name _____

Respondent's contact number: _____ Personal/On request (Mark ✓)

Husband/Father's Name _____

Village: _____ Union: _____ District _____

Branch Office: _____ Area Office: _____

1. Mother and Child health related information:

Child health related information	Number	Causes/ Comments
1. Current number of children of your family (0 to 6 months)	Number: Age:	
2. Current number of children of your family (6 months to 2 years)	Number: Age:	
3. Current number of children of your family (2 to 5 years)	Number: Age:	
4. Total children who received colostrum (0 to 2 years)		
5. In case of 6 months plus to 2 years children: Children (0 to 6 months) who received exclusive breast feeding	Number: Age:	
6. In case of 0 to 6 months old children, in which age each child started to receive supplementary feeding?	Number: Age:	
7. In case of 6 months plus to 2 years children, in which age each child started to receive supplementary feeding?	Number: Age:	
8. Status of children (2 years plus to 5 years) who received all vaccines according to EPI schedule		
9. Stillbirth (Status based on last 6 month's delivery)		
Child health related information	How many children died during the last 6 months	
	Number	Data source Cause/Remarks
10. Up to 28 days		
11. 29 days to 1 year		
12. 1 year to 5 years		
13. Current status of the children (0-2 years) who are under growth monitoring		BEES: Government: Non-government:

Delivery service related information	In case of all deliveries during the last 6 months		
	Number	Birth attendant	
14. Delivery with the assistance of trained birth attendant at home (Paramedic, nurse, midwife, FWV, doctor)			
15. Delivery with the assistance of unskilled birth attendant at home			
16. Delivery at Govt./Non-Govt./Clinic	Caeserian: Govt./Non-Govt.		
	NVD: Govt./Non-Govt.:		

2. Health related knowledge and practices:

Water source	Purpose of use (Put tick)					Service provider (Person or organization)
	Drinking water	Washing kitchen utensils	Cooking water	Water for hand wash	Others (e.g. bath, after defecation etc.)	
4. Tube well (Arsenic free)						
5. Tube well (Arsenic)						
3. Pond						
Type of used toilet (Mark tick)						
Subject			Yes/No	Service provider (Person or organization)		Remarks
Hygienic (With ring/slab and unbroken water seal)						
Kutcha (pit toilet without ring/slab)						
Toilet with broken water seal						

3. Preventive and remedy related services

ANC health service related information

Number of deliveries at home during last 6 months (In case of all delivery e.g. living, stillbirth & dead):

	Have you received ANC service?	Measure blood pressure of pregnant women	Test albumin/sugar in urine	Measure weight	Test haemoglobin in blood	Discuss about breast feeding within 1 hour of birth	Discuss about exclusive breast feeding up to 6 months of birth	If yes, from where h/ she received services (Doctor, nurse, midwife, paramedic, FWV or others)	Number of total ANC
In case of one delivery	Yes/No								
	If yes how many								
In case of two delivery	Yes/No								
	If yes how many								
In case of three delivery	Yes/No								
	If yes how many								

PNC health service related information (for mothers)

Number of all deliveries within the range from 43rd day to 6 months (In case of all delivery including living, stillbirth and dead)

	Have you received PNC service?	Measure Blood pressure of PNC mother	Test albumin/sugar in urine	Measure weight	Test haemoglobin in blood	If yes, from where h/ she received services (Doctor, nurse, midwife, paramedic, FWW or others)	Number of total PNC
In case of one delivery	Yes/No						
	If yes how many						
In case of two delivery	Yes/No						
	If yes how many						
In case of three delivery	Yes/No						
	If yes how many						

Services	Yes/No	How many (put tick)			Service provider's/ organization's name	Causes/Remarks
		1	2	3		
Existence of growth monitoring service for the children >2-5 years old					Govt.: Non-Govt.:	
					Govt.: Non-Govt.:	
Existence of BMI service for adolescent girls in the family					Govt.: Non-Govt.:	
					Govt.: Non-Govt.:	
Existence of BMI service for pregnant women in the family					Govt.: Non-Govt.:	
					Govt.: Non-Govt.:	

4. Was there any initiative taken to reduce the risk during pregnancy in past 6 months? Yes/No.

If yes, what was that and who took that initiative?

5. Have you received health card for your family from any institution to receive health services?

Yes/No

If yes, from which institution you have received it?

Have you been benefited by receiving the health card? How?

6. Information on services regarding Static and Satellite Clinic: (Received health services from government and other services centres)

Services	Yes/No	Organization's name	Remarks
Have you received general health services in past 6 months? (fever, cold, cough, diarrhoea etc.)		Govt.: Non-Govt. Others:	
Number of Married fertile couple in the family	Number:		
Fertile couple who receiving birth control method	Number:		Type of birth control method:
Critical pregnant mothers or other critical patients were referred to govt. hospital/clinic in the last 6 months	Number: Type of Patient:	Govt.: Non-Govt. Own: Govt.: Non-Govt. Own:	

7. Was there any demonstration session organized for pregnant mothers and children on supplementary food intake? If yes, who organized it and when it was organized?

Have you been benefited after participating in the demonstration session? How?

8. What is your concept about balanced diet?

9. Have you introduced any changes in your family regarding food habit? Why?

Interviewer's Name:

Designation:

Date: 2018

Annex 3: Data collection tool for treatment sample (In Bangla)

ইমপ্যাক্ট মূল্যায়ন জরিপ প্রশ্নমালা ২০১৮
সেবা স্বাস্থ্য কর্মসূচি
বাংলাদেশ এক্সটেনশন এডুকেশন সার্ভিসেস (বিজ)

তথ্য সংগ্রহের পদ্ধতিঃ ব্যক্তি সাক্ষাৎকারের মাধ্যমে

উত্তরদাতার নাম (সমিতির সদস্য)ঃ-----

উত্তরদাতার মোবাইল নম্বরঃ----- (নিজ/ অন্যের - টিকদিন)

স্বামী/পিতার নামঃ-----

গ্রামঃ-----ইউনিয়ন-----উপজেলাঃ-----জেলাঃ-----

শাখা অফিসঃ-----এরিয়া অফিসঃ-----

১. মা ও শিশু স্বাস্থ্য সংক্রান্তঃ

শিশু স্বাস্থ্য সংক্রান্ত তথ্যাবলী	সংখ্যা	কারণ/মন্তব্য
১) বর্তমানে আপনার খানায় মোট শিশু (০ থেকে ৬ মাস)	সংখ্যাঃ বয়সঃ	
২) বর্তমানে আপনার খানায় মোট শিশু (৬ মাসের পর থেকে ২ বৎসর)	সংখ্যাঃ বয়সঃ	
৩) বর্তমানে আপনার খানায় মোট শিশু (২ বৎসরের পর থেকে ৫ বৎসর)	সংখ্যাঃ বয়সঃ	
৪) শালদুধ খাওয়ানো হয়েছে এমন শিশু (০ থেকে ২ বৎসর বয়স পর্যন্ত)		
৫) ৬ মাস পূর্ণ হওয়ার পর থেকে ২ বৎসর বয়স পর্যন্ত বাচ্চাদের ক্ষেত্রে: ০ থেকে ৬ মাস পর্যন্ত শুধুমাত্র মায়ের বুকের দুধ খাওয়ানো হয়েছে এমন শিশু (মধু, মিস্তির পানি, বাডফুঁকের পানি, পানি, গরু/ছাগলের দুধ অথবা অন্য কোন বাড়তি খাবার)	সংখ্যাঃ বয়সঃ	
৬) ০ থেকে ৬ মাস বয়সের শিশুদের ক্ষেত্রে কোন শিশুকে কত বয়স থেকে বাড়তি খাবার খাওয়ানো হয়েছিল? (সংখ্যার ঘরে খাবার খাওয়ানোর শুরু বয়স উল্লেখ করুন)	সংখ্যাঃ বয়সঃ	
৭) ৬ মাসের পর থেকে ২ বৎসর বয়স পর্যন্ত শিশুদের ক্ষেত্রে কোন শিশুকে কত বয়স থেকে বাড়তি খাবার খাওয়ানো হয়েছিল? (সংখ্যার ঘরে খাবার খাওয়ানোর শুরু বয়স উল্লেখ করুন)		
৮) ইপিআই শিডিউল অনুযায়ী সব ভ্যাক্সিন পেয়েছে এমন শিশু (২ বৎসরের পর থেকে ৫ বৎসর বয়স পর্যন্ত শিশুদের ক্ষেত্রে) - ইপিআই কার্ড চেক করুন		
৯) মৃত শিশুর জন্ম (বিগত ৬ মাস পর্যন্ত যতগুলো প্রসব হয়েছে) - কান্না, নড়াচড়া কিম্বা শ্বাসপ্রশ্বাস- এ তিনটির যে কোন একটি ঘটলে মৃত জন্মহিসাবে গণ্য না করে নবজাতকের মৃত্যু হিসাবে গণ্য করতে হবে)		

শিশুস্বাস্থ্য সংক্রান্ত তথ্যাবলী	গত ৫ বছরে কতজন শিশুর মৃত হয়েছে		
		উপাত্তের উৎস	কারণ/মন্তব্য
১০) ০-২৮দিন বয়স পর্যন্ত			
১১) ২৯ দিন থেকে ১ বৎসর বয়স পর্যন্ত			
১২) ১ বৎসরের পর থেকে ৫ বৎসর বয়স পর্যন্ত			
১৩) বৃদ্ধি পর্যবেক্ষণ করা হচ্ছে এমন শিশু (০ থেকে ২ বৎসর বয়স পর্যন্ত) (বর্তমান) - বৃদ্ধি পর্যবেক্ষণ কার্ড দেখুন		বিজ্ঞঃ সরকারীঃ বেসরকারীঃ	

ডেলিভারী সেবা সংক্রান্ত তথ্যাবলী	গত ৬ মাসের সকল প্রসবের ক্ষেত্রে প্রযোজ্য		
	সংখ্যা	প্রসব সহায়তাকারী	মন্তব্য
১৪) বাড়িতে দক্ষ প্রসব সহায়তাকারী দ্বারা (প্যারামেডিক, নার্স, মিডওয়াইভ, FWV, Doctor) প্রসব			
১৫) বাড়িতে অদক্ষ প্রসব সহায়তাকারী দ্বারা			
১৬) সরকারী/ বেসরকারী হাসপাতাল/ক্লিনিকে প্রসব	সিজারিয়ানঃ		
	সরকারী/বেসরকারী		
	নরমালঃ		
	সরকারী/ বেসরকারী		

২. স্বাস্থ্যবিধির উপর জ্ঞান ও অনুশীলনঃ

খানার পানির উৎস	ব্যবহারের উদ্দেশ্য (টিক দিন)					সেবা প্রদানকারী ব্যক্তি বা সংস্থা
	খাবার পানি	রান্নাঘরের পাত্রসমূহ ধোয়ার পানি	রান্নারপানি	হাত ধোয়ার পানি	অন্যান্য (উদাঃ গোসলের জন্য কিংবা মলত্যাগের পর ব্যবহৃত পানি)	
১) নলকূপ (আর্সেনিকমুক্ত)						
২) নলকূপ (আর্সেনিকযুক্ত)						
৩) পুকুর						

ব্যবহৃত পায়খানার ধরন (টিক দিন)			
বিষয়	হ্যাঁ / না	সেবাপ্রদানকারী ব্যক্তি বা সংস্থা	মন্তব্য
স্বাস্থ্যসম্মত (রিং/স্ল্যাব অথবা পাকা পায়খানা যেখানে Water seal ভাঙ্গা নয়)			
কাঁচা (রিং এবং স্ল্যাব ছাড়া মাটির গর্তের পায়খানা)			
Water seal ভাঙ্গা পায়খানা			

৩. প্রতিরোধ ও প্রতিকার সংক্রান্ত স্বাস্থ্যসেবাঃ

ANC স্বাস্থ্যসেবা সংক্রান্ত তথ্যখানায় বিগত ৬ মাস পর্যন্ত সকল ডেলিভারির সংখ্যা (জীবিত, মৃত এবং মৃত্যু সকল প্রসব)ঃ

	এএনসি সেবা নিয়েছিলেন কি?	গর্ভবতী মহিলার ব্লাড প্রেসার পরিমাপ করা হয়েছিল	ইউরিন-এ এন্ডুমিন/ সুগার টেস্ট করা হয়েছিল	ওজন পরিমাপ করা হয়েছিল	রক্তে হিমোগ্লোবিন টেস্ট করা হয়েছিল	জন্মের ১ ঘণ্টার মধ্যে বুকের দুধ খাওয়ানোর বিষয়ে আলোচনা করা হয়েছিল	৬ মাস পর্যন্ত শুধুমাত্র বুকের দুধ খাওয়ানোর বিষয়ে আলোচনা করা হয়েছিল	হ্যাঁ হলে কার কাছ থেকে সেবা নিয়েছে (Doctor, নার্স, মিডওয়াইফ, প্যারামেডিক, FWW বা অন্যান্য)	মোট ANC এর সংখ্যা
১টি প্রসবের ক্ষেত্রে	হ্যাঁ/না হ্যাঁ হলে কতবার								
২টি প্রসবের ক্ষেত্রে	হ্যাঁ/না হ্যাঁ হলে কতবার								
৩টি প্রসবের ক্ষেত্রে	হ্যাঁ/না হ্যাঁ হলে কতবার								

PNC স্বাস্থ্য সেবাসংক্রান্ত তথ্য (মা'দের ক্ষেত্রে) ৪৩ দিন পার হয়েছে এবং ৬ মাস পর্যন্ত সকল ডেলিভারির সংখ্যা (জীবিত, মৃত এবং মৃত্যু সকল প্রসব)ঃ

	পিএনসি সেবা নিয়েছিলেন কি?	PNC মহিলার ব্লাড প্রেসার পরিমাপ করা হয়েছিল	ইউরিন-এ এন্ডুমিন/ সুগারটেস্ট করা হয়েছিল	ওজন পরিমাপ করা হয়েছিল	রক্তে হিমোগ্লোবিন টেস্ট করা হয়েছিল	হ্যাঁ হলে কার কাছ থেকে সেবা নিয়েছে (Doctor, নার্স, মিডওয়াইফ, প্যারামেডিক, FWW বা অন্যান্য)	মোট PNC এর সংখ্যা
১টি প্রসবের ক্ষেত্রে	হ্যাঁ/না হ্যাঁ হলে কতবার						
২টি প্রসবের ক্ষেত্রে	হ্যাঁ/না হ্যাঁ হলে কতবার						
৩টি প্রসবের ক্ষেত্রে	হ্যাঁ/না হ্যাঁ হলে কতবার						

সমীক্ষার দিকসমূহ	হ্যাঁ / না	কতবার (টিকদিন)			সেবা প্রদানকারী/সংস্থার নাম	কারণ/মন্তব্য
		1	2	3		
>২-৫ বৎসর বয়সের শিশুদের বৃদ্ধি মনিটরিং এর সেবা বিদ্যমান আছে কিনা					সরকারীঃ বেসরকারীঃ	
ঐ খানায় বিএমআই সেবা বিদ্যমান আছে কিনা (কিশোরী)					সরকারীঃ বেসরকারীঃ	
ঐ খানায় বিএমআই সেবা বিদ্যমান আছে কিনা (গর্ভবতীদের জন্য)					সরকারীঃ বেসরকারীঃ	

৪. বিগত ৬ মাসে গর্ভাবস্থায় ঝুঁকি হ্রাসের জন্য কি কোন উদ্যোগ নেয়া হয়েছিল? হ্যাঁ / না
হ্যাঁ হলে সেটা কি ছিল এবং উদ্যোগটা কে নিয়েছিল ?

৫. স্বাস্থ্যসেবাসমূহ গ্রহণের জন্য আপনার পরিবার কি কোন প্রতিষ্ঠান থেকে স্বাস্থ্য কার্ড পেয়েছে ?
হ্যাঁ / না

যদি পেয়ে থাকে তবে কোন প্রতিষ্ঠান থেকে পেয়েছে ?

স্বাস্থ্যকার্ড পেয়ে আপনারা কি উপকৃত হয়েছিলেন ? কিভাবে ?

৬. স্ট্যাটিক ও স্যাটেলাইট ক্লিনিক সংক্রান্ত তথ্যঃ (সরকারী/অন্যান্য সেবাকেন্দ্র থেকে প্রাপ্ত স্বাস্থ্যসেবা)

সেবাসমূহ	হ্যাঁ/না	সংস্থার নাম		মন্তব্য
গত ৬ মাসে সাধারণ রোগের চিকিৎসা সেবা নিয়েছিলেন কিনা? (জর, ঠাণ্ডা, কাশি, ডায়ারিয়া ইত্যাদি)		সরকারীঃ বেসরকারীঃ অন্যান্যঃ		
খানায় বিবাহিত সক্ষম দম্পতি	সংখ্যাঃ			
জন্মনিয়ন্ত্রণ পদ্ধতি ব্যবহারকৃত সক্ষম দম্পতি	সংখ্যাঃ			
গত ৬ মাসে গর্ভজনিত সেবা ও অন্যান্য রোগের ক্ষেত্রে সরকারী হাসপাতাল / ক্লিনিকে জরুরী রেফার করতে হয়েছিল	সংখ্যাঃ রুগীর ধরনঃ	সরকারীঃ বেসরকারীঃ নিজঃ		জন্মনিয়ন্ত্রণ পদ্ধতির ধরনঃ
		সরকারীঃ বেসরকারীঃ নিজঃ		

৭. আপনার এলাকায় গর্ভবতী মা ও শিশুদের সম্পূর্ণ খাবার গ্রহণের উপর কি কোন প্রদর্শনী এর ব্যবস্থা করা হয়েছিল? যদি হয়, তাহলে এটা কে করেছিল এবং কখন করা হয়েছিল?

আপনি কি উক্ত প্রদর্শনী থেকে উপকৃত হয়েছিলেন? কিভাবে?

৮. সুস্থ খাদ্য সম্পর্কে আপনার ধারণা কি?

৯. খাদ্যাভ্যাসে আপনার পরিবারে কি কোন ধরনের পরিবর্তন প্রবর্তন করা হয়েছে? কেন?

তথ্য সংগ্রহকারীর নামঃ

পদবীঃ

তারিখঃ ২০১৮

Annex 4: Data collection tool for control (in Bangla)

এই ফরমেটটি বিজের কর্ম এলাকার বাইরের জন্য

ইমপ্যাক্ট মূল্যায়ন জরিপ প্রশ্নমালা ২০১৮
সেবা স্বাস্থ্য কর্মসূচি
বাংলাদেশ এক্সটেনশন এডুকেশন সার্ভিসেস (বিজ)

তথ্য সংগ্রহের পদ্ধতিঃ ব্যক্তি সাক্ষাৎকারের মাধ্যমে

উত্তরদাতার নাম (সমিতির সদস্য)ঃ-----

উত্তরদাতার মোবাইল নম্বরঃ----- (নিজ/ অন্যের - টিকদিন)

স্বামী/পিতার নামঃ-----

গ্রামঃ-----ইউনিয়ন-----উপজেলাঃ-----জেলাঃ-----

শাখা অফিসঃ-----এরিয়া অফিসঃ-----

১. মা ও শিশু স্বাস্থ্য সংক্রান্তঃ

শিশুস্বাস্থ্য সংক্রান্ত তথ্যাবলী	সংখ্যা	কারণ/মন্তব্য
১) বর্তমানে আপনার খানায় মোট শিশু (০ থেকে ৬ মাস)	সংখ্যাঃ বয়সঃ	
২) বর্তমানে আপনার খানায় মোট শিশু (৬ মাসের পর থেকে ২ বৎসর)	সংখ্যাঃ বয়সঃ	
৩) বর্তমানে আপনার খানায় মোট শিশু (২ বৎসরের পর থেকে ৫ বৎসর)	সংখ্যাঃ বয়সঃ	
৪) শালদুধ খাওয়ানো হয়েছে এমন শিশু (০ থেকে ২ বৎসর বয়স পর্যন্ত)	সংখ্যাঃ বয়সঃ	
৫) ৬ মাস পূর্ণ হওয়ার পর থেকে ২ বৎসর বয়স পর্যন্ত বাচ্চাদের ক্ষেত্রে: ০ থেকে ৬ মাস পর্যন্ত শুধু মাত্র মায়ের বুকের দুধ খাওয়ানো হয়েছে এমন শিশু (মধু, মিসির পানি, বাড়ফুঁকের পানি, পানি, গরু/ছাগলের দুধ অথবা অন্য কোন বাড়তি খাবার)	সংখ্যাঃ বয়সঃ	
৬) ০ থেকে ৬ মাস বয়সের শিশুদের ক্ষেত্রে কোন শিশুকে কত বয়স থেকে বাড়তি খাবার খাওয়ানো হয়েছিল? (সংখ্যার ঘরে খাবার খাওয়ানোর শুরু বয়স উলেখ করুন)	বয়সঃ	
৭) ৬ মাসের পর থেকে ২ বৎসর বয়স পর্যন্ত শিশুদের ক্ষেত্রে কোন শিশুকে কত বয়স থেকে বাড়তি খাবার খাওয়ানো হয়েছিল? (সংখ্যার ঘরে খাবার খাওয়ানোর শুরু বয়স উলেখ করুন)	সংখ্যাঃ	

শিশুস্বাস্থ্য সংক্রান্ত তথ্যাবলী	সংখ্যা	কারণ/মন্তব্য	
৮) ইপিআই শিডিউল অনুযায়ী সব ভ্যাক্সিন পেয়েছে এমন শিশু (২ বৎসরের পর থেকে ৫ বৎসর বয়স পর্যন্ত শিশুদের ক্ষেত্রে) - ইপিআই কার্ড চেক করুন	সংখ্যাঃ		
৯) মৃত শিশুর জন্ম (বিগত ৬ মাস পর্যন্ত যতগুলো প্রসব হয়েছে) - কান্না, নড়াচড়া কিম্বা শ্বাসপ্রশ্বাস- এ তিনটির যে কোন একটি ঘটলে মৃত জন্ম হিসাবে গণ্য না করে নবজাতকের মৃত্যু হিসাবে গণ্য করতে হবে)			
শিশুস্বাস্থ্য সংক্রান্ত তথ্যাবলী	গত ৫ বছরে কতজন শিশুর মৃত হয়েছে		
	শিশুস্বাস্থ্য সংক্রান্ত তথ্যাবলী	উপাত্তের উৎস	কারণ/মন্তব্য
১০) ০-২৮ দিন বয়স পর্যন্ত			
১১) ২৯ দিন থেকে ১ বৎসর বয়স পর্যন্ত			
১২) ১ বৎসরের পর থেকে ৫ বৎসর বয়স পর্যন্ত			
১৩) বৃদ্ধি পর্যবেক্ষণ করা হচ্ছে এমন শিশু (০ থেকে ২ বৎসর বয়স পর্যন্ত) (বর্তমান)- বৃদ্ধি পর্যবেক্ষণ কার্ড দেখুন		বিজঃ সরকারীঃ বেসরকারীঃ	
ডেলিভারী সেবাসংক্রান্ত তথ্যাবলী	গত ৬ মাসের সকল প্রসবের ক্ষেত্রে প্রযোজ্য		
	সংখ্যা	প্রসব সহায়তাকারী	মন্তব্য
১৪) বাড়িতে দক্ষ প্রসব সহায়তাকারী দ্বারা (প্যারামেডিক, নার্স, মিডওয়াইভ, FWV, Doctor) প্রসব			
১৫) বাড়িতে অদক্ষ প্রসব সহায়তাকারী দ্বারা			
১৬) সরকারী/ বেসরকারী হাসপাতাল/ক্লিনিকে প্রসব	সিজারিয়ানঃ		
	সরকারী/বেসরকারী		
	নরমালঃ		
	সরকারী/ বেসরকারী		

২. স্বাস্থ্যবিধির উপর জ্ঞান ও অনুশীলনঃ

খানার পানির উৎস	ব্যবহারের উদ্দেশ্য (টিক দিন)					সেবাপ্রদানকারী ব্যক্তি বা সংস্থা
	খাবার পানি	রান্নাঘরের পাত্রসমূহ ধোয়ার পানি	রান্নারপানি	হাত ধোয়ার পানি	অন্যান্য (উদাঃ গোসলের জন্য কিংবা মল ত্যাগের পর ব্যবহৃত পানি)	
১) নলকূপ (আর্সেনিকমুক্ত)						
২) নলকূপ (আর্সেনিকযুক্ত)						
৩) পুকুর						
ব্যবহৃত পায়খানার ধরন (টিক দিন)						
বিষয়	হ্যাঁ / না	সেবাপ্রদানকারী ব্যক্তি বা সংস্থা			মন্তব্য	

স্বাস্থ্যসম্মত (রিং/স্ল্যাব অথবা পাকা পায়খানা যেখানে Water seal ভাঙ্গা নয়)			
কাঁচা (রিং এবং স্ল্যাব ছাড়া মাটির গর্তে পায়খানা)			
Water seal ভাঙ্গা পায়খানা			

৩. প্রতিরোধ ও প্রতিকার সংক্রান্ত স্বাস্থ্যসেবাঃ ANC স্বাস্থ্যসেবা সংক্রান্ত তথ্য

খানায় বিগত ৬ মাস পর্যন্ত সকল ডেলিভারির সংখ্যা (জীবিত, মৃত এবং মৃত্যু সকল প্রসব)ঃ

	এএনসি সেবা নিয়েছিলেন কি?	গর্ভবতী মহিলার রক্ত প্রেসার পরিমাপ করা হয়েছিল	ইউরিন-এ এলুমিনি/ সুগার টেস্ট করা হয়েছিল	ওজন পরিমাপ করা হয়েছিল	রক্তে হিমোগ্লোবিন টেস্ট করা হয়েছিল	জন্মের ১ ঘণ্টার মধ্যে বুকের দুধ খাওয়ানোর বিষয়ে আলোচনা করা হয়েছিল	৬ মাস পর্যন্ত শুধুমাত্র বুকের দুধ খাওয়ানোর বিষয়ে আলোচনা করা হয়েছিল	হ্যাঁ হলে কার কাছ থেকে সেবা নিয়েছে (Doctor, নার্স, মিডওয়াইফ, প্যারামেডিক, FWV বা অন্যান্য)	মোট ANC-এর সংখ্যা
১টি প্রসবের ক্ষেত্রে	হ্যাঁ/না								
	হ্যাঁ হলে কতবার								
২টি প্রসবের ক্ষেত্রে	হ্যাঁ/না								
	হ্যাঁ হলে কতবার								
৩টি প্রসবের ক্ষেত্রে	হ্যাঁ/না								
	হ্যাঁ হলে কতবার								

PNC স্বাস্থ্য সেবা সংক্রান্ত তথ্য (মায়ীদের ক্ষেত্রে)

৪৩ দিন পার হয়েছে এবং ৬ মাস পর্যন্ত সকল ডেলিভারির সংখ্যা (জীবিত, মৃত এবং মৃত্যু সকল প্রসব)ঃ

	পিএনসি সেবা নিয়েছিলেন কি?	PNC মহিলার রক্ত প্রেসার পরিমাপ করা হয়েছিল	ইউরিন-এ এলুমিনি/সুগার টেস্ট করা হয়েছিল	ওজন পরিমাপ করা হয়েছিল	রক্তে হিমোগ্লোবিন টেস্ট করা হয়েছিল	হ্যাঁ হলে কার কাছ থেকে সেবা নিয়েছে (Doctor, নার্স, মিডওয়াইফ, প্যারামেডিক,FWV বা অন্যান্য)	মোট PNC এর সংখ্যা
১টি প্রসবের ক্ষেত্রে	হ্যাঁ/না						
	হ্যাঁ হলে কতবার						
২টি প্রসবের ক্ষেত্রে	হ্যাঁ/না						
	হ্যাঁ হলে কতবার						
৩টি প্রসবের ক্ষেত্রে	হ্যাঁ/না						
	হ্যাঁ হলে কতবার						
সমীক্ষার দিকসমূহ	হ্যাঁ / না	কতবার (টিকদিন)			সেবা প্রদানকারী/সংস্থার নাম	কারণ/মন্তব্য	
		১	২	৩			
>২-৫ বৎসর বয়সের শিশুদের বৃদ্ধি মনিটরিং এর সেবা বিদ্যমান আছে কিনা					সরকারীঃ বেসরকারীঃ		
ঐ খানায় বিএমআই সেবা বিদ্যমান আছে কিনা (কিশোরী)					সরকারীঃ বেসরকারীঃ		
ঐ খানায় বিএমআই সেবা বিদ্যমান আছে কিনা (গর্ভবতীদের জন্য)					সরকারীঃ বেসরকারীঃ		
					সরকারীঃ বেসরকারীঃ		

৪. বিগত ৬ মাসে গর্ভাবস্থায় ঝুঁকি হ্রাসের জন্য কি কোন উদ্যোগ নেয়া হয়েছিল? হ্যাঁ / না
হ্যাঁ হলে সেটা কি ছিল এবং উদ্যোগটা কে নিয়েছিল ?

৫. স্বাস্থ্যসেবাসমূহ গ্রহণের জন্য আপনার পরিবার কি কোন প্রতিষ্ঠান থেকে স্বাস্থ্য কার্ড পেয়েছে ?
হ্যাঁ / না

যদি পেয়ে থাকে তবে কোন প্রতিষ্ঠান থেকে পেয়েছে ?

স্বাস্থ্যকার্ড পেয়ে আপনারা কি উপকৃত হয়েছিলেন ? কিভাবে ?

৬. স্ট্যাটিক ও স্যাটেলাইট ক্লিনিক সংক্রান্ত তথ্যঃ (সরকারী/অন্যান্য সেবা কেন্দ্র থেকে প্রাপ্ত স্বাস্থ্যসেবা)

সেবাসমূহ	হ্যাঁ/না	সংস্থার নাম	মন্তব্য
গত ৬ মাসে সাধারণ রোগের চিকিৎসা সেবা নিয়েছিলেন কিনা? (জ্বর, ঠাণ্ডা, কাশি, ডায়ারিয়া ইত্যাদি)		সরকারীঃ বেসরকারীঃ অন্যান্যঃ	
খানায় বিবাহিত সক্ষম দম্পতি	সংখ্যাঃ		
জন্মনিয়ন্ত্রণ পদ্ধতি ব্যবহারকৃত সক্ষম দম্পতি	সংখ্যাঃ		জন্মনিয়ন্ত্রণ পদ্ধতির ধরনঃ
গত ৬ মাসে গর্ভজনিত সেবা ও অন্যান্য রোগের ক্ষেত্রে সরকারী হাসপাতাল / ক্লিনিকে জরুরী রেফার করতে হয়েছিল	সংখ্যাঃ রুগীর ধরনঃ	সরকারীঃ বেসরকারীঃ অন্যান্যঃ	
		সরকারীঃ বেসরকারীঃ অন্যান্যঃ	

৭. আপনার এলাকায় গর্ভবতী মা ও শিশুদের সম্পূর্ণ খাবার গ্রহণের উপর কি কোন প্রদর্শনী এর ব্যবস্থা করা হয়েছিল? যদি হয়, তাহলে এটা কে করেছিল এবং কখন করা হয়েছিল?

আপনি কি উক্ত প্রদর্শনী থেকে উপকৃত হয়েছিলেন? কিভাবে?

৮. সুস্বাদু খাদ্য সম্পর্কে আপনার ধারণা কি?

৯. খাদ্য অভ্যাসে আপনার পরিবারে কি কোন ধরনের পরিবর্তন প্রবর্তন করা হয়েছে? কেন?

তথ্য সংগ্রহকারীর নামঃ

পদবীঃ

তারিখঃ ২০১৮

Annex 5: Data collection tool for key informant

**Impact study survey Questionnaire /2018
(Sheba Health Program)
Bangladesh Extension Education Services (BEES)**

Data collection date:

Data Collection Method: Key Informant Interview (Teachers/Doctors/UP Chairman. Members and other local elites)

Respondent's Name:-----

Profession/Designation-----

Age-----Working Place:-----

Respondent's mobile number: -----

Village:-----Union:-----Upazila-----District-----

Branch Office:-----Area Office-----

1. Is there any static, satellite clinic in your area? If any, which types of services they are providing? What are your comments about their contribution?
2. Are there any more sectors from where the community people have been receiving health services? Which sectors these are and what types of services they are providing? How is their service quality?
3. Is there any service provider in the community for promoting safe water, sanitary latrine and practiced healthy habits? If any, please give detailed about that.
4. What types of health services are more required for family members?
5. What types of health services are required for providing mother and child health issues? Why?

Interviewer's Name:

Designation:

Annex 6: Data collection tool for key informant (in Bangla)

বাংলাদেশ এক্সটেনশন এডুকেশন সার্ভিসেস (বিজ)
বেইজলাইন জরিপ প্রশ্নমালা ২০১৮
সেবাস্বাস্থ্য কর্মসূচি

সংগ্রহকালঃ-----থেকে -----২০১৮

তথ্য সংগ্রহের পদ্ধতিঃ ব্যক্তি (এলাকার গন্যমান্য ব্যক্তি - শিক্ষক, ডাক্তার, চেয়ারম্যান, মেম্বর)
সাক্ষাৎকারের মাধ্যমে

উত্তরদাতার নামঃ-----

পেশা/পদবীঃ-----

বয়সঃ-----কর্মস্থলের নামঃ-----

গ্রামঃ-----ইউনিয়নঃ-----উপজেলাঃ-----জেলাঃ-----

শাখা অফিসঃ-----এরিয়া অফিসঃ-----

- ১। আপনার এলাকায় কি স্ট্যাটিক, স্যাটেলাইট ক্লিনিক আছে? যদি থাকে, এগুলোর কোনটি কি ধরনের সেবা দিচ্ছে? এগুলোর অবদান সম্পর্কে আপনার মতামত কি?
- ২। এ এলাকার জনগন আর কোন কোন সেক্টর থেকে স্বাস্থ্যসেবা পাচ্ছে? কি ধরনের সেবা পাচ্ছে? সেবার মান কেমন বলে আপনি মনে করেন?
- ৩। এই কমিউনিটিতে কি কোন সেবাপ্রদানকারী ব্যক্তি বা সংস্থা আছে যে নিরাপদ পানি, স্বাস্থ্যসম্মত পায়খানা এবং স্বাস্থ্যকর অভ্যাস অনুশীলনের জন্য জনগণকে উৎসাহিত করে? যদি থাকে তবে তার বিস্তারিত।
- ৪। পরিবারের সদস্যদের জন্য কোন ধরনের সেবা বাস্তবায়ন করা বেশী প্রয়োজন বলে মনে করেন ?
- ৫। এ এলাকায় মা ও শিশুস্বাস্থ্য বিষয়ে সেবাপ্রাপ্তির জন্য আরও কি ধরনের স্বাস্থ্যসেবা প্রদান করা প্রয়োজন বলে আপনি মনে করেন এবং কেন?

তথ্য সংগ্রহকারীর নামঃ

পদবীঃ

তারিখঃ

