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SIX MONTHS REPORT

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WOMEN'S HEALTH AND DEVELOPMENT PROGRAMME

01 JULY - 31 DECEMBER 1992

BANGLADESH RURAL ADVANCEMENT COMMITTEE (BRAC)
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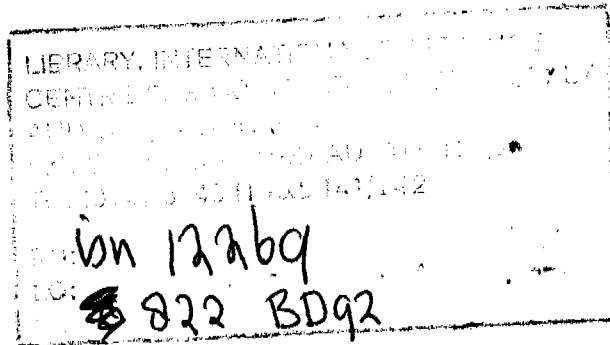
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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

This report is intended as a descriptive progress report on the process of implementation of the various components of WHDP, the status to date and a discussion on observations and lessons learnt. Furthermore, it is also intended to contribute to discussions of women's health in total and health seeking behavior of the women, their families and the community as a whole, the response of the existing system to the demand and the gaps. This is felt to be critical specially in view of the discussions currently taking place in BRAC regarding the organizational role in the national health arena.

Through past experience BRAC has realised that health improvement can only be sustained by income generation linked with socio-economic development. Taking this into consideration it launched the Women's Health and Development Programme (WHDP) in July 1991 targeted specially at the rural landless poor. It will not only benefit women but also rely on their services as well.

WHDP incorporates the five following interrelated projects.

1. Comprehensive Health Development Project (CHDP)
2. Expanded Programme on Immunization (EPI) -Facilitation
3. Primary Health Care - Rural Development Programme(PHC - RDP)
4. Non-Formal Primary Education (NFPE)
5. Health Resource Centre (HRC)

The progress of work in the five interrelated projects of WHDP are described in details in this report with data on achievement from July through December 1992.

COMPREHENSIVE HEALTH DEVELOPMENT PROGRAMME (CHDP)

Comprehensive Health Development Project (CHDP) has been implemented in ten thanas of Dinajpur, Bogra and Mymensingh regions with the sole purpose of improving the quality of life in terms of health and nutritional status among the most vulnerable and neglected section of the society i.e. women and children. It is also concerned with developing capacities at the community level among village participants to sustain the attained status in health and nutrition. The specific goal of the programme is to reduce the high maternal, child and infant mortality rates in Bangladesh.

WOMEN:

In the past six months a total of 37397 that is 9% of the total female population of reproductive age within the total WHDP areas were identified as pregnant.

Of them 80% were motivated to avail antenatal care either through government satellite clinics or the antenatal care clinics (ANCC) set up by WHDP. This is an improvement over the previously recorded attendance of 50% during the July 1991 to June 1992 reporting period.

The data indicates that 57% of the pregnant women were from the BRAC "target group" (TG) of whom 80% sought antenatal care through the government or BRAC established health care facilities. 72% of the women seeking health care attended the BRAC established Antenatal Care Clinics while 28% attended the government Satellite Clinics. The reasons cited by the program staff and the Monitoring Cell are absence of the FWA, lack of medical and other supplies/ equipment and the clinic not being held on the schedule date.

Therefore in terms of motivating and mobilizing the women to avail antenatal care, the program has been successful. However the majority of the women are seeking this care from BRAC facilities and not the government centres. In terms of health seeking behavior this is a positive trend, but with regard to WHDP's objective to improve the regularity and performance of the government service facilities so as to increase accessibility to and availability of services through these centres, increased attention needs to be directed towards achieving this part of the programme objective.

Out of the 20764 deliveries reported from the ten WHDP thanas 98% (20389) were live births with 89 maternal deaths resulting in a MMR of 6 per 1000 live births. If the data from the eight thanas are segregated from the above, the MMR is found to be 7 per 1000 live births, while the MMR in the two thanas with the pilot project on Maternal Mortality Reduction has been computed at 4 per 1000 live births. The MMR derived from the data of all the ten thanas as well as the eight thanas is slightly higher than the national average of 5.5/1000 live births while that from the pilot thanas is less.

Eclampsia, post-partum hemorrhage, obstructed labour account for majority of the maternal deaths, along with abortion and other preventable causes. In regard to causes other than pregnancy related, deaths of women have also been reported from the field mainly due to suicide (17%), diarrhea (13%) and malnutrition (8%).

14% (2324) of the women who took advantage of the antenatal care services were screened out as high risk cases, out of whom 686 were referred to secondary and tertiary care facilities. It must be noted that field reports indicate that not all the cases referred for services received or could benefit from those services due to distance, no accompanying person, lack of funds to pay for the services, and/or lack of medical supplies or service providers. The actual numbers and the specific causes need to be analysed for enhanced quality of care.

The percentage of pregnant women immunized with Tetanus Toxoid rose to 60% from the recorded 32% of the preceding year and the contraceptive acceptance rate in the WHDP areas was calculated to be 44%.

CHILD:

The total number of births recorded in the WHDP area during the past six months were 20764, with 98% being live births. 2466 deaths of children under 6 was reported, with the main causes being malnutrition (24%), pneumonia (14%), diarrhoea (12%), tetanus(8%), low birth weight (5%). These figures represent the birth and death information from all areas under WHDP. Information from the WHDP Monitoring Cell indicates that there is some under-reporting of the births and deaths from the NTG group. This is due to the fact that information from NTG households are updated only once in six months, and therefore all data may not be available in time for the six-monthly reports.

20626 or 71% of the U-2 children from the target group registered for growth monitoring. The data collected from the growth monitoring centres show growth faltering recorded for 5902 out of the above children. Records of the preceding period demonstrate faltering among 4358 children out of the 11462 registered under the growth monitoring centres.

Motivation during the July-December 1992 period ensured that out of the total target of 29016 children under one year of age, 78% of the infants have completed the DPT/OPV. This is an increase from the previous record of 60% coverage. 65% of these children have also received the measles vaccine.

The coverage of Vitamin A Capsule in the six months under reporting rose from 75% of the preceding year to 89%. This however does not include the 25000/50000 I.U of Vit A coverage received by a child with each dose of vaccine in the EPI sessions in the first year of life.

COMMUNITY PROGRAMMES:

In the Tuberculosis identification program from the total 6040 individuals identified as symptomatic during the reporting period, 1022 cases were diagnosed as positive in the past six months through microscopic sputum examination. Out of the sputum positive cases 87% have been brought under treatment at the time of reporting. The main cause of the remaining 13% not receiving treatment has been the inability of the patient and/or family to give the guarantee money of Taka 200.

This has made us alter our strategy. In order to ensure that the patient starts immediate treatment and does not continue to be a source of infection for the community, the programme staff mobilize the community regarding the importance and necessity of early treatment of these patients to prevent spread and effective control of the disease. Emphasis is also being given to motivate the community members to act as a guarantor for the patient, and ensure that the Tk 200 is given and treatment completed.

Subsequently, treatment is being initiated once the case has been identified as sputum positive and the community members have agreed to gather the Tk 200 guarantee money for the patient. It has also been noticed that the stigma attached to the word "tuberculosis", serves as a deterrent for the people to openly accept treatment.

At present 55025 households have access to safe drinking water through tubewells while 113378 households have sanitary latrines. Therefore the challenge for the programme to educate and affect the practice of the community on personal hygiene still remains.

INSTITUTION AND CADRE DEVELOPMENT:

A total number of 2266 Traditional Birth Attendants(TBAs) and 1463 Shastho Shebikas and 158 Shastho Kormis (village health workers) had been trained during this preceding period. At present, 2224 or 98% TBAs, 1413 or 97% Shastho Shebikas (SS) and all the Shastho Kormis (Sks) are actively involved with the programme.

WHDP's strategy in respect to the TBAs is to have them actively involved in articulating the woman's problems to the service provider at the health care facility, understand the advice given and ensure that this advice is followed by the women and her family. However we notice in the field that the TBA's involvement is restricted to identification of pregnant women; accompanying them to health care centres and being present during labour only to remove the placenta and clean the woman. Her role in decision making for referral or any follow-up or post-natal care is questionable. Requests have been made to the Monitoring Cell to further investigate this issue so that any required alterations can be made in the programme strategy.

The Gram Committees-GC (Village Committees) held 5731 meetings while the Mohila Shobhas-MS (Women's Forum) met 12136 times in the past six months. This represents an average monthly meeting of each GC and a quarterly meeting of each MS. The programme had envisioned the GCs as the organizational base for continuation of WHDP activities after cessation of the programme. So far we have not been able to achieve the spontaneity required for the GCs to be driven by their own momentum.

This is probably due to the fact that the concept of voluntary participation in welfare activities such as health are still very low on the priority list of the community. Thus the spirit of voluntarism is short lived, with enthusiasm diminishing as immediate results and material gain are not evident.

PILOT PROGRAMMES:

Maternal Mortality reduction:-

A pilot project geared towards maternal mortality reduction is underway in two thanas i.e. Dinajpur and Bogra Sadar for women from TG and NTG groups. The routine antenatal care

services provided in the other eight thanas has been further intensified and a Maternity Waiting Home established by BRAC within five kilometer radius of the government tertiary care centre. The objective of this project is to ensure that risk pregnancies are identified and referred to the secondary/tertiary care facilities with appropriate follow-up by the project staff. The project expects to address the issues of inaccessibility and lack of knowledge through heightened education of the community and the establishment of the Waiting Home.

The total pregnancies reported from the two thanas in this period were 5854 out of which there were 3662 deliveries. 93% of the 3662 deliveries were conducted at home, out of which 53% were attended by the TBAs trained by BRAC. 15% of the pregnancies were identified as high risk cases. 669 of the women with risk pregnancies delivered during the period and 94% of them had live births.

Of the referrals from this pilot project, 246 were high risk cases and 130 emergencies. There seems to be little difference between the number of high risk and emergency cases referred, indicating that emergencies can arise at any moment during pregnancy and delivery, even for those women who have had a normal, uncomplicated pregnancy, and all women are at risk of complications the moment they become pregnant. We hope to have a more thorough analysis of the data generated through this project to make definite and conclusive comments on this point.

Out of the fifteen maternal deaths the largest number was due to eclampsia, a cause which is preventable with early detection. However most of the cases were late detections with inadequate time for referral and care; departure from the area for the paternal home (outside the project area) for confinement; lack of conviction about the risk nature of the case among the woman and family members, leading to doubts regarding necessity of care at secondary and/or tertiary facilities. All this indicate need for intensified education of the women, the decision makers in their families, and the community.

Birth Weight Monitoring:-

To analyze the information on trend and variations in birth weight in the three WHDP region and use it as a base for any programme modification, a pilot project has been undertaken to record the birth of new born within 24 hours of birth. 2000 population per area have been identified for this purpose.

Out of the total 496 birth weights recorded during the July-December 1992 period 30% were found to be below the cut off point of 2.5 kg. This corresponds to the national statistics released by World Bank. There however may be a geographical variation in this, which we hope to highlight in a later report.

Pneumonia Control Project:-

A pilot pneumonia (ARI) control project for U-3 children has also been undertaken in

Bogra and Dinajpur Sadar thanas. Through this project the Shastho Shebikas (Voluntary Health Workers) are trained to identify and treat the disease in mild and moderate stages, and refer cases in the severe stage.

2717 children were identified by the Shastho Shebikas(SS) as suffering from pneumonia. 97% or 2652 of them were treated by the Shastho Shebikas in the community with a 99% cure rate. During the previous reporting period 217 children were identified and 52% of them were treated by the SS. As expected cure rates are better with early identification and this also assists in reducing the number of severe cases. The case detection will have to be intensified with continuous feedback to and re-training of the SSs and supply of timers for accurate judgement of the respiratory rate.

Community Based Nutrition Supplementation:-

The community based nutrition pilot project has been established by WHDP in Muktagachha, Mymensingh to identify community based means to harness endemic malnutrition through immediate/short term and long term measures. The short term measure is to address the faltering of weight of the under two through supplementation and education; and the long term measures are to affect birth weight through education and supplementation of pregnant and lactating women, and the growth of the would-be mothers i.e. the adolescent girls. The data from this work is expected to be discussed in details at a later date.

Short Term TB Therapy Pilot Project:-

A pilot project is also being implemented in Phulpur on the cure rate and cost effectiveness in the community based identification, treatment and control of TB using the six, eight and twelve months of anti tubercular chemotherapy.

EPI FACILITATION PROGRAMME

The immunization facilitation programme has been undertaken by WHDP to facilitate the government EPI programme in eight districts thus reducing deaths among women of child bearing age specially those pregnant and of children U-2 from preventable causes.

The programme recorded a 55% coverage rate with the DPT/OPV, 61% coverage with BCG, and 60% with measles/OPV vaccine out of the total U-1 children population. During the previous reporting period the coverage for DPT/OPV, BCG and measles was 48%, 43% and 39% respectively. As expected the community mobilization programme has been instrumental in raising awareness and achieving a higher coverage. The programme expects to increase this in the coming reporting period.

RURAL DEVELOPMENT PROGRAMME - PRIMARY HEALTH CARE

The PHC - RDP is being implemented in twenty seven areas to make a lasting improvement of the health and nutritional status of the community through improved income generating capacities of the target group.

The programme has reported the following achievements. 1251 Shebikas and 1350 TBAs have been trained in these areas. Out of the eligible couples accepting Family Planning methods 95% of the eligible couples within the programme area were motivated to procure temporary methods of contraception while the remaining 5% accepted surgical contraception during this period.

79% of the 6199 children under one year of age received DPT/OPV while 54% received measles vaccine. 87% of the women of child bearing age and 98% of the 4773 pregnant women were completely covered with the TT vaccine during the reporting period.

NON - FORMAL PRIMARY EDUCATION

The Non Formal Primary Education programme in the WHDP areas focusses only on adolescent girls (11-16 years). The programme hopes to prepare these young girls through practical training on health, nutrition and issues for safe motherhood as well as community leaders.

8740 adolescent girls joined the BRAC schools at this time bringing the total of learners under this programme during the last six months to 38740. These girls are also taking an active part in the school based growth monitoring of U-2 children and provision of health and nutrition education to the mothers and other community members.

It should be noted that 19% of the learners of the total 362 schools within WHDP area are currently boys in the age bracket of 10 - 16. This is due to the fact that the required number of learners from the adolescent girls group was not available and so, following discussions with WHDP the NFPE programme decided to admit boys to make up the class strength of 30 students.

HEALTH RESOURCE CENTRE

The Health Resource Centre has been introduced as an integral part of WHDP to control the quality of the programme. In fact, research has become an integral part of the total process of project formulation, monitoring and evaluation of development interventions at BRAC. Research-based information is used in making strategic decisions and formulating management policies of WHDP.

**COMPREHENSIVE HEALTH
DEVELOPMENT PROGRAMME
(CHDP)**

INTRODUCTION

The world has entered the era of health interdependence, where health status can only be improved and maintained with socio-economic development and vice-versa. Women's Health and Development Programme (WHDP) emerged in July 1991 as a revised health strategy of BRAC. It aims at gaining access into the community via health development and education of the adolescent girls. This will be overlapped by income generation, skill development, conscientization and awareness raising through BRAC's Rural Development Programme (RDP) and subsequently the Rural Credit Programme (RCP).

A. COMPREHENSIVE HEALTH DEVELOPMENT PROGRAMME (CHDP)

Progress in our society is retarded by multiple factors like poverty, malnutrition, overpopulation, lack of education and unemployment. So the approach of WHDP is community based responding to the needs and problems of the target population namely the rural landless poor (those owning less than 50 decimals of land and having at least one family member annually selling 100 days of manual labour) and neglected vulnerable group (women and children under 6). WHDP has been implemented in ten Thanas of Dinajpur (Dinajpur Sadar, Parbotipur and Fulbari), Bogra (Bogra Sadar, Kahaloo), Gaibanda (Gobindogang) and Mymensingh (Mymensingh Sadar, Muktagachha, Fulpur and Trishal) Districts.

TABLE A.I BASELINE SURVEY OF WHDP AREAS

Information	Dinajpur	Bogra	Mymensingh	Total
No. of Thanas	3	3	4	10
No. of areas	8	10	12	30
No. of villages	400	524	713	1637
No. of households	91974	118474	155289	365733
Total population	443540	550536	753587	1747663

The total population upto December 1992 under WHDP was 1.7 million out of which 0.8 million belonged to BRAC's target group.

FIG A1 DEMOGRAPHIC INFORMATION

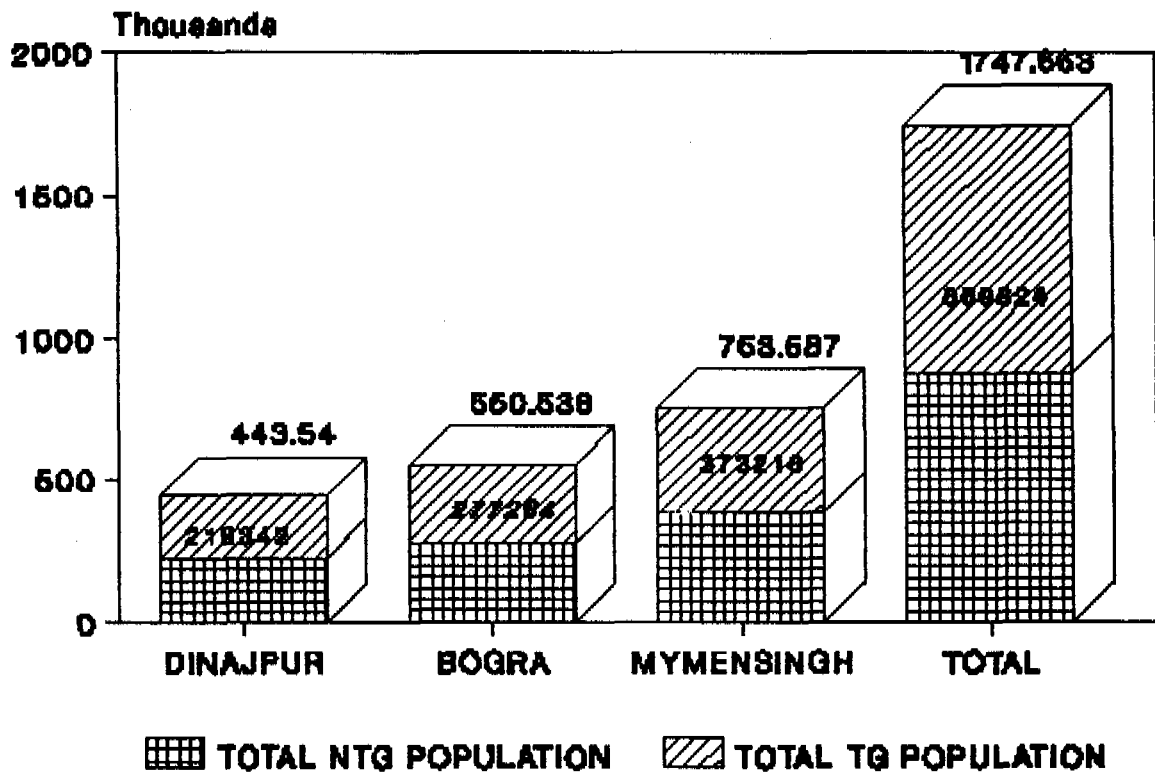


FIG A2 WOMEN OF CHILD BEARING AGE UNDER CHDP (15 - 49 YEARS)

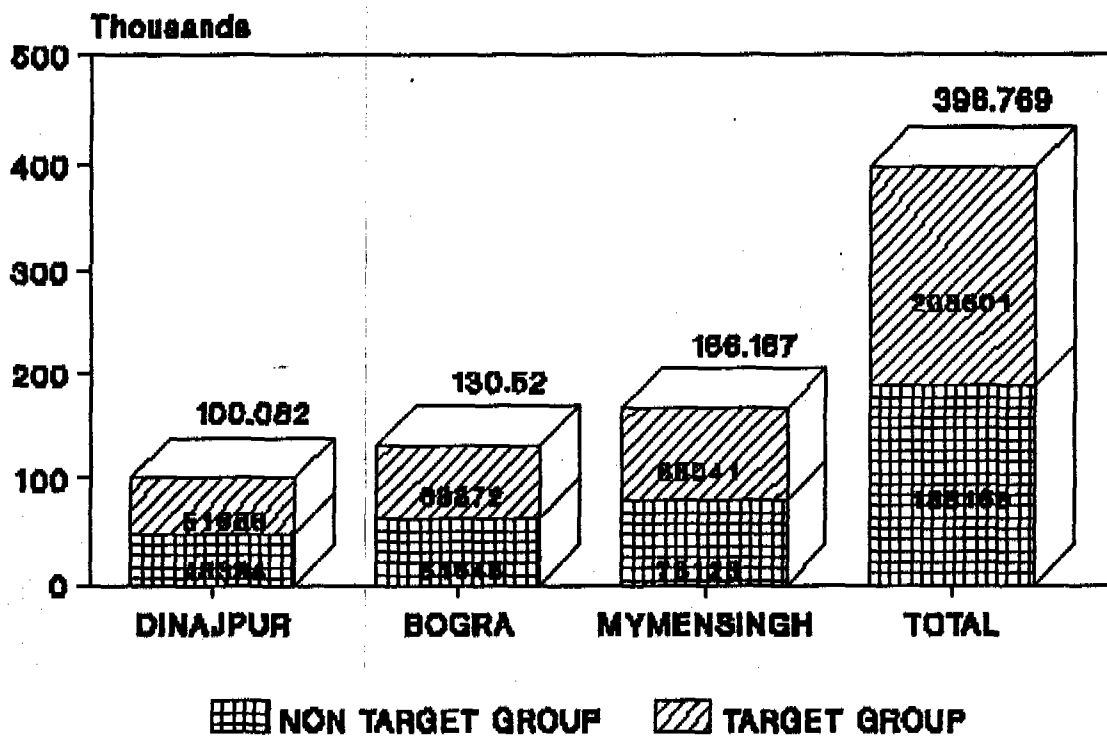
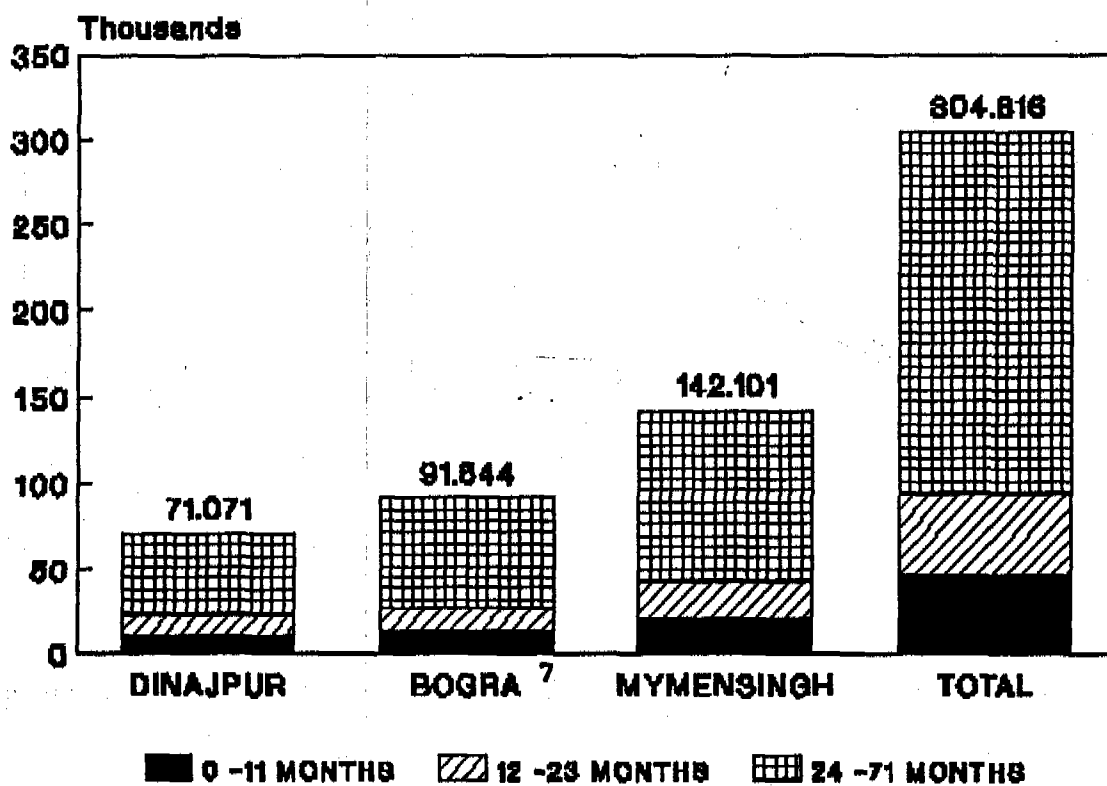


FIG A3 NO. OF U - 6 CHILDREN

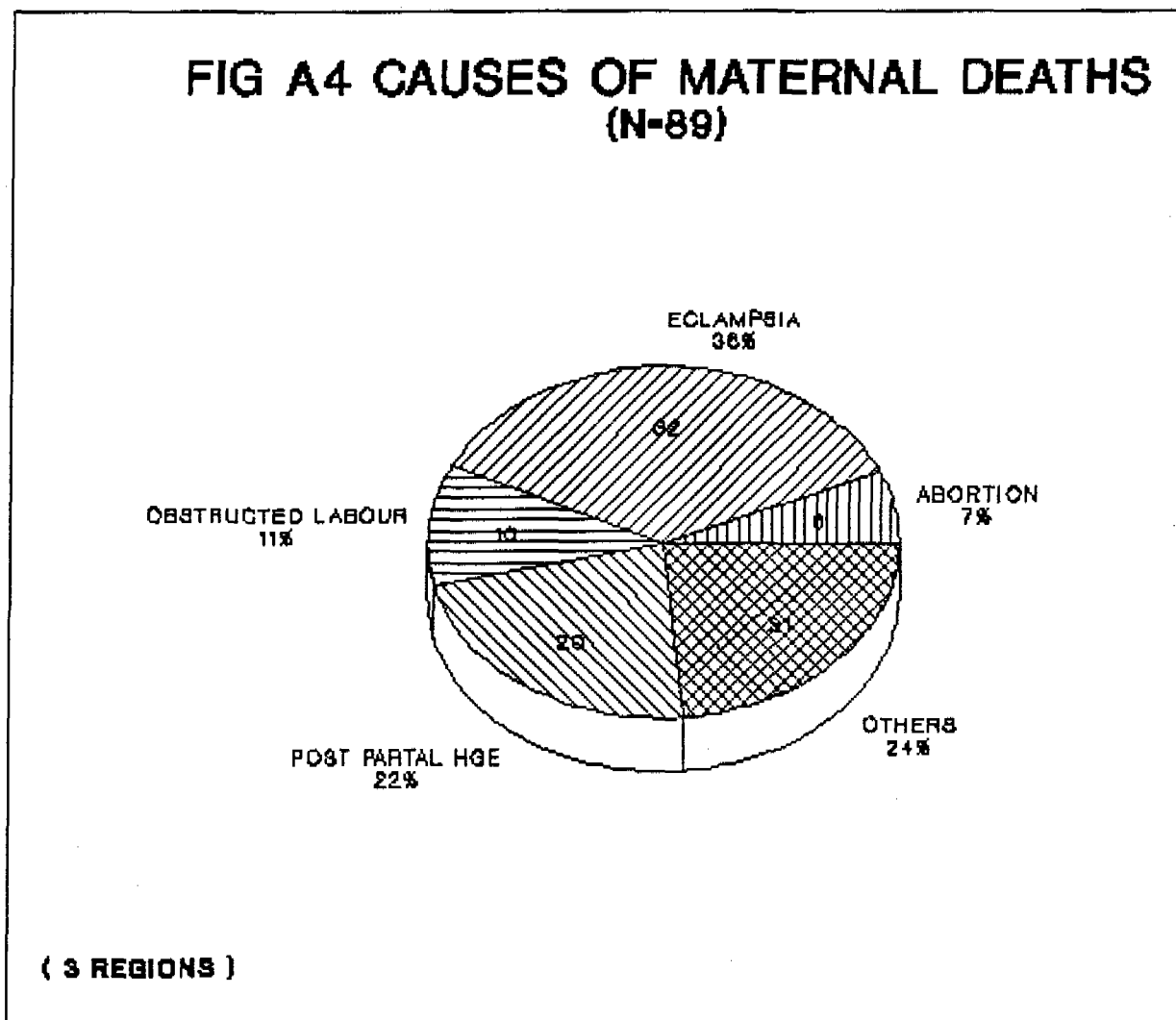


WHDP aims directly at improving the health and nutritional status of the women and children specifically. Furthermore it focusses at retaining this quality of life already attained, by providing the community the means to do so through developing capacities at the community level.

Figures A 2 and A 3 show that the total female population of child bearing age under the WHDP area was 396769 out of which 208601 belonged to the Target Group. 17 % (304816) of the population were recorded to be children under six.

1. Women

In Bangladesh females occupy a lower status than males in access to health services, nutrition and education. 35000 mothers die every year for want of prenatal and other pregnancy related care (BBS '90).



In the total WHDP area out of 37397 pregnancies in the 6 months 89 deaths have been reported so far. The cause was due to eclampsia (36%), obstructed labour (11%), post partal hemorrhage (22%), abortion (7%) and other obstetrical causes (24%) like severe anaemia, tetanus, fever, antepartal hemorrhage.

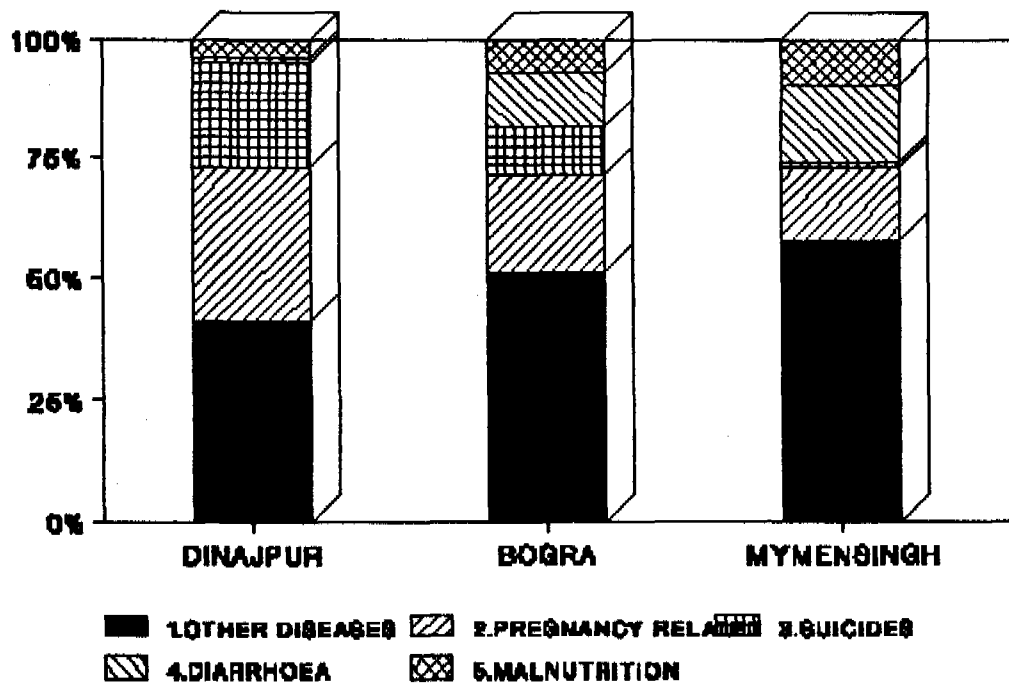
Reduction of maternal mortality is one of the particular goals of WHDP, so improvement of the ante and postnatal care has been given special consideration. Along with this immunization, family planning and nutritional care services for adolescent girls and women in the reproductive age is also continuing.

Aside from pregnancy related causes the death of 455 women within the WHDP areas have been reported to be due to suicides (17%), malnutrition (8%), diarrhoea (13%), and other causes (cardiac and respiratory diseases etc.) as shown by Figure A5 and Table A2.

Table A2. COMMON CAUSES OF DEATH OF WOMEN

Causes	Dinajpur	Bogra	Mymensingh	Total
Pregnancy related	25	29	35	89
Suicides	17	14	03	34
Malnutrition	03	10	22	35
Diarrhoea	01	17	39	57
Other diseases	32	73	135	240
Total	78	143	234	455

FIG A5 COMMON CAUSES OF DEATH OF WOMEN



1.1 Safe motherhood

Undoubtly the major factor which determines a pregnant woman's risk of dying is access, ability, availability and the knowledge of well equipped health care services. So to ensure safe motherhood WHDP has emphasized services for pregnant women by facilitating and strengthening the existing government services.

The Programme Organizers (PO)s are required to make one round of the households under their responsibilities once every three months. Pregnant women are identified by the Programmes Organizers (PO) during their household visits. Traditional birth attendants(TBA); Shastho shebikas (SS) and Gram committee (GC) members also provide information on pregnancies identified by them during their meetings with the POs. All identified pregnancies are registered and the women then motivated to attend ANCC (Antenatal Care Centre), Satellite Clinics or Family Welfare Centres for antenatal care. Physical and urine examinations are done at the satellite clinics and ANCCs.

Table A3 shows that of the 37397 women identified as pregnant during the period, 29656 (80 %) availed the pre-natal care provided through the government set up satellite clinics and the antenatal care centres. Availing of prenatal services has been defined by the programme as minimum of three prenatal contacts.

TABLE A.3 TOTAL NUMBER OF WOMEN UNDER ANTENATAL CARE PROGRAMME

Region	Total Pregnant women (n)	Total Women Attending clinic	
		No.	%
Dinajpur	12914	10207	79.03
Bogra	14694	11630	79.14
Mymensingh	9389	7819	83.28
Total	37397	29656	80.16

Special emphasis has been given to motivate women belonging to the target population to take antenatal care either through satellite clinics (SC) or antenatal care clinic (ANCC).

All the following data has been taken of the target group from eight WHDP areas excepting the two MMR pilot projects.

As the table A4 indicates, that in spite of this effort approximately 80% of pregnant women from the target group are being covered by the antenatal care and screening efforts.

TABLE A.4 PREGNANT WOMEN FROM TARGET GROUP TAKING ANTENATAL CARE

Region	Total No(n) registered	Total under care	Attendance in ANCC	Attendance in SC
Dinajpur	7199	6110 85%	4402 72%	1708 28%
Bogra	5819	4882 83%	3433 70%	1449 30%
Mymensingh	8395	6661 79%	5158 77%	1503 23%
Total	21409	16653 80%	12993 72%	4660 28%

Intensive efforts are being undertaken by the POs to ensure that the remaining 28% women avail the prenatal care services.

The pregnant women are motivated to take 2 doses of tetanus toxoid (TT) if they have not previously been immunized. In case of previous history of being immunized the woman requires only one dose. They are given 60 tablets of iron and folic acid each month. They are also given nutritional advice in terms of a minimum calorie diet, rich in proteins specially one containing 2300 kcal per day and 75 gm protein (pulses, beans, peas, sesame seeds etc.).

TABLE A.5 NUMBER AND PERCENTAGE OF PREGNANT WOMEN IMMUNIZED

Region	No. registered	no. immunized	%
Dinajpur	6110	2155	30
Bogra	4882	4983	86
Mymensingh	6661	5756	69
Total	17653	12894	60

Table A.5 indicates the percent of TG pregnant women who have completed their booster dose of Tetanus toxoid as being 60%.

TABLE A.6 STATISTICAL REPORT ON BIRTH

Region	Total no. pregnant	Total no. of deliveries	Live births		Still births	
			No.	%	No.	%
Dinajpur	7199	1012	980	98%	32	2
Bogra	5819	1885	1845	98%	40	2
Mymensingh	8395	6515	6385	98%	130	2
Total	21409	9412	9210	98%	202	2

48% of the total target group pregnant women within the eight WHDP areas delivered during the reporting period out of which there were 98% live births.

All the postnatal mothers are visited during the 42 days postnatal period. They are advised upon colostrum and breastfeeding. The lactating mothers are also educated about the intake of adequate and appropriate food for their proper nutrition (containing 2500 kcal) during the lactating period and birth spacing.

The high risk cases are carefully screened out and educated upon the need to attend any hospital or institution during delivery or any emergency.

TABLE A7 IDENTIFICATION OF HIGH RISK CASES

Region	Total attending	High risk cases	
Dinajpur	6110	655	11%
Bogra	4882	590	12%
Mymensingh	6661	1079	16%
Total	16653	2324	14%

For appropriate medical care and safe delivery, the high risk and emergency cases who have to be hospitalized are referred to the government hospitals.

TABLE A.8 REPORT ON REFERRED CASES

Region	Total under care	Total cases referred	Emergencies referred	High risks referred
Dinajpur	6110	281 5%	112 40%	169 60%
Bogra	4882	303 6%	121 40%	182 60%
Mymensingh	6661	409 6%	74 18%	335 82%
Total	17653	993 6%	307 32%	686 69%

As shown by Table A8 out of the 993 referred cases were already screened out as high risk cases and the 32% emergency cases referred shows that emergencies can occur even after pre natal care.

As shown by the graph A6 and table A9 maternal mortality was 7/1000 live births within the six months reporting period.

To achieve a drop in this rate appropriate measures regarding prenatal care and safe delivery has to be continued for all women of child bearing age in the WHDP areas.

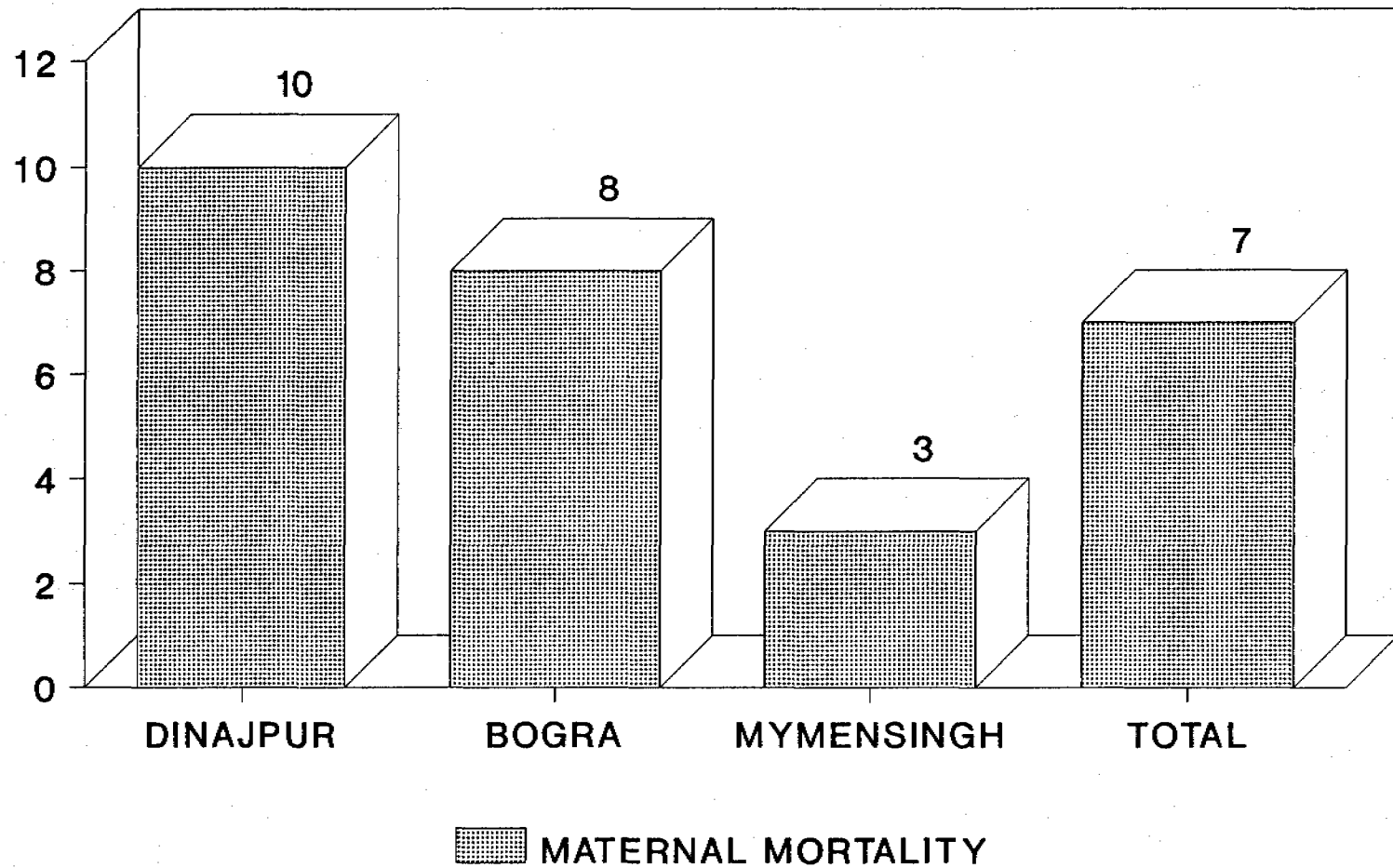
TABLE A.9 NUMBER AND PERCENTAGE & MATERNAL MORTALITY RATE (MMR)

Region	Number of live births	No. of Maternal deaths	MMR/1000 live births
Dinajpur	980	10	10
Bogra	1845	15	8
Mymensingh	6385	22	3
Total	9210	47	7

1.2 Birth Spacing and Contraception

The woman not only has a high MMR but she also undergoes the risk of dying much more often through her child bearing age. So to facilitate fertility control several steps have been undertaken by WHDP. First the community is being educated through GC members, TBAs and POs. Second contraceptive services are being made available through depot holders. The depot holders are Shastho Shebikas who have received a special 2 days training on various contraceptive

FIG A6 MATERNAL MORTALITY RATE
PER 1000 LIVE BIRTHS



methods and motivational skills given jointly by the Family Welfare Visitor and BRAC PO. Each depot holder is responsible for 200 families and works in close conjunction with government FP workers. She provides temporary methods of contraception and maintains a register of the eligible couples. The POs motivate and provide follow up and referral.

TABLE A.10 Report on contraception of target group.

Region	No. of eligible couples	No. using modern contraceptives	Contraceptive acceptance rate
Dinajpur	44648	20315	45 %
Bogra	54456	26190	48 %
Mymensingh	71829	25130	40 %
Total	170933	71635	44 %

Efforts are being made to ensure that all the eligible couples know and have access to a range of contraceptive methods but during the reporting period the total CAR % has been only 44%.

2. CHILD

A large percentage of children in Bangladesh start life undernourished from maternal malnutrition mainly due to poverty and disparity in the intrafamilial food distribution resulting in deprivation of women and children in particular. The under-six mortality in this country is reported to be 188 per 1000 live births (UNICEF '87). Most of the common causes of U-6 mortality in the WHDP areas have been reported due to malnutrition (24%), pneumonia (14%), diarrhoea (12%), tetanus (8%) and prematurity (5%) and the rest due to other infectious and systemic diseases.

Table A.11 Causes of death of children

Causes	Dinajpur	Bogra	Mymensingh	Total
Malnutrition	68	216	303	587
Pneumonia	41	115	197	353
Diarrhoea	42	89	169	300
Tetanus	32	95	59	186
Prematurity	29	18	84	131
Other diseases	86	199	624	909
Total	298	732	1436	2466

As such a package programme has been evolved under WHDP involving growth monitoring, nutrition and health education, immunization facilitation programme and Vitamin A capsule intake mobilization.

2.1 Children U-2

The rapid rate of growth during the first two years of infancy makes it the most critical period in the life cycle as far as food and eating practices are concerned. The U-2 are weaned early and often on an inadequate diet usually due to poverty, unequal intrafamilial food distribution and lack of awareness of appropriate feeding practices.

A Growth monitoring centre covers 20-25 U-2 children. Each has been opened under the guidance of a NFPE school teacher. They are assisted by the Gram Committee members and the adolescent school girl. Each girl is responsible for one U-2 registered under that centre. She has to ensure that the child receives coverage of all vaccines under EPI at the appropriate time and also that the mother and child attend the growth monitoring sessions regularly.

TABLE A.12 CHILDREN UNDER TWO IN GROWTH MONITORING CENTRES

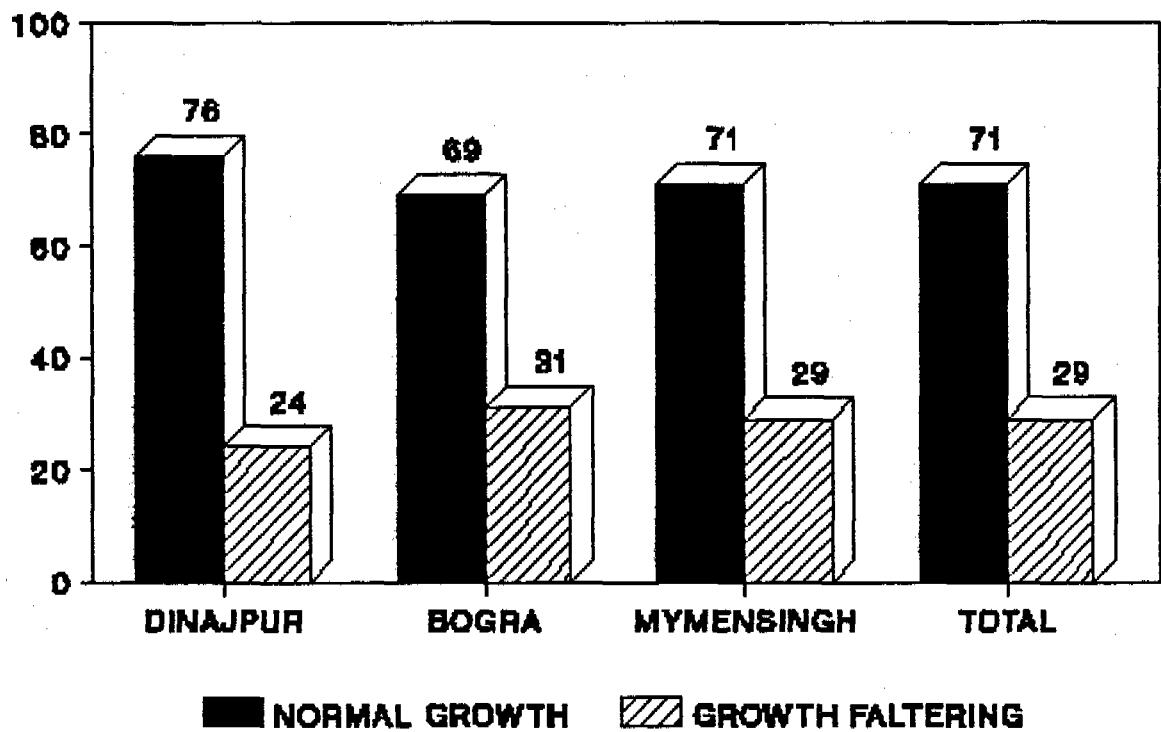
Region	Population U-2	No. of sessions held	U2 weighed
Dinajpur	8164	382	5864 72%
Bogra	10265	513	7289 71%
Mymensingh	9862	562	7473 76%
Total	28291	1457	20626 71%

The mothers are given education on proper nutrition, appropriate supplementary feeding, maternal and child care during the growth monitoring sessions held at NFPE schools; during the mohila shobha sessions and also during the household visits. During the reporting period the total number of U-2 among the target group was 28291 out of which 71% were mobilized to attend the GM centres.

TABLE A.13 WEIGHT GAIN OF U-2

REGION	U-2 weighed	U-2 gaining weight	U-2 with growth faltering
Dinajpur	5864	4450 76%	1414 24%
Bogra	7289	4995 69%	2294 31%
Mymensingh	7473	5279 71%	2194 29%
Total	20626	14724 71%	5902 29%

**FIG A8 WEIGHT GAIN OF UNDER-TWO
(N = 20826)**



• VALUES IN PERCENTAGE

Under the GM centres 71% of the children weighed were observed to be gaining normal weight.

2.2 Expanded Programme of Immunization (EPI).

It was estimated by UNICEF that 277400 children under five die of communicable diseases each year in Bangladesh which could be prevented by immunization. So WHDP undertook to facilitate the government EPI programme specially for the U-1 under WHDP areas.

TABLE A.14 NUMBER OF CHILDREN IMMUNIZED

Region	Total target	DPT/OPV I	DPT/OPV II	DPT/OPV III	Measles /OPV
Dinajpur	6557	5413	5332	5239	4852
Bogra	10714	9702	8981	8828	6956
Mymensingh	11718	9395	9095	8665	7255
Total	29016	24510 84%	23408 80%	22732 78%	19063 65

The table A14 shows that 84% of the total targeted children could be mobilized for the DPT/OPV I but 22% did not turn up for the DPT/OPV III and 30% failed to receive their measles and final OPV.

2.3 Vitamin A Capsule distribution

Of the 200 million U-5 children in Bangladesh almost 100 are going blind each day (40000/year) due to Vit A deficiency. Two thirds of them die each year due to depleted Vitamin A store in the body resulting to reduced ability to fight infection (HKI 1989). Under WHDP BRAC workers assist the government health workers to mobilizes the children upto 6 years receive vitamin A capsules (VAC). The government strategy is to give two drops (50000 IU) of VAC with each DPT/OPV and Measles/OPV making a total of 200000 IU vitamin A within the first year of life. The children over one year receive a full capsule (200000 IU). Awareness of the natural sources of Vitamin A is also created among the mothers by the BRAC workers during the household visits and nutrition education sessions through Mohila Shobhas, Growth Monitoring sessions and immunization programmes.

TABLE A.15 U-6 children receiving Vitamin A capsule

Region	No. of U-6 children	No. receiving vitamin A (35 cycle)	%
Dinajpur	62800	54261	86.40
Bogra	84316	79328	94.08
Mymensingh	87159	75115	86.18
Total	234275	208704	89.04

89% of the U-6 children could be mobilized for VAC intake during the reporting period.

3. COMMUNITY PROGRAMMES

3.1 Tuberculosis Control Programme

Tuberculosis, the ancient killer is still present in Bangladesh and is responsible for about one quarter of all avoidable adult deaths in the developing world. Unless controlled it will keep on increasing. According to lessons learnt through the Manikgonj community based tuberculosis control programmes (where 95% were sputum positive, 70% were drug sensitive; the rest resistant to one or combined drug and 79% completed treatment) TB identification and treatment programme were set up by WHDP among both the TG and NTG population. The Shastho Shebikas (SS) identify the TB cases by the major symptoms of chronic cough for 1 month, fever, weight loss and coughed up blood. They collect the sputum of the suspected symptomatic. Slides made from the sputum are stained and checked for tuberculous bacilli at BRAC's sputum testing laboratories.

The National Tuberculosis Control Project (NTCP) provides technical consultancy and training to BRAC laboratory technicians and medical officers (MO). The medicines are purchased by BRAC.

The cases showing positive sputum were contacted, explained about the results and asked to register to a 12 months free treatment course. Patients willing to participate were asked to deposit Taka 200 as a guarantee to complete the treatment course. Upon completion of treatment Tk 100 will be given to the shebika as an incentive for her services and the remaining Taka 100 returned to the patient.

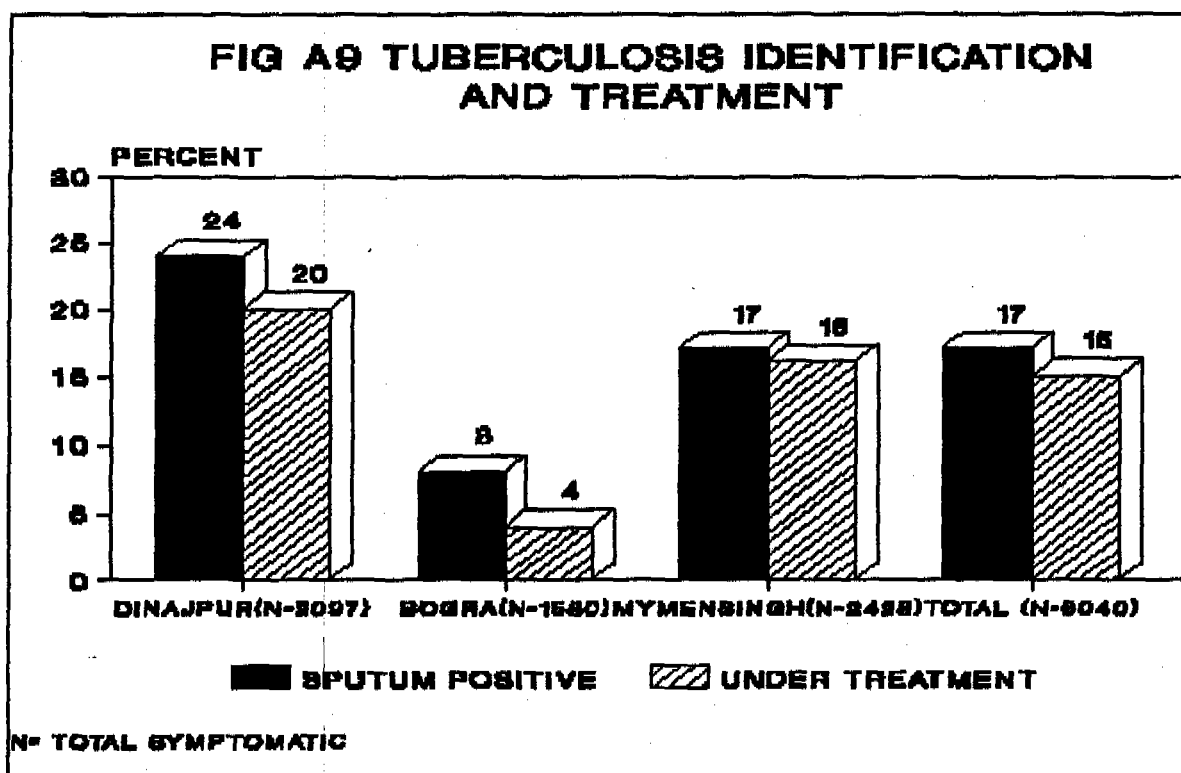


Figure 1

In the July - December 92 period 6040 persons were identified as symptomatic out of which 17% were diagnosed as sputum positive. 87% of them are currently undergoing treatment.

TABLE A.16 TUBERCULOSIS IDENTIFICATION AND TREATMENT

Region	Total symptomatic	Total sputum positive	Total No. under treatment.
Dinajpur	2097	504	420
Bogra	1530	122	104
Mymensingh	2423	414	382
Total	6050	1040 17%	906 87%

The treatment is the conventional therapy (appendix 2). The injections are given by the Shebikas, who also provide the drugs once every two weeks. She also makes sure that the previously given drugs are consumed. In case patients have complications of drug resistance or reaction (appendix 2) or are still sputum positive after 5 months, the SSs refers them to the Medical Officers.

TABLE A.17 NUMBER OF CASES REFERRED

Region	No. of cases referred	No. of cases with reaction	No. of cases with resistance
Dinajpur	19	08	11
Bogra	09	08	01
Mymensingh	36	17	19
Total	64	33 52%	31 48%

A total number of 64 patients had to be referred by the SS to the MO, out of which 52% had drug reaction and 48% were resistant.

3.2 Water and Sanitation

In the developed countries of the world diseases like diarrhoea, helminthiasis, amoebiasis and hepatitis have been prevented through sanitary development. Unsafe water and exposed latrines are the major sources of many diseases in rural Bangladesh. To ensure a healthy atmosphere the use of tubewells and sanitary latrines are recommended through the Mohila Shobhas and Gram Committee meetings and Masjid forums by the Shastho Shebikas and GC members.

TABLE A.18 THE NUMBER OF TUBEWELLS

Region	Number of Tubewells	
	New	Total
Dinajpur	530	7229
Bogra	1218	34935
Mymensingh	623	12863
Total	2371	55027

92% of the population are using tubewells for drinking water.

TABLE A.19 REPORT ON SANITATION.

Region	No. of pit latrines	No. of slab latrines	Total
Dinajpur	23133	7478	30611
Bogra	43197	4225	47422
Mymensingh	24133	11211	35344
Total	90464	22914	113377

There are 113377 latrine users.

4. INSTITUTION AND CADRE DEVELOPMENTS

The concept of community participation has assumed an increasingly important role in development. Since women are better communicators than men, women are recruited to work as health workers so as to assist health care and other developmental benefits.

The Shastho Shebikas (SS) are women belonging to BRAC's Target Group of the village with virtually no education. They receive training to serve as health cadre in the villages. Their training period is for 3 months with 1 month theoretical and 2 months practical training in the field under the direct supervision of a BRAC PO. They are also given refreshers course every 2 months.

These women from the target groups are selected so that there is at least one village health worker per village. These motivated and trained health workers will recognize and treat the common diseases, conduct immunization drives and impart basic health and nutrition messages to the villagers.

All the causes of maternal mortality point to the problem of basic practices and knowledge during delivery, skill in recognition and management of high risk cases, knowledge on maternal and child nutrition and care. So to ensure safe motherhood for all traditional birth attendants (TBA) receive a training spread over seven days and a one day refressors course quarterly.

TABLE A.20

TRAINING OF TRADITIONAL BIRTH ATTENDANTS AND SHASTHO SHEBIKAS

Region	Number of TBA		Number of SS	
	Basic Trained	Active	Basic Trained	Active
Dinajpur	614	577	400	387
Bogra	733	772	532	505
Mymensingh	919	875	531	521
Total	2266	2224	1463	1413

A total of 2224 trained TBAs and 1413 SSs are actively working under WHDP areas during the reporting period.

In addition Shastho Kormi (SK) (Health Worker) concept has been introduced as a pilot project at Muktagachha, Mymensingh where the 8 women are selected from the Target Group to work as health workers. They are paid Taka 500 monthly for their services whereas the TBAs and SSs are volunteers.

TABLE A.21 TOTAL NUMBER OF SHASTHO KORMIS

	Total number of S K (Health Worker)
Basic training	158
Active	158

A Gram (village) Committee consisting of 9-11 women from the village has been developed. They are enthusiastic women from the Target Group, receptive by the villagers. The GC has been developed as a village based institution which will assist the community to determine health needs. These members meet once a month under supervision of a BRAC PO.

The concept of Mohila Shobhas (Womens' Forum) was developed to serve as a health and nutrition education centre. It aims to empower the Target Group women on preventive and promotive health issues. There is one MS for every 25 households consisting of women having capability to understand and disseminate knowledge. It is an additional force to GC. They meet every month and discuss specific issues like motivation, EPI, installation of latrine etc under the supervision of a PO. The GC members are also part of the MS.

TABLE A.22 REPORT ON GRAM COMMITTEE (GC) AND MOHILA SHOBHAS (MS)

Region	No. of GC meetings	Member present	No. of MS meetings	Member present
Dinajpur	2167	19382	4379	76989
Bogra	2850	25911	4488	85995
Mymensingh	714	6709	3269	71429
Total	5731		12136	

During the present reporting period 5731 GC meetings and 12136 Mohila Shobhas were held.

TABLE A.23 NUMBER OF GRAM COMMITTEES AND MOHILA SHOBHAS FORMED

Region	No. of GCs formed	No. of MSs formed
Dinajpur	400	1962
Bogra	524	2357
Mymensingh	713	3372
Total	1637	7691

A total number of 1637 Gram Committees and 7691 Mohila Shobhas has been formed.

PILOT PROJECTS WITHIN CHDP

B. PILOT PROJECTS

B.1. Maternal Mortality Reduction Projects

The maternal mortality rate is 5.5/1000 live births (BBS 1990) in Bangladesh. Out of the maternal deaths 21% die of eclampsia and 27% die of complicated labour (Jahan 1984). Neonatal death is 89/1000 live births and 31% die due to tetanus (Islam et al 1981).

To help reduce the number of preventable maternal deaths pilot projects for maternal mortality reduction are being implemented in Bogra and Dinajpur Sadar Thanas. Pregnant women both from BRAC's Target Group and Non Target Group come under the project. This project has been undertaken to observe the effect of good motivation; education of patient, family and community. In addition to the normal prenatal care services and risk assessment as described in the preceding pages, a maternal waiting home has been established by BRAC.

The maternal waiting home is situated within 5 km radius of the government hospital. This has been done with the view to increase access to prenatal and natal services by reducing distances. The WHDP staff maintains a good referral linkage and network with the government hospital staff. This is to ensure that adequate and appropriate care is provided to the referred women.

The pregnant women without any complications are given a normal antenatal regime of iron and folic acid, two doses of tetanus toxoid and education on issues like nutrition, family planning, breast feeding etc. The vast majority of the deliveries that is the ones without any complications are motivated to be performed by the TBAs trained by BRAC.

Table B1 TOTAL NUMBER OF PREGNANCY AND DELIVERY

Region	Total pregnant	Total delivered	Place of delivery	
			Hospital	Home
Dinajpur	3355	2164	197	1967
Bogra	2499	1498	56	1442
Total	5854	3662	253	3409

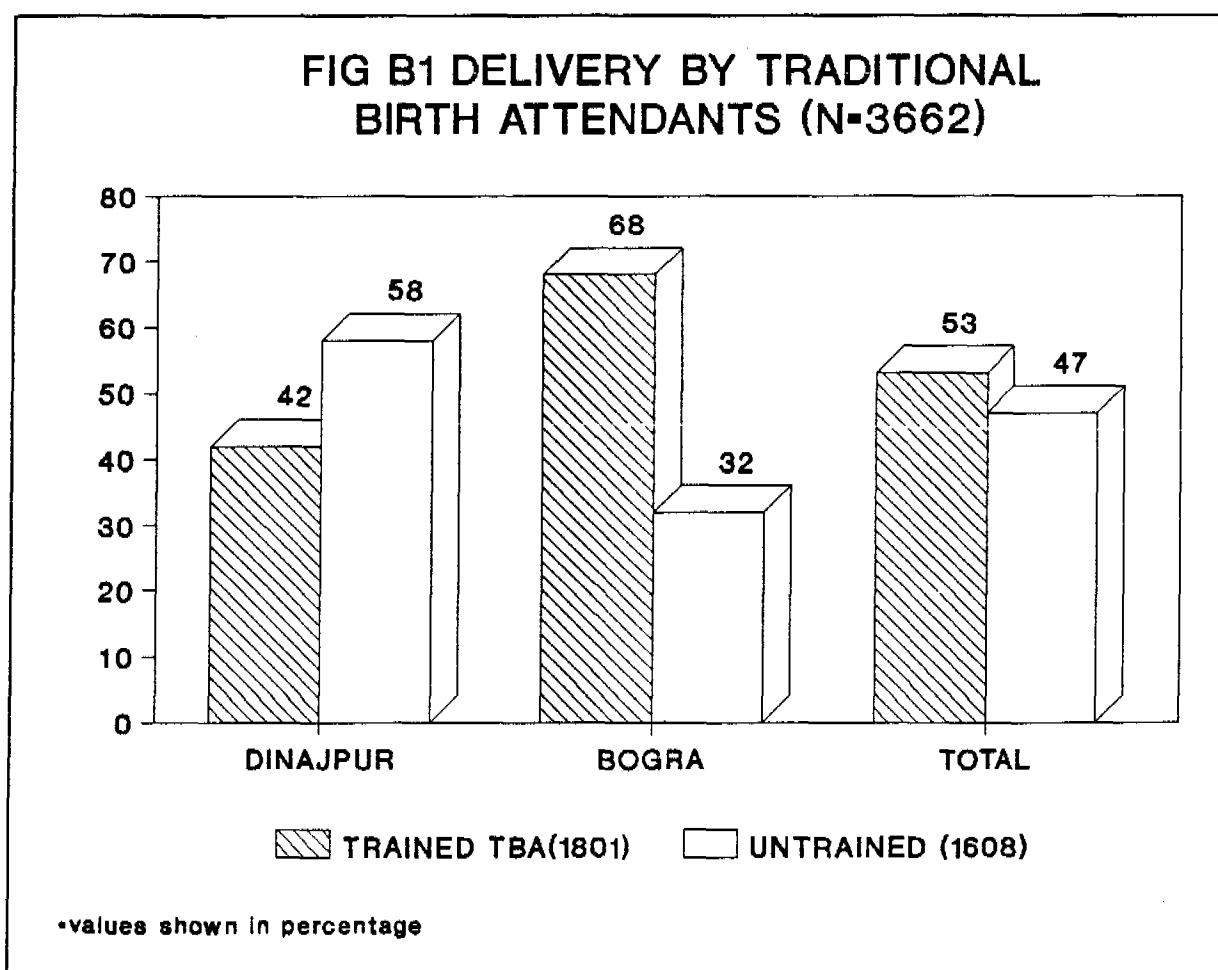
There were 3662 deliveries out of 5854 pregnant women and there were 3409 deliveries at home.

It was estimated that in Bangladesh more than 95% of all babies are delivered at home by women out of whom 80% have no education and 99% no clinical training (Khan et al 1981).

WHDP's MMR project shows that out of the total 3409 home deliveries, 53% were done by the TBAs trained by BRAC.

TABLE B.2 REPORT ON DELIVERY (N=3662)

Region	Deliveries at home	Traditional birth attendants	
		Trained	Untrained
Dinajpur	1967	820 42%	1147 58%
2Bogra	1442	981 68%	461 32%
Total	3409	1801 53%	1608 47%



Out of the 5854 pregnant women, who came to the ANCC of these two pilot projects 852 (15%) were identified as high risk cases (appendix 1) by the Programme Organizers during the July to December 1992 period.

TABLE B.3 IDENTIFICATION OF HIGH RISK

Region	Total Pregnant women	High risk cases	
		%	No.
Dinajpur	3355	445	13
Bogra	2499	407	16
Total	5854	852	15

The high risk cases are referred to the medical officers and junior consultants of the MMR pilot project. They are educated upon safe delivery preferably in the hospital and advised to go to the waiting home at least 10 days prior to delivery. These women are motivated go to the hospital at the time of delivery under care of the PO.

TABLE B.4 DATA ON HIGH RISK CASES

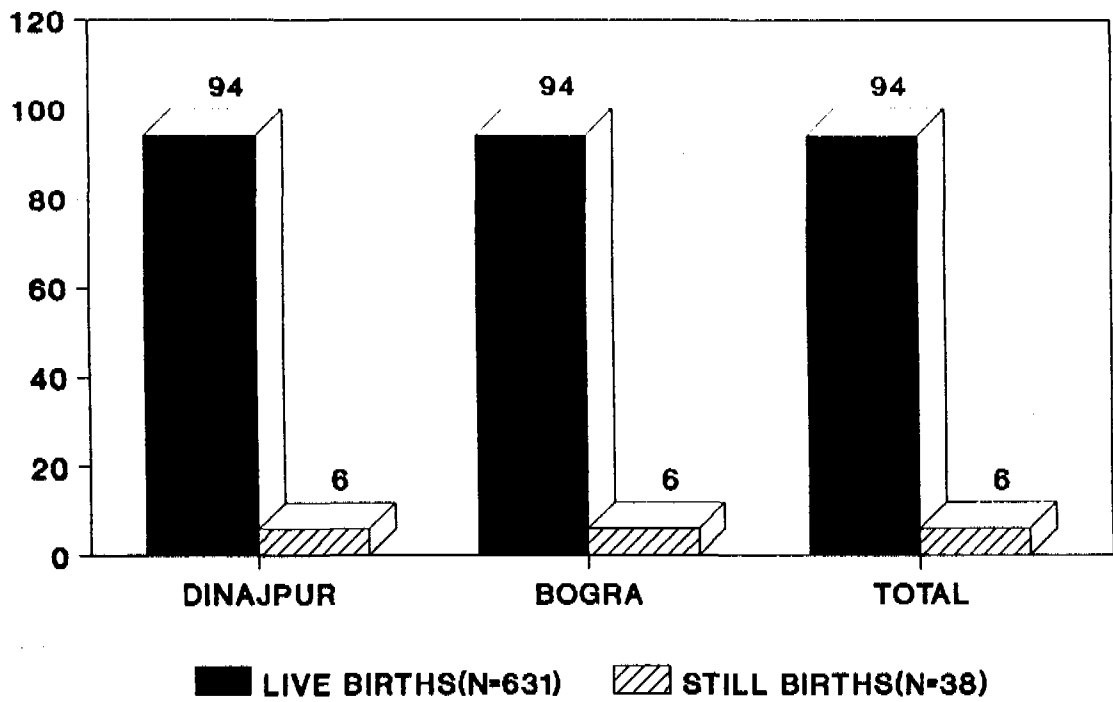
Region	No. of high risk delivered	Delivery at	
		Hospital	Home
Dinajpur	397	119	278
Bogra	272	37	235
Total	669	156 23%	513 77%

Even though the above mentioned women belonged to the high risk category only 23% delivered at the hospital via the waiting home.

Table B5 DELIVERY OF HIGH RISK CASES

Region	No. of deliveries	Live births	Still births
Dinajpur	397	374	23
Bogra	272	257	15
Total	669	631 94%	38

**FIG B2 BIRTH OUTCOME OF HIGH RISK CASES
N= 669**



• values shown in percentage

Probably the concept of hospital delivery has yet not been established. Luckily 94% of them had live births.

It is not only those women identified as high risk pregnancies who may have complicated labour but all women have equal chances of having complications.

TABLE B6 OBSTETRICAL HISTORY AND THE TYPE OF LABOUR.

Type of labour	High risk cases	Normal cases	Total
Complicated labour	200	211	411
Normal labour	469	2782	3251
Total	669	2993	3662

The relative risk between the high risk and the normal cases undergoing complicated labour was 3.37 showing that high risk cases has only three times more chances of having complications. Therefore the pregnant women should come under supervision early and a strong referral system be established to avoid preventable maternal deaths.

To ensure appropriate medical care and safe delivery the pregnant women specially those identified antenatal as high risk pregnancies are kept in the waiting homes and referred to the government hospitals accordingly.

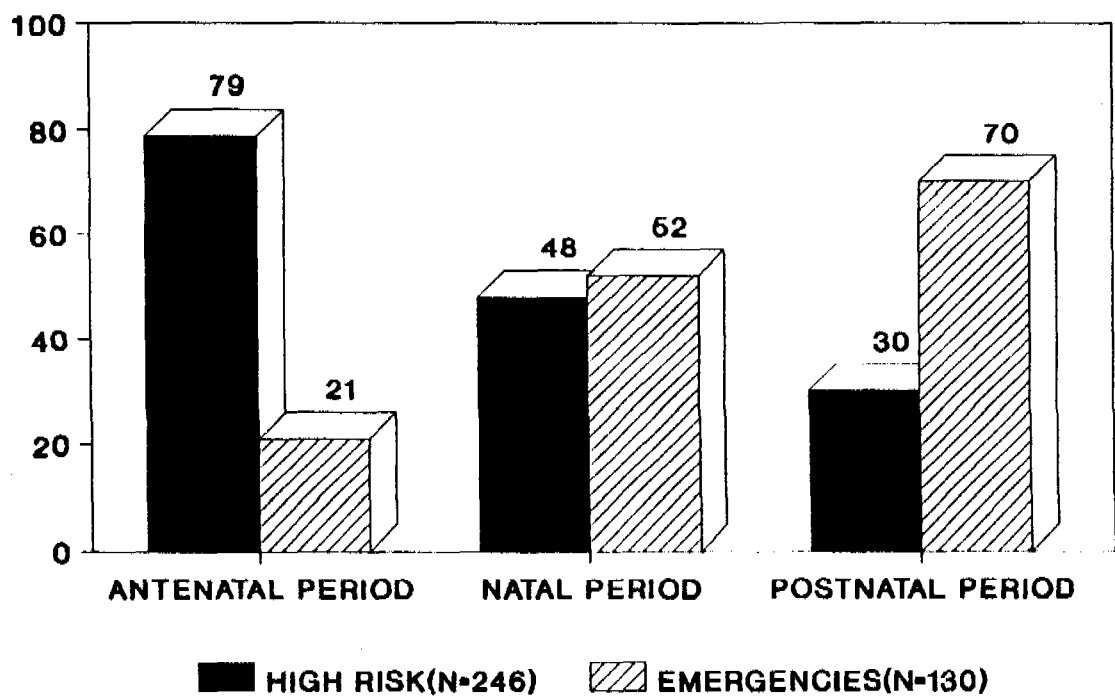
TABLE B7 WOMEN REFERRED TO HOSPITAL WITH TIME.

Region	High risk cases (246)			Emergency cases (130)		
	Ante-natal	Natal	Post-natal	Antenatal	Natal	Post-natal
Dinajpur	91	25	04	24	43	11
Bogra	85	39	02	24	25	03
Total	176	64	06	48	68	14

Out of the total 376 cases referred to the government hospital, 130 were emergencies according to the previous graph and table.

During the antenatal period 97% (176) of referred cases belonged to the high risk group. The most revealing part of the graph is 70% (14) emergency referral cases during the postnatal period.

**FIG B3 REFERRAL OF PREGNANT WOMEN
N=376**



*values shown in percentage

TABLE B8 REPORT ON MATERNAL MORTALITY (MM)

Region	Number of live births	No. of Maternal Death			MMR/1000 live births
		NTG	TG	TOTAL	
Dinajpur	2114	06	01	07	3
Bogra	1458	05	03	08	5
Total	3578	11	04	15	4

The MMR within the pilot project area is 4/1000 live births. Maternal death occurs more among the target population as shown by the above table. This could be the result of undernourished anaemic mother, or overworked women.

TABLE B9 CAUSES OF MATERNAL MORTALITY

Cause	Period	Dinajpur	Bogra	Total	%
Eclampsia	Antenatal	03	06	09	60
Obstructed labour	Natal	01	01	02	13
Hemorrhage	Postnatal	03	01	04	27
Total		07	08	15	

Death due to eclampsia during the antenatal period is shown to be 60% among 15 cases, while the Matlab 1981 study records it to be 30% (Rochat et al Int. J. Gynaecol. Obstet 1981 19:155-164).

TABLE B10 NUMBER OF MATERNAL DEATHS BY CASES

Region	High risk cases	Normal pregnant women
Dinajpur	05	02
Bogra	07	01
Total	12	03

Death data recorded also shows that it has occurred more among the high risk mothers.

B.2 Birth weight recording project

The birth weight of a child is the single most important determinant of its chance of survival and development. Of the 40,00,000 infants born each year in our country, 30% (World Bank 1991) are classified as low birth weights (LBW) or born with weight below 2.5 kg (2500 grams). Not only the proportion of infants born with LBW closely reflect the health status of the community in which they are born, these infants also carry with them the high risk of fatality from the moment they are born.

A pilot programme has been undertaken to record the birth weight among 60000 population. The objective is to gather accurate information on trends of birth weight in terms of variables like birth order, parity, income, occupation, education, survival and also effects of programme intervention on birth weight over time. The pregnant mothers identified as part of the ongoing safe motherhood programme within the selected area are followed up at delivery and the infants weight recorded within 24 hours.

TABLE B.11 Report on the birth weight

Region	Population covered	Birth weight recorded	LBW	
			No.	%
Dinajpur	16025	137	38	28
Bogra	20054	124	37	30
Mymensingh	23634	235	75	32
Total	59713	496	150	30

The record shows that LBW is still 30% of the total births.

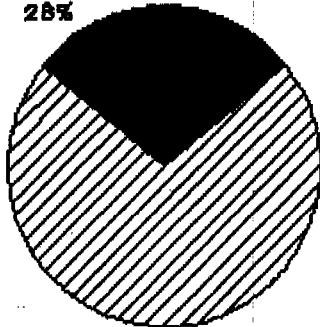
5.3 ARI (pneumonia) Treatment and control

In Bangladesh acute respiratory tract infection (ARI) is responsible for 18% of all deaths among the U-5. This is now the leading cause of death of U-5's since the introduction of ORT for diarrhoea. Therefore in an attempt to tackle this affliction at the community level, the pneumonia control pilot programme for the U-5s was introduced in the two Sadar Thanas of Dinajpur and Bogra.

During the household visits, Mohila Shobhas and GC meetings the Programme Organizers train and educate the Shastho Shebikas (SS), Gram Committee members, and the mothers themselves to identify the ARI cases through symptoms of rapid breathing, subcostal indrawing of the chest, refusal of food or drink intake, unable to awake, coma. The mild cases (fever, running nose, rapid breathing) are advised home treatment i.e. breast feeding, continuation of normal food and keeping the child warm. The moderate cases (more than 50 breaths/minute, and indrawing of

FIG B4 PERCENTAGE OF BIRTH WEIGHT

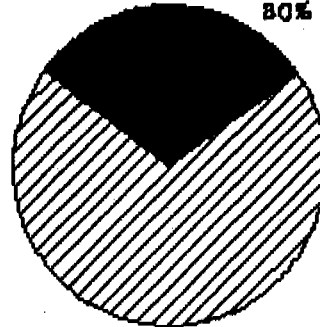
BELOW 2500 GMS
28%



2500 GMS & ABOVE
72%

DINAJPUR

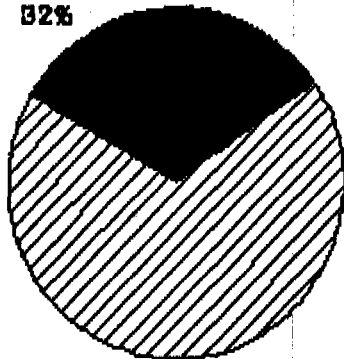
BELOW 2500 GMS
30%



2500 GMS & ABOVE
70%

BOGRA

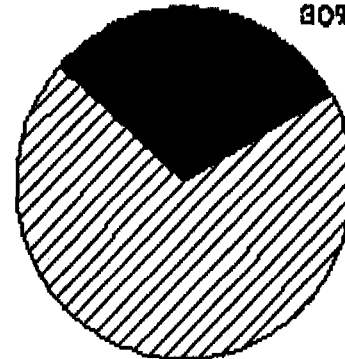
BELOW 2500 GMS
32%



2500 GMS & ABOVE
68%

MYMENSINGH

BELOW 2500 GMS
30%



2500 GMS & ABOVE
70%

TOTAL

chest) are prescribed antibiotics (Syrup Cotrimoxazole) by the SS who also provides the drugs. The complicated or severe cases (in addition to above mentioned symptoms child refuses to take any food or drink, mother cannot awaken child from sleep) are referred to the Medical officer WHDP by the SSs and POs . The M.O. WHDP further refers the child to the district hospital under care of the SS GC member and PO who also does the follow up. In some cases the hospital referrals are done directly by the SS and POs.

TABLE B.12 ARI CASES DETECTED ACCORDING TO STAGE

Region	Total No. of U-5 children	Total Pneumonia patients identified	Mild cases	Moderate cases	Severe cases
Dinajpur	10600	1742	1605	82	55
Bogra	12312	975	711	253	11
Total	22912	2717	2316	335	66

A total number of 2717 children were identified as suffering from pneumonia out of which there were 2316 mild cases.

TABLE B.13 Treatment of ARI cases

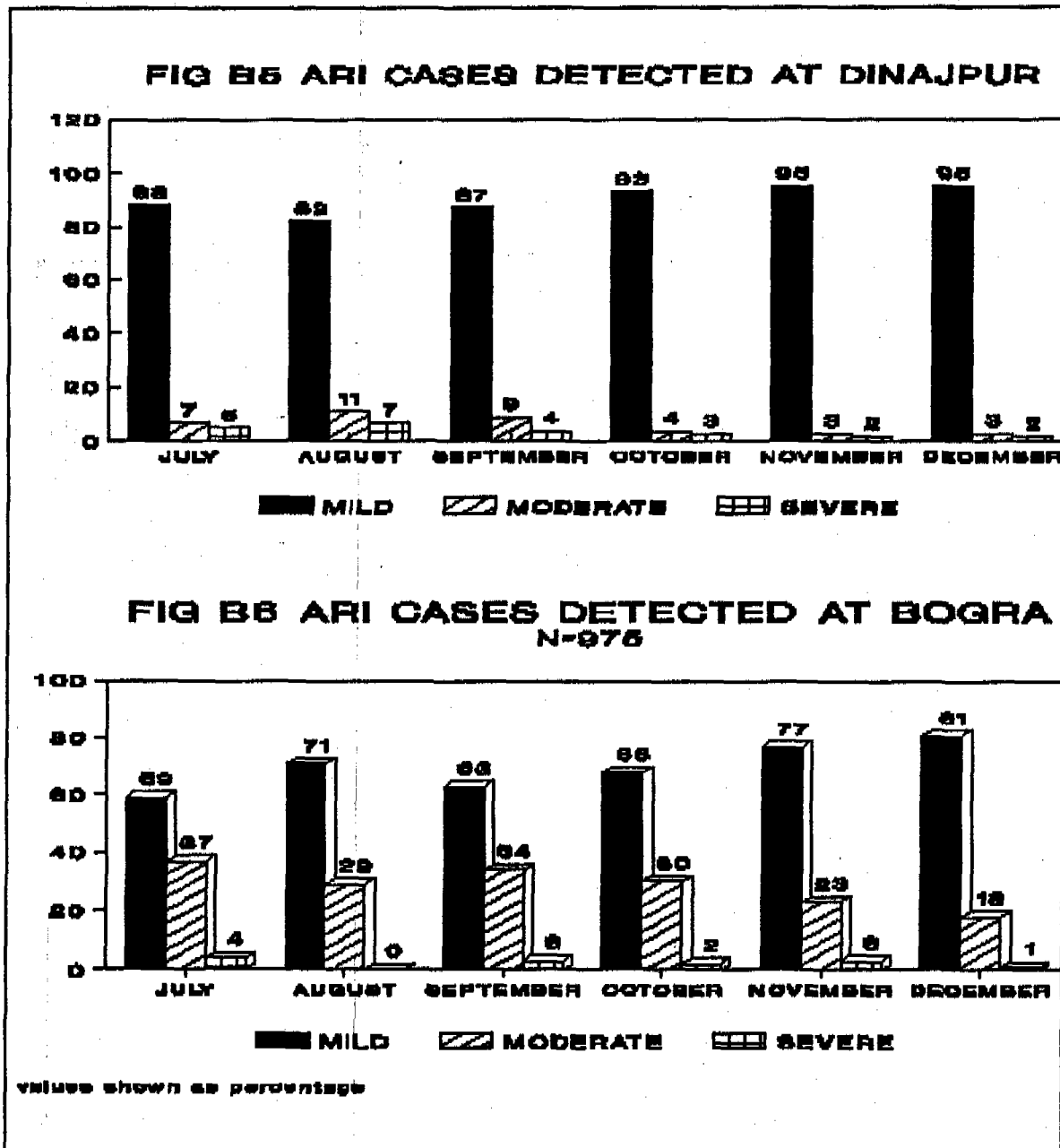
Region	No. of patients identified	No. of patients treated by SS	No. of patients referred
Dinajpur	1742	1687	55
Bogra	975	955	18
Total	2717	2652 97%	73 3%

97% (2652) were treated by the SSs and only 3% had to be referred. 99% of the children were cured.

Table B14 CURE RATE OF PNEUMONIA PATIENTS

Region	Total Patients	Total cured	No. died
Dinajpur	1742	1739	03
Bogra	975	968	07
Total	2717	2707 99%	10

The following graphs show that the number of moderate and severe cases are much less than the mild cases. The reason maybe that due to earlier detection children do not become severely sick.



B4. Community based nutrition programme.

A poor environment providing inadequate nutrition can prevent a child from reaching its full potentials, not only in physical growth but also in mental development as well. Growth occurs continuously from conception to full maturity but it is not a regular process. There are two periods of rapid growth, one during fetal life and infancy and the second during adolescence. The

long term effects of malnutrition may relate to the socio-economic development of a nation and the community should be aware of it, specially of the above two mentioned periods.

A community based nutrition pilot project for the U-2, adolescent girls and pregnant women has been undertaken in Muktagachha, Mymensingh where the actual activity is education in the form of nutrition supplementation.

B.4.1 CHILD U-2

A child attains half his adult size by the second year. All the registered U-2 children in the Muktagachha Thana are brought under the growth monitoring centre. Here children under 12 months not gaining 500 gm between three successive weighing and children from 12 to 24 months not gaining 300 gm between four successive weighing are considered to be faltering behind the normal growths pattern. These children are taken into the supplementation programme for 90 days (see appendix for flow chart).

A package consisting of roasted and powdered rice and pulse with molasses is prepared by the GC members under supervision of the SK and PO. It is supplied to the mother at the feeding centre, where she mixes the food in the package and feeds the child.

TABLE B.15 NUTRITIONAL VALUE OF SUPPLEMENTARY DIET

Nutrition	Amount	Energy	Protein	Calcium	Iron
Rice	25 gms	87 kcal	1.75 gms	3.75 mg	1.5 mg
Pulse	10 gms	34 kcal	2.50 gms	1.5 mg	0.6 mg
Molasses	10 gms	39 kcal	-	1.0 mg	-
Total		160 kcal	4.25 gms	6.25 mg	2.1 mg

160 K.cal is definitely not the total kcal requirement for a U-2 child requiring 1500 kcal. This supplementation is a nutrition education tool to educate and encourage the mother to prepare similar food at home. The weight of the child is monitored upto the twenty third months.

Adolescent girls :

The growth spurt of an adolescent girl usually occurs at 11-13 years. This is the period of not only her growth spurt and rapid development of mental state but also the period when she has to prepare herself for marriage and motherhood.

Under the supplementation programme for the AG the 11-16 year old girls under the NFPE schools of the WHDP areas are given a supplementary diet as a tiffin. They are educated upon the need to take excess of calories to assist in their growth spurt, mental acumen, make up for

the menstrual loss and adequate tissue, bone and muscle development. This food is also prepared by the GC members and the girls take it within the school hours under supervision of the SK and the school teacher.

TABLE B.17 NUTRITIONAL SUPPLEMENTATION OF ADOLESCENT GIRLS

Food	Amount	Energy	Protein	Calcium	Iron
Puffed rice	50 gm	163 kcal	3.75 mg	3 mg	3mg
Molasses	50 gm	197 kcal	-	5 mg	-
Peanuts	50gm	280 kcal	12.00mg	3 mg	1mg
Total	150gm	640 kcal	15.75mg	11mg	4mg

Women of child bearing age

Pregnancy makes many demands on the prospective mother not the last of which are her nutritional needs and those of the unborn child. Mother's nutritional status before and during pregnancy is important for the outcome of pregnancy which should be a child of normal birth weight. Complications of pregnancy such as anaemia, toxæmia, may result from an inadequate diet. Even prolonged or complicated labour or postpartal hemorrhage may be the indirect result of undernutrition/malnutrition.

All the primiparas in two areas and all pregnant women in one area with a BMI less than 17.5 will be provided with a nutritional supplementation. Their weight will be monitored during the antenatal visits. After delivery the supplementation will continue upto the sixth month of lactation (see appendix for flow chart).

The food is prepared by the GC members into balls of flat rice and peanuts with molasses (moas:4 in number) and supplied to the targeted women at their house daily by the Shastho Kormi.

TABLE B.18 WOMEN OF CHILD BEARING AGES

Food	Amount	Energy	Protein	Calcium	Iron
Flat rice	50 gm	162 kcal	3.75 gm	3 mg	3 mg
Molasses	100 gm	394 kcal	-	10 mg	-
Peanuts	50 gm	280 kcal	12 gm	3 mg	1 mg
Total	200 gm	836 kcal	15.75 gm	16 mg	4 mg

COMMUNITY BASED TB PILOT PROJECT:

Phulpur Thana of Mymensingh has been selected for a pilot project on Tuberculosis. The purpose of the project is to analyse the cure rate and cost effectiveness of the community based identification, treatment and control programmes of Tuberculosis using the various regimen of anti-tubercular drugs.

TABLE B: 18 12 MONTHS REGIME

Drug	Inj. Streptomycin	Isoniazide	Thiacetazone
Duration in months	2	12	12

TABLE B: 19 8 MONTHS REGIME

Drugs	Inj. Streptomycine	Isoniazide	Rifampicine	Pyrazina-mide	Thiaceta-zone
Duration in months	2	8	2	2	6

TABLE B : 20 6 MONTHS REGIME

Drugs	Inj. Strep-tomycine	Isoniazide	Rifampicin	Pyrazina-mide
Duration in months	2	6	6	2

To monitor the treatment sputum is tested every 15 days until 2 consecutive sputums are negative and every 2 months after the sputum has been converted to negative.

TABLE B: 21 IDENTIFICATION AND TREATMENT

Name of Area	Kashigonj	Phulpur	Tarakanda	Balia	Total
Total symptomatic	395	320	272	401	1388
Sputum positive	39	43	45	54	181
Treatment started	32	40	41	51	164

**EXPANDED PROGRAMME ON
IMMUNIZATION**

C. EXPANDED PROGRAMME OF IMMUNIZATION FACILITATION

The government undertook EPI programme to achieve universal child immunization. To help the government fulfil this effort and also because of BRACs' previous success in the EPI facilitation programme, WHDP has taken the responsibility to continue to help in mobilization and facilitation of the EPI programme.

Thirty teams consisting of four members each have been working in three districts of Chittagong Division. They work alongside the government EPI workers.

BRAC health workers educates the mothers about the six diseases (Diphtheria, pertussis, tetanus, polio, tuberculosis and measles) during the household visits, making, group meetings and Masjid forums. The mothers are advised to give their children three doses of DPT, four doses of OPV and one dose of measles and BCG.

TABLE C.1 NUMBER AND PERCENTAGE OF CHILDREN(0-1 years) IN EPI

Region	Target population	DPT / OPV		BCG		Measles/OPV	
		No.	%	No.	%	No.	%
Chittagong	136130	77246	57	78436	58	82800	61
Chandpur	70540	37251	53	43258	61	42059	60
Hobigonj	71375	37945	53	46216	65	41755	59
Total	278045	152442	55	167908	60	166614	60

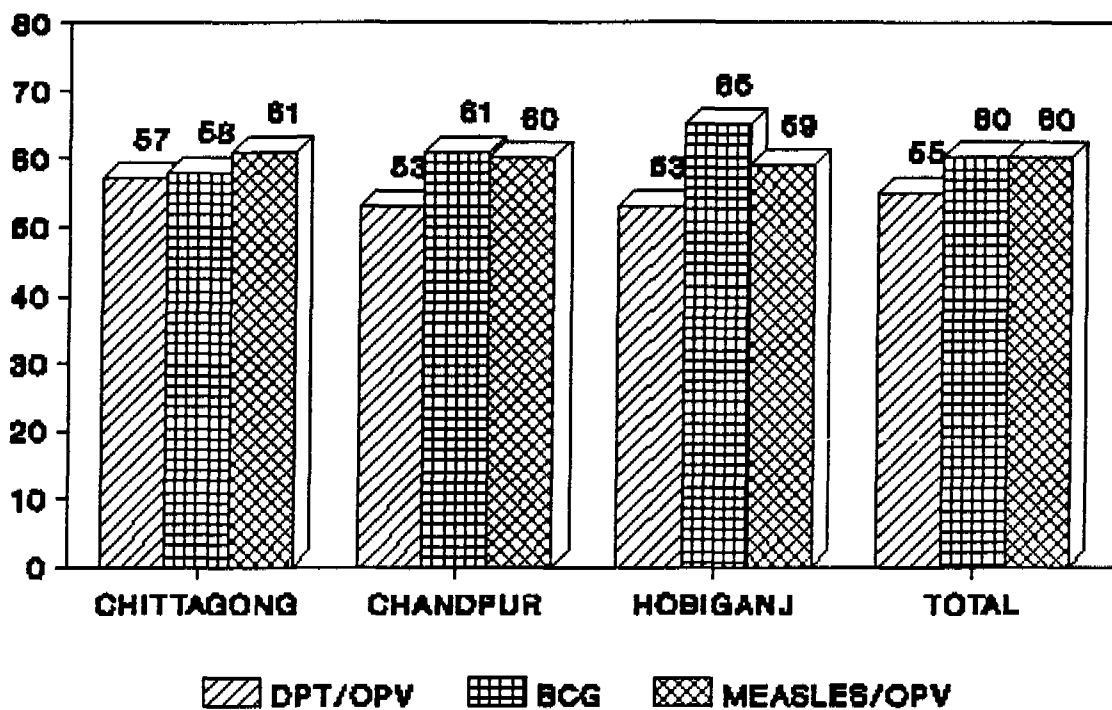
In the July to December 1992 reporting period, 55% of the registered U-2 children completed their DPT/OPV dose, 60% received their BCG and 60% completed their measles/OPV dose.

TABLE C.2 IMMUNIZATION OF PREGNANT WOMEN

Region	Target population	No. receiving TT	% receiving TT
Chittagong	167413	72906	44
Chandpur	87087	44641	51
Hobigonj	88119	31887	36
Total	342619	149434	44

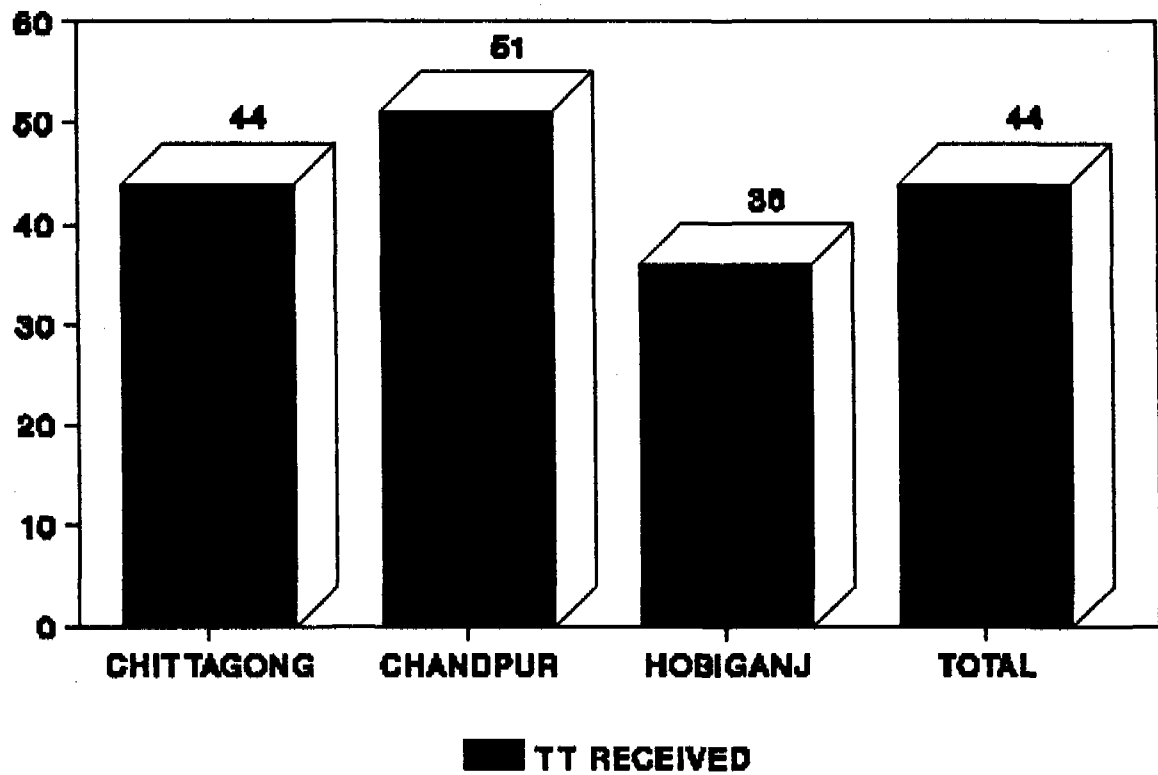
44% (149434) women could be immunized against tetanus.

**FIG C1 IMMUNIZATION COVERAGE OF U- 1
N=278045**



• values given in percent

FIG C2 IMMUNIZATION OF PREGNANT WOMEN



TT vaccine was not available at the field from November 1992 so the EPI project advised to focus only on pregnant women and not women of child bearing age.

So all women of child bearing age (CBA) showed the following achievement which was not favourable.

TABLE C.3 REPORT ON CBA

Region	Population	No.	%
Chittagong	206646	24316	12
Chandpur	296637	9287	3
Hobigong	189408	19721	10
Comilla	692691	53324	8

53324 women of child bearing age were immunized against tetanus.

**RURAL DEVELOPMENT PROGRAMME -
PRIMARY HEALTH CARE**

D. RURAL DEVELOPMENT PROGRAMME - PRIMARY HEALTH CARE

Unless the income generation capacity of the poor is improved lasting health and nutritional status cannot be maintained. Keeping this in mind Primary Health Care programmes (PHC) were introduced within twenty seven Rural Development Programmes (RDP) areas and two areas of Kutubdia. The activities within this component are similar to that within WHDP and are listed below :-

TABLE D 1 ACTIVITIES UNDER RDP.

No	Activities
1.	Traditional Birth Attendant training
2.	Shastho Shebika training
3.	Oral rehydration therapy
4.	Health and Nutrition education
5.	E P I facilitation programme
6.	Water and Sanitation education
7.	Family Planning motivation and service

TABLE D 2 POPULATION UNDER RDP-PHC

	Total	Target group
Total population (TG +NTG)	1077729	415748
Number of villages	1197	1197
Number of households	206289	82744

RDP-PHC provides family planning services through sale of oral pills and condoms (supplied by the Social Marketing Company) by trained Shastho Shebikas. The Shebikas are allowed to sell with a mark-up of 20% which they are allowed to retained.

TABLE D 3 FAMILY PLANNING SERVICE

Number of eligible couples	185023
Number of new family planning acceptors	18576
a. Temporary method	17737 95%
b. Permanent method	839 5%

Within the 18,576 new FP acceptors within the six months 95% took the temporary method and the rest opted for the permanent method.

TABLE D 4 SAFE DRINKING WATER AND SANITATION

Number of tubewells installed	1866
Number of latrines constructed	6427
a. slab	4979
b. pit	1448

Under the RDP-PHC programme to provide a good sanitary environment tubewells are supplied and latrines made. 4979 H/H preferred the slab latrine and 1448 preferred the pit type.

As in all other places of Bangladesh the immunization schedule not only includes infants and pregnant women but also all other women aged between 15-49 years.

TABLE D 5 ACHIEVEMENTS OF EPI

Subject		Registered	Achievement
Infant(0-1)year	DPT	6199	4923 79%
	Measles	13541	7097 54%
Women(15-45)years		154465	134815 87%
Pregnant women		4773	4689 98%

79% of the targeted children were immunized with DPT and 54% with measles vaccine. 87% of women of child bearing age (15-49 years) were immunized against tetanus and 98% of the pregnant women completed their tetanus toxoid dose.

In this programme 50 TBAs and 50 SSs have been trained in each area and village health committee and mohila shobhas have been formed.

TABLE D 6 TRAINING AND MEETINGS UNDER RDP-PHC

No of sebikas trained	1251
No of TBA trained	1350
No of VHC held	4920
No of MS held	5789

The SSs are trained to prescribe medicine for common ailments on the basis of signs and symptoms. They also buy and sell the common medicine for a 20% profit to common villagers and a 10% profit to VO members. The list of drugs is attached as appendix 3.

NON FORMAL PRIMARY EDUCATION

E. NON FORMAL PRIMARY EDUCATION FOR ADOLESCENT GIRLS (NFPE AG)

Without education it is virtually impossible to emancipate women. On this belief the NFPE AG programme was undertaken. These schools are located in rural areas, one for every village where CHDP is operational and meant for 11-18 years old girls of the poorest landless families. In June 1992, 500 new schools were to be opened. However due to lack of adequate number of girls only 362 schools could be opened and in some of the schools boys had to be included as well. 100% teachers of the schools are females.

TABLE I SIX MONTHS INFORMATION ON NFPE

No. of schools opened	No. of enrollment		
	Boys	Girls	Total
362	2120 19%	8740 81%	10860

Since the ultimate goal is to develop these girls into health cadres certain activities other than Bangla , arithmetic , social studies and health education are added to the curriculum. Each student is assigned three homes where they must assume responsibility for the growth monitoring for at least one U-2 child. They have to impart health and nutrition education to the parents of these children. The students form a Kishori club where two health related messages are formed with the help of the teachers and imparted to the assigned families. These NFPE schools for adolescents have been a major breakthrough in not only creating more educated and equipped young women, but also in slowly changing the attitudes of the community towards the women and the need for their education.

**HEALTH RESOURCE CENTRE
(WHDP MONITORING)**

F. MONITORING

Monitoring, research and evaluation constitute an integral part of Women's Health and Development Programme (WHDP) to control the quality of the programme. A two-tier monitoring mechanism is in operation in WHDP for generating needful data to inform the management on the progress of different activities. Internal Monitoring starts at the Area Office and the data is analysed at all levels for a quick management decision and sent to HO for a consolidated analysis on a monthly basis. This is accompanied by in-depth analysis of the programme at period interval. A separate Monitoring Cell known as WHDP-MC was established at Research and Evaluation Division (RED) of BRAC to ensure a routine flow of accurate data from an external source for efficient management of WHDP. WHDP-MC conducts continuous monitoring as well as operations research and evaluations. This has involved the setting of quick diagnostic tools through which weaknesses are identified and timely feedback is provided to the management for taking proper measures. Likewise, research studies are conducted to capture the changes that are occurring in the status of health and nutrition of the target people and community over time.

The WHDP/MC is a multi-disciplinary team of professionals who are responsible for designing and conducting monitoring, research and evaluation on various aspects of WHDP.

Apart from longitudinal studies on maternal morbidity and consequences of low birth weight babies, a variety of short and ad-hoc studies have been initiated (list given below). Data collection of these studies has been completed and processing is underway.

1. Health behaviour of rural women: Benchmark evidence from WHDP and control areas.
2. Benchmark study on maternal mortality in WHDP and control areas.
3. Role of Gram (village) committees in basic health care service delivery.
4. Targeting the bottom 50%: Is it an effective way to provide them the health care services?
5. Post-training knowledge of the Shastho Kormis in WHDP
6. Post-training knowledge of the Shastho Shebikas.
7. Evaluation of TB Laboratory operations in WHDP
8. Evaluation of Trained TBAs' performance.
9. Study on the status of ante-natal to the mothers facing still birth hazards.
10. Mohila Shobhas : Does it make a difference ?

Another dimension of WHDP-MC activity was the identification of basic strategic assumptions behind WHDP for monitoring and evaluation.

OTHER ACTIVITIES

G. OTHER ACTIVITIES

G1. Management Information System (MIS).

To improve the information system for better collection, analysis and feedback WHDP has set up its own Management Information System. Dr. Nirmala Murthi of the Foundation for Research in the Health System in India was invited to come to Dhaka to assist in this process.

The objectives of her work with WHDP were to:

1. Review the existing data being collected in terms of its flow and quality.
2. Assess usefulness of the data being collected for indicating the progress being made in implementing the programme.
3. Prepare a comprehensive , simple information system useful for management at all levels.
4. Assist WHDP to computerize the system for quick collection, analysis and feedback.

She reviewed the programme and went on a field trip to Mymensingh and on this basis outlined a design for MIS for use at different levels, consisting of four components.

1. Monthly monitoring report from PO-- Area -- Thana -- Region-- Headquarter.
2. Indepth analysis of recorded date on a sample basis once a year.
3. Rationalization of registers.
4. Rapid assessment on selected topics.

The MIS thus evolved is now a modified version of the current report to be filled by the Programme Organizer, consolidated at the area and thana levels and sent to the Head Office. This gives a quick feedback for operational management and analysed to produce standard performance indicators.

The rich data maintained by the POs is to be made accessible to the programme managers by an indepth analysis 6once a year.It will be done to assess coverage of the different programmes, quality and effectiveness of the services.An individual specialized data entry and analysis is going to assist the process both in the field and HO.

Focus group interviews and Rapid surveys through the Gram Committee meetings and the Mohila Shobhas are being planned for qualitative information.

On the basis of the above the reporting format has been changed and an indepth analysis reporting form was prepared (appendix). The rest of the changes are being done according to the need. This is expected to result in an improved and comprehensive health information system.

G2. DISASTER PREPAREDNESS

Bangladesh situated within the tropical belt is prone to natural calamities. The highest death toll and property destruction due to this was recorded in April 1991 when a devastating cyclone hit the south eastern coast of Bangladesh. BRAC immediately rushed 30 relief teams to the worst affected areas on 30th April 1991 with whatever means was available.

A similar storm was expected over Cox's Bazar and the rest of the coastal areas in November. The WHDP team was prepared to face the consequences of the calamity within hours notice. Fortunately the crisis subsided and relief was not required.

A pre and post disaster program divided into four phases was then developed. An operational strategy paper combining both RDP and WHDP approaches was also developed.

- | | |
|--------------------------------------|--|
| First phase (pre disaster) | <ol style="list-style-type: none">1. Form an advance team.2. Give warning through miking.3. Remove people to a safer zone.4. Store candles, matches, drinking water and dry food. |
| Second phase (after disaster) | <ol style="list-style-type: none">1. Provide temporary shelter.2. Give primary health care.3. Refer to hospital if needed.4. Supply drinking water, dry food, medicine, clothes.5. Bury the dead. |
| Third phase (1 - 3 month) | <ol style="list-style-type: none">1. provide relief including water purifying tablets,bleaching powder and cleaning of tubewells etc.2. Supply temporary shelters, latrines and utensils.3. Give primary health education. |
| Fourth phase (rehabilitation) | <ol style="list-style-type: none">1. Provide permanent house.2. Supply equipment for work.3. Reopen educational institutions. |

All development activities are centred around the Village Organizations (gram committee members and shastho shebikas).

G3. PARTICIPATION OF WHDP STAFF MEMBERS IN SEMINARS, WORKSHOPS, TRAINING COURSES AND PAPERS PRESENTED UPTO DECEMBER, 1992.

STAFF DEVELOPMENT

1. Mr. Jalaluddin Ahmed Programme manager WHDP received a training on "Managing Health Programme in Developing Countries" at Harvard School of Public Health, USA from June 22 to August 14 1992 .
2. Dr. Shahaduzzaman and Dr. Masud Ahmed, Medical officers received Teacher's Training on Clinical and Community Nutrition, July 1992 at Centre for Nutrition Unit, Save the Children Fund (UK), Dhaka.
3. 7 Medical officers took a special training course on Tuberculosis and Leprosy at Dhaka, July 1992.
4. 33 Programme Organizers received training on Tuberculosis and Leprosy at Dhaka, August 1992.
5. 33 POs attended a orientation course in Depot Holder Concept in Family Planning and Contraceptive Method, September 1992.

SEMINARS AND WORKSHOPS ATTENDED :

Dr. Sadia A Chowdhury Director, WHDP Discussant at a seminar on "Prostitution in Bangladesh" arranged by Centre for Social studies Dhaka, October 1992. She also participated as part of the national team in SARRC meeting on the child, October 1992 at Columbo, Srilanka and as a NGO representative involved in field level implementation programme, in the International conference on Nutrition, 3 - 10 December 1992, Rome, Italy.

Mr. Jalaluddin Ahmed Programme Manager WHDP :

1. "Development of guidelines for combined Health & Family Planning service delivery", BARD, Comilla 2-3 November 1992.
2. "Integration of Tuberculosis Control Programme into general health services", Dhaka, 15 December by National Tuberculosis Control Project .
3. "Mid Term Evaluation Report ", Niport, Dhaka, 15 December 1992.

PUBLICATIONS AND PRESENTATIONS

1. WHDP Annual report for the period July 91 to June 92.
2. Video material - Flip charts on PHC.
3. Dr. Sadia A. Chowdhury, Director, WHDP presented papers on
 - a. Primary Health Care in Sustainable Development Programmes at National workshop on Primary Health Care Intensification Dhaka in July 1992.
 - b. A Community Based Rural Development Approach for Affecting Family Planning and Birth Spacing : The BRAC experience at Asia Regional Meeting on Women's Perspective on the introduction of Fertility Regulation, Manilla Philippines, October 1992.
4. Mr. Jalaluddin Ahmed PM; WHDP presented paper on " BRAC's experience on MCH " at a workshop organised by VHSS and Bangladesh Obstetric and Gynecological Society, 8 October 1992, BIRDEM Dhaka.

H. VISITORS TO WHDP

	Visitor	Purpose of visit	Place	Time	
1.	Jumla Project staff	Orientation	Mymensingh	Jan'92	Katmandu , Nepal
2.	Mr. John Rohde	Nutrition project Development	Mymensingh	Sept'92	
3.	World Bank Team	Operational strategy	"	Oct'92	
4.	World Vision Team from Cambodia	Orientation	"	"	
5.	Dr. Nirmala Murti	MIS Consultancy	"	Nov'92	

Appendix 1.

The following are considered as high risk cases :

1. Under 18 years
2. Over 35 years
3. Short stature (less than 145 cm)
4. Multigravida (3+)
5. Pre Eclamptic toxæmia (Hypertension, oedema, albuminuria - any one of the symptoms)
6. Severe anaemia in the last trimester
7. Past bad obstetrical history
 - a) Outcome of first pregnancy ended in abortion / still birth / complicated labour.
8. Twin pregnancy
9. Malpresentation
10. Malposition

Appendix 2:

DRUGS FOR TUBERCULOSIS:

Conventional therapy:

1. Injection Streptomycin- 1 injection every other day :2 MONTHS
2. Tab. INH + Tab. Thiacetazone 1 tablet daily : 12 MONTHS

Side effects:

Skin rash

Skin blister

Nausea

Vomiting

CNS disorder (vertigo, neuritis).

Other therapy in case of side effects:

The doses of the conventional therapy is reduced.

1. Ethambutol (400 mg)
2. Rifampicin

Appendix 3 :

Drugs sold by Shastho Shebikas :

1. Syrup Ficillin
2. Capsule Ficillin
3. Syrup Fisat
4. Tablet Fisat
5. Syrup Metronid
6. Tablet Metronid
7. Syrup Cetamol
8. Tablet Cetamol
9. Syrup Meben
10. Tablet Meben
11. Tablet Folfetab.

Appendix 5

CHDP MONTHLY PERFORMANCE REPORT FOR MIS

P.O/Area/Thana _____ Reporting for Month & year _____

(1.A) ANC program:

	No. of Clinics Held	ANCC		Satellite	
		TG	NTG	TG	NTG
a.	Expected pregnant women(old)	----	---	---	---
b.	New pregnant women	----	----	----	----
c.	High Risk Identified	----	----	----	----
d.	Pregnant Women Present	----	----	----	----
e.	Weight Taked	----	----	----	----
f.	BP Measured	----	----	----	----
g.	Urine Examinations	----	----	----	----
h.	women given Iron Tabs.	----	----	----	----
i.	High Risk Referred	----	----	----	----

(1.B) Emergency Referrals

(2) Growth Monitoring: (TG only)

	No. of Sessions	Age 0-12 months	13-23 months
a.	Old children expected	-----	-----
b.	Children Weighed from a	_____	_____
c.	Gained Weight from b	_____	_____
d.	New Children Weighed	_____	_____

(3) Pilot Project : Birth Weight Monitoring:

Population _____
 Births _____ Weight Taken _____ BW Below 2 kg _____

(4) Vit-A : Cycle _____ Children Expected _____ Received _____
 Night Blindness identified _____ treated _____

(5) Tuberculosis Program:

a.	No. sputum examined _____	b. No. positive _____
c.	Under treatment _____	12 mths _____ 8mths _____ 6mths _____
	Old patients _____	_____
	New patients _____	_____

d. Lost to
Treatment: Deaths _____ Migrated _____ Dropout _____

e. Referred: Reaction _____ Resistance _____ Other _____

f. Patients cured _____ TB cumulative _____
TB cured cumulative _____

(6) Immunization :

No. of centres _____	1st dose	2nd dose	3rd dose	Measles
Children Expected _____	_____	_____	_____	_____
Children Received _____	_____	_____	_____	_____
	TT1	TT2/B		
Women expected _____	_____	_____		
Women present _____	_____	_____		

(7) Outcome of pregnancy and death:

	TG	NTG
a. Births : Live births _____	_____	_____
Still births _____	_____	_____
b. Abortions _____	_____	_____
c. Deaths : Total _____	_____	_____
Children under 5 yrs _____	_____	_____
Maternal deaths _____	_____	_____

8.A) Family Planning: (one third HOUSEHOLDS covered in month)

	TG	NTG
No. ECs visited _____	_____	_____
No. using contraception _____	_____	_____
No. pregnant _____	_____	_____

B) FP Depot Holders

No. of women given oral pill _____
No. of persons given condoms _____

(9) Water and Sanitation : (one third AREA covered in month)

A. Tubewells: New _____ Cumulative Total _____
No. of Tubewells followed up _____
No. functioning _____ No. with Platform _____

B. Latrines : Pit Slab
New _____
Cumulative total _____

(10) TBA and Sebika Report:

	TBAs	Sebikas	Shasto kormi
Total No. Trained	_____	_____	_____
No. Active	_____	_____	_____
No. given Refresher trainig	_____	_____	_____

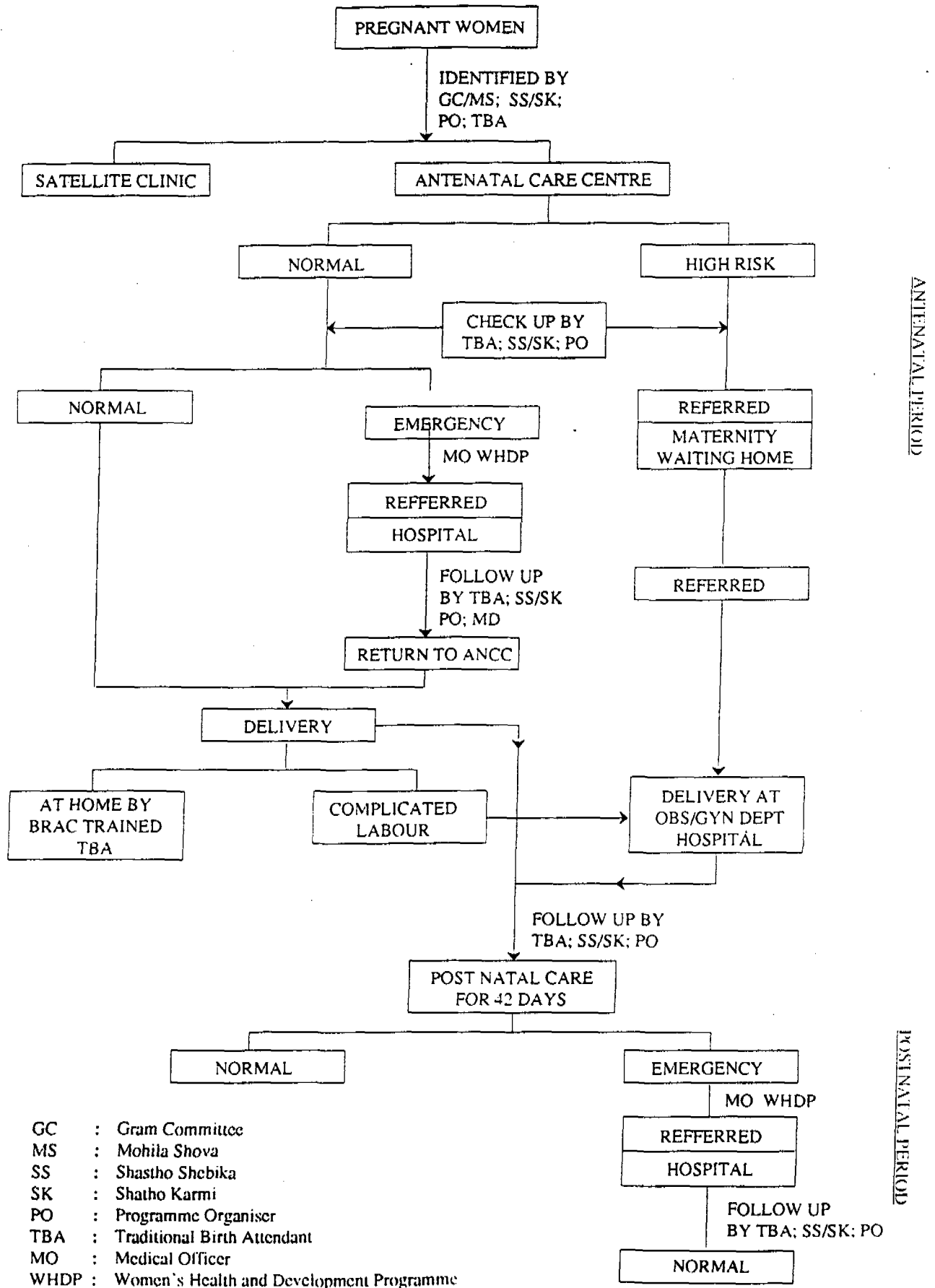
(11d) Forum Report

	Meetings	Attendance
Gram Committee	_____	_____
Mahila Shava	_____	_____
Mosque Forum	_____	_____
Imam Mahfil	_____	_____
Village Doctor Meeting	_____	_____
Male seminar	_____	_____
Others	_____	_____

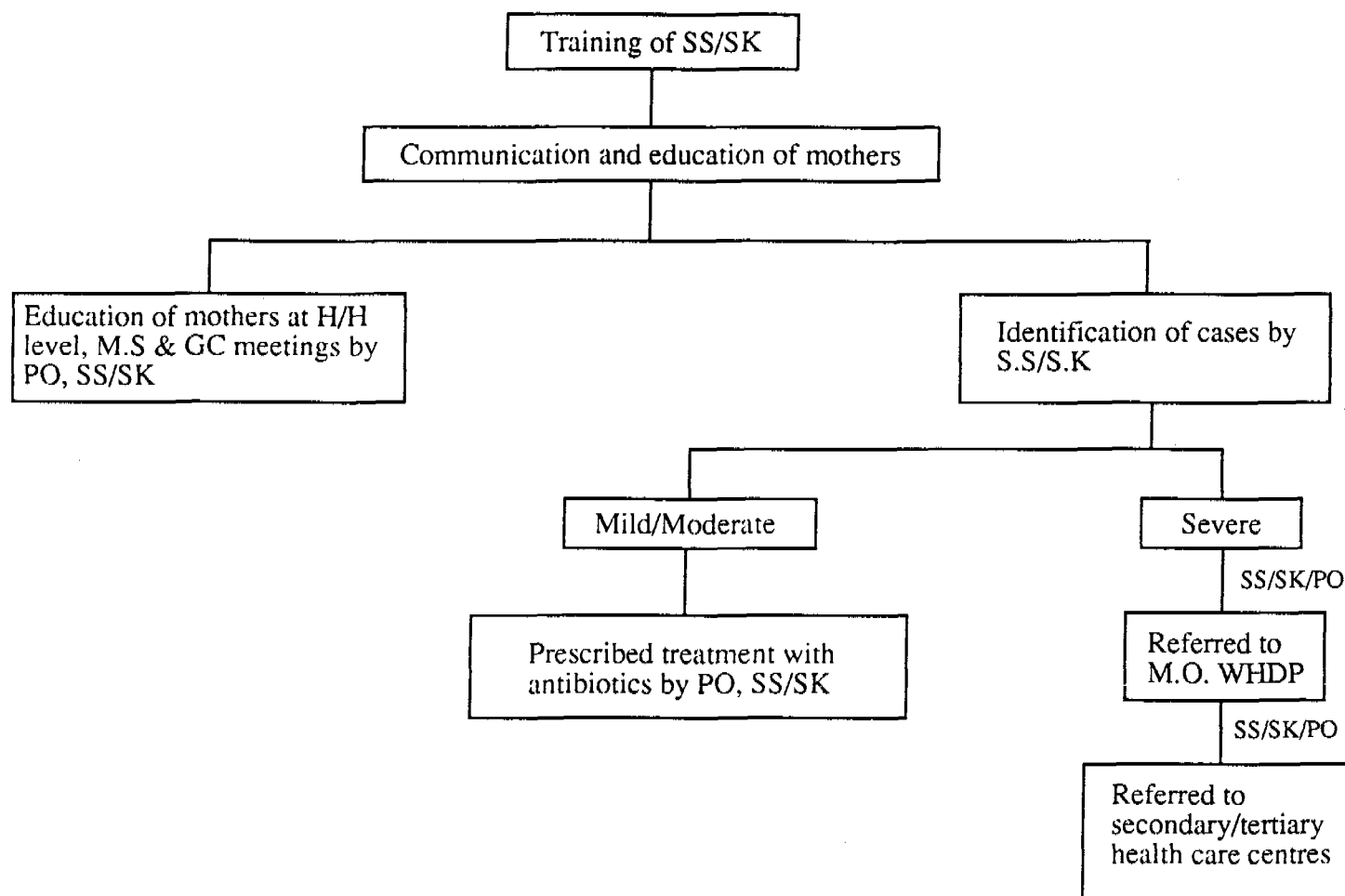
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PO/AM/AC/RM

MATERNAL MORTALITY REDUCTION PILOT PROJECT

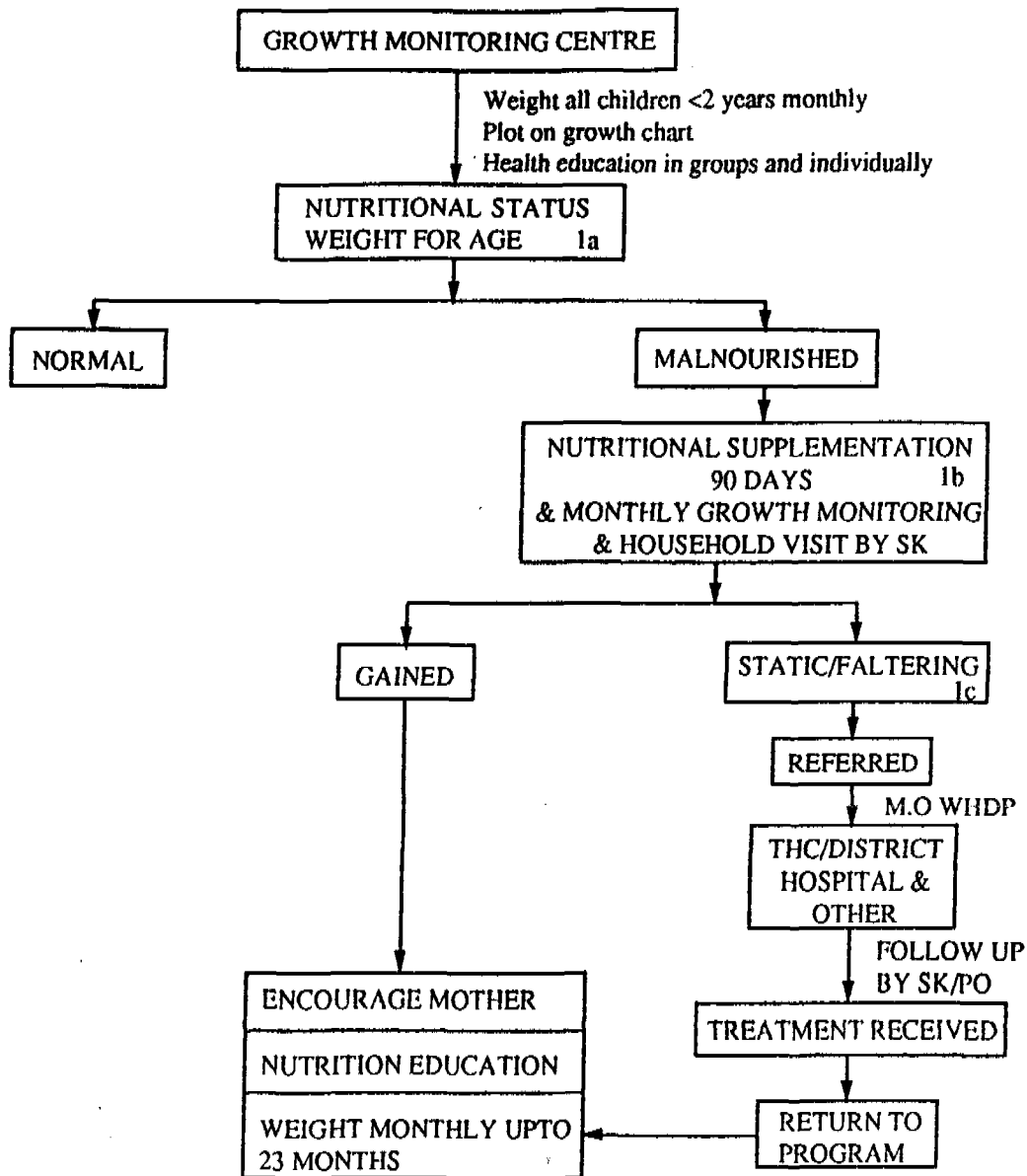


PNEUMONIA CONTROL PILOT PROJECT



SS : Shastho Shebika
 SK : Shastho Kormi
 HH : House Hold
 MS : Mohila Shova
 GC : Gram Committee
 PO : Programme Organiser
 MO : Medical Officer
 WHDP : Women's Health and Development Programme

ALGORITHM OF NUTRITION PILOT PROGRAM OF CHILDREN U-2



WHDP : Women's Health and Development Program

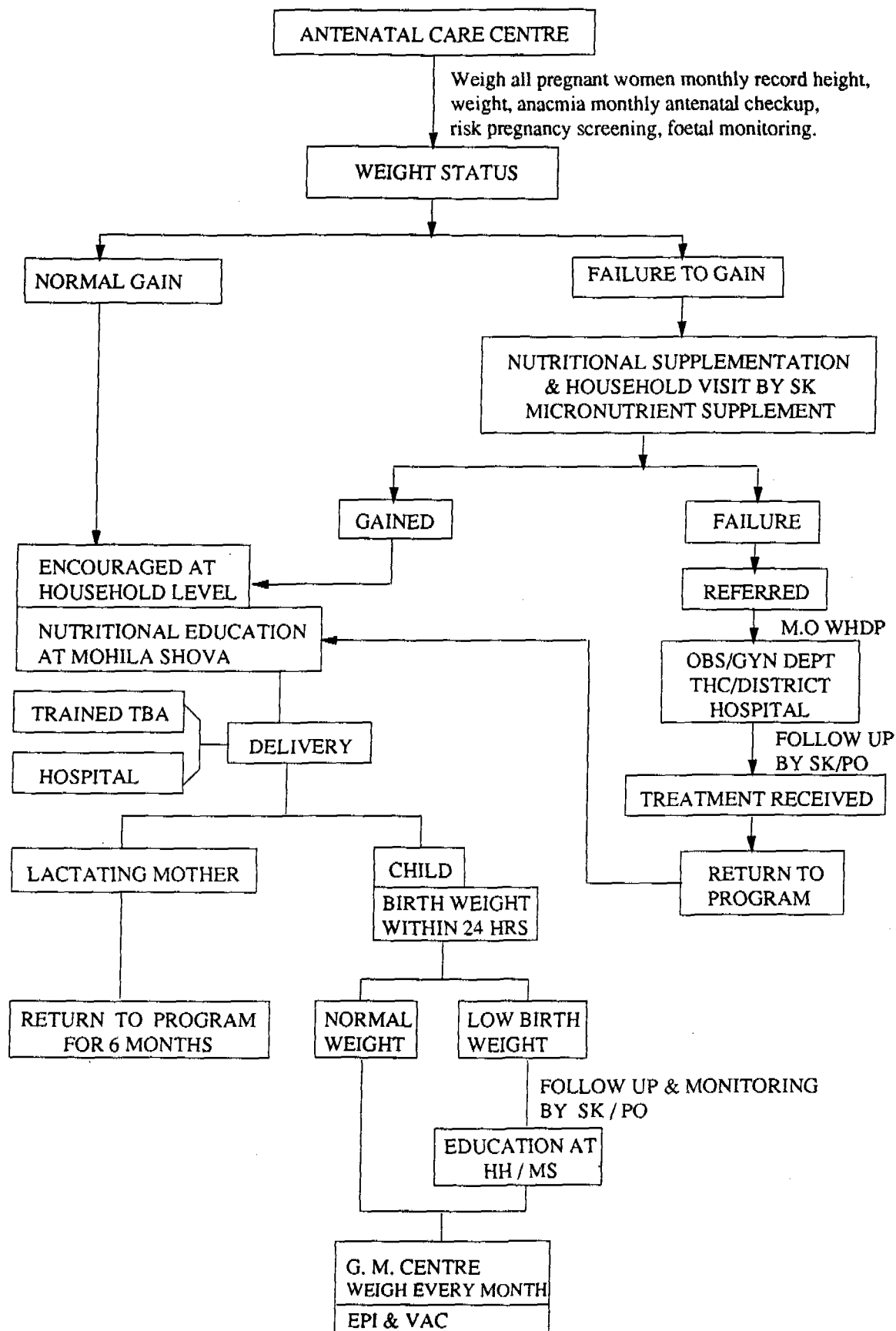
M.O : Medical Officer

T.H.C : Thana Health Complex

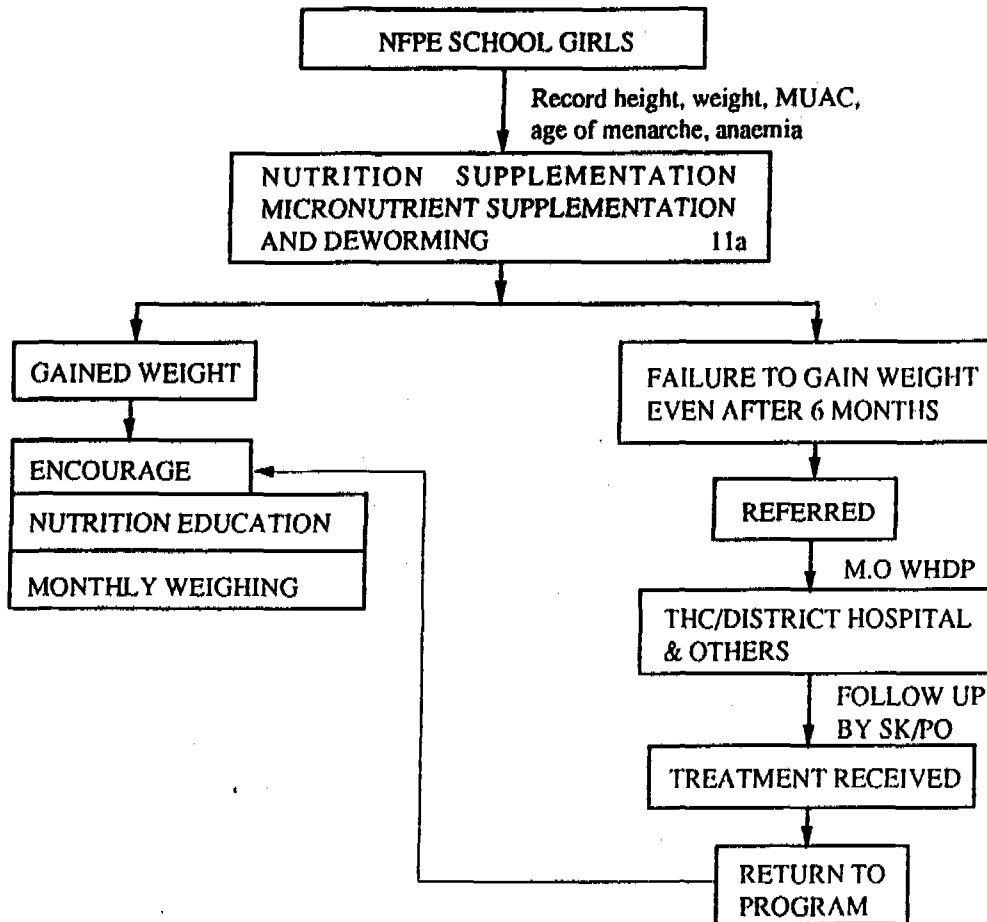
S.K : Shastho Karmi (Health Worker)

P.O : Programme Organiser

ALGORITHM OF NUTRITION PILOT PROGRAM OF PREGNANT WOMEN



ALGORITHM OF NUTRITION PILOT PROGRAM OF ADOLESCENT GIRLS



WHDP : Women's Health and Development Program

M.O : Medical Officer

T.H.C : Thana Health Complex

S.K : Shastho Karmi (Health Worker)

P.O : Programme Organiser