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WORLD VISION RELIEF & DEVELOPMENT INC.

**FIRST ANNUAL REPORT
DHAKA URBAN INTEGRATED
CHILD SURVIVAL PROJECT
DHAKA CITY, BANGLADESH**

**Beginning Date: October 1, 1991
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Submitted to:

**PVO Child Survival Grant Program
Office of Private and Voluntary Cooperation
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LIST OF ACRONYMS

AC	Area Coordinator
ACSS	Active Continuous Surveillance Sites
ALRI	Acute Lower Respiratory Infections
CDW	Community Development Worker
CSP	Child Survival Project
CSSP	Child Survival Support Program
CV	Community Volunteer
DCC	Dhaka City Corporation
DIP	Detailed Implementation Plan
DUICSP	Dhaka Urban Integrated Child Survival Project
DVF	Domiciliary Visit Form
FMG	Focus Mothers Groups
EPI	Expanded Program of Immunization
IPHN	Institute of Public Health Nutrition
K/P	Knowledge and Practice
MOHFW	Ministry of Health and Family Welfare
NGO	Nongovernmental Organizations
NHC	Neighborhood Health Committee
NNMS	Neonatal Mortality Survey
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHN	Public Health Nurse
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
VAC	Vitamin A Capsule
WCC	Ward Coordination Committee
WHO	World Health Organization
WVB	World Vision Bangladesh

1. RESULTS IN YEAR ONE

1.1 Major Achievements

Most of the project objectives for FY92 have been attained except the following: (a) children 12-23 months' receipt of appropriate dose of VAC during immunization (Area B only)*; (b) contraceptive use among mothers with children 0-23 months (Area A only)*; and (c) Vitamin A capsule (VAC) coverage among postpartum women* as seen in the table below:

Objectives	FY92 Achievement			FY92 Target	FY94 Target
	Area A Kamalapur	Area B Mohammadpur	Areas A & B		
Children 12-23 months fully immunized by their first birthday.	83.3%	84.3%	83.8%	85%	85%
Mothers who delivered in the last 12 months immunized with TT2/TT2+.	87.6%	90.0%	88.8%	85%	85%
Children 0-59 months who had diarrhea in the last two weeks and treated with ORT.	61.7%	67.6%	64.0%	60%	75%
Children 12-71 months who received VAC in the last six months.	91.7%	89.9%	90.8%	90%	90%
Children 12-23 months who received appropriate doses of Vitamin A during immunization.*	71.9%	35.7%	53.5%	85%	85%
Mothers with children 0-23 months who know correct weaning and infant feeding practices.	95.7%	93.8%	94.7%	60%	80%
Mothers with children under 0-23 months currently using modern methods of contraception.*	36.9%	52.8%	44.9%	50%	60%
Mothers who delivered in the last 12 months who had at least three checkups (two prenatal, one postnatal).	30%	60.5%	45.2%	30%	90%
Mothers who delivered in the last 12 months who received a single dose of VAC within two weeks after delivery.*	27.1%	25.2%	26.2%	40%	90%
Mothers with children 0-59 months who can correctly name two out of three signs of pneumonia.	30.5%	31.3%	30.9%	20%	50%

Major activities during the year include:

Social Mobilization: To promote Child Survival (CS) interventions to a larger audience, the project launched the School Health Education program. The activities included (a) selection of 12 schools; (b) dialogue with school authorities; (c) preparation of an Action Plan; (d) a day-long workshop for schoolteachers and officials from different government agencies where the program will be implemented; and (e) trainers' training for selected schoolteachers.

In Area A (Kamalapur), 50 Neighborhood Health Committees' (NHCs) conveners/ members, in collaboration with Dhaka City Corporation (DCC), conducted a week-long mosquito control program in April. Forty percent of the cost for this program was picked up by the NHCs.

In Area B (Mohammadpur), the residents, led by their NHCs, contributed to defray the cost of environmental sanitation activities such as construction of latrines, drainage clean-up, and repair/installation of water tanks and pipes. World Health Day was observed in both impact areas with a speech competition, group health education sessions among Community Volunteers (CVs), and essay writing on different health messages by the NHC members.

Sharing Lessons Learned: To reinforce active participation and community sense of "ownership," the project held annual and semiannual reunions to share lessons learned with NHCs and CVs in Kamalapur and Mohammadpur, respectively. In Kamalapur, 204 NHC members and 101 CVs turned out for the reunion, while 175 NHC members and 140 CVs did the same in Mohammadpur.

Establishment of Savings Cooperatives: CVs formed cooperative societies in their respective catchment areas. These societies were organized to monitor progress of the CVs' monthly savings groups. CVs make a monthly deposit to the cooperative society to start a revolving fund. Funds are then borrowed/withdrawn to finance income-generating activities proposed by the CVs. Approximately 205 CVs (Area A - 85; Area B—120) joined the co-op and have saved about \$800 since September 1991.

During the first quarter, 40 CVs went on a field trip to Demra. They visited "Nari Moitree," an NGO which implements IGAs. The CVs gained valuable information on how to run IGAs.

Government/Nongovernment Coordination: The project participated in the bimonthly coordinating/exchange forum among GOs and NGOs in and around the project area. This year, 100 representatives from these organizations attended a workshop to share experiences and to improve coordination at the field level. The DCC mayor inaugurated the workshop. Dr. Khalilullah, MOHFW Joint Secretary, praised the project's initiative to organize the workshop, the first of its kind in Bangladesh.

Training: From October 1991 to September 1992, the project staff conducted various training workshops for the following community-based health workers.

- 1.1.1 One hundred eighteen CVs (six batches) for five days' (30 hours) preservice training on CS interventions, and 311 CVs (11 batches) for one day for re-orientation/retraining on Child Survival Project (CSP) interventions.
- 1.1.2 Forty-one Focus Mothers Groups (FMGs) (four batches) for two days' preservice training on new interventions—ARI and Safe Motherhood.
- 1.1.3 Twenty-six Traditional Birth Attendants (TBAs) for 120 hours' basic training.
- 1.1.4 Sixteen schoolteachers for five days' "Training of Trainers" on the School Health Education Program.
- 1.1.5 Seventy-four NHC members (four batches) for one hour on basic training, and 81 NHC members (five batches) for eight hours' orientation/retraining sessions and phaseover strategies.

EPI: A key activity this year was the implementation of a neonatal mortality survey under the direction of Dr. R. N. Basu, a WHO EPI consultant in Bangladesh. The interviews were done

by 73 CVs and 21 CDWs who received training prior to the interviews. CDWs, CVs, and NHCs received training in surveillance of neonatal tetanus, polio, and measles, as well as in investigating outbreaks of vaccine-preventable diseases. Appendix A contains the neonatal survey report.

National Immunization Week was celebrated with the DCC health staff through a joint tetanus toxoid vaccination outreach at a local garments factory. Key government officials, Ministry of Health and Welfare (MOHFW) staff, and the Zonal Chief Executive of DCC graced the occasion. There was also a health rally at the project site.

ORT: The semiannual domiciliary visit provided opportunity for CVs to test the competence of mothers about ORT. During these visits, mothers were asked to demonstrate the proper method of preparing, mixing, and administering oral rehydrating solution (ORS) using ORS packets. Dietary management was heavily emphasized during these visits.

Nutrition: Eight hundred schoolchildren from grades 4 to 10 in 12 schools participated in the first semester examination on nutrition and on personal and environmental hygiene under the school health education program initiated by the project. New CDWs were trained how to teach mothers correct infant feeding practices, while NHCs were encouraged to motivate other adults to promote locally available weaning and enriched foods for children. In FY93, the project hopes to begin a pilot growth-monitoring promotion targeted at children 6 to 23 months in three slum areas of Mohammadpur.

Vitamin A: Aside from prophylactic VAC administration to target mothers and children, and identification and treatment of children with nightblindness, CDWs and CVs taught pregnant and lactating mothers how to prepare, cook, and consume locally available Vitamin A-rich foods. A report on the Nightblindness Prevention Program is found in Appendix B.

Birth Spacing: CDWs and CVs were trained how to refer potential acceptors for IUD insertion, tubectomy, and vasectomy. Emphasis was placed on sustained motivation of current acceptors to continue and prolong the use of contraceptives.

Pneumonia Control: This is a new project intervention. CDWs and CVs were trained to teach mothers how to recognize signs and symptoms of pneumonia which necessitate treatment or referral.

Safe Motherhood: This is another new intervention. Training for TBAs practicing in the impact areas began during the third quarter. Ten were trained at the TBA training unit of Koinonia, an NGO based in Dhaka.

1.2 Change in Approach to Individuals at Higher Risk

There has been no change in the approach to individuals at "higher risk." The definition for risk-group remains the same.

1.3 Staffing

There has been no change in the project's organizational structure.

Mrs. Monju Maria Palma replaced Mr. Nibash Dey, Area B Area Coordinator, who took a new position at WV Bangladesh (WVB). Mr. Dey was a seconded staff from WVB since February 16, 1992.

Mrs. Palma has a Masters of Social Science in Public Administration degree from Dhaka University. Her job description is attached as Appendix C.

1.4 Continuing Education

The project has a strong human resource component. Concrete plans were drawn for staff development. From October 1991 to September 1992, the staff, singly or in groups, attended the following training events.

- ▶ Preservice training on CS interventions and project planning and implementation, attended by 25 field staff.
- ▶ Inservice training program such as the Rapid Knowledge/Practice Survey training for staff, October 30—November 14. Training was conducted by Kenneth Sklaw, survey trainer from Johns Hopkins University's Institute for International Programs/PVO CS support office.
- ▶ A three-day workshop on Communications for the Control of Diarrheal Diseases, organized by NCDDP, MOHFW, attended by the operations coordinators.
- ▶ A four-day workshop on National EPI Workplan for '92, organized by MOHFW/EPI, attended by the operations coordinator of Area A.
- ▶ A two-day workshop on Sentinel Surveillance organized by MOHFW/EPI attended by the project manager from Area B and the operations coordinator of Area A.
- ▶ A two-day workshop on the Prevention of AIDS in Bangladesh, organized jointly by MOHFW and WHO, attended by the project managers of Areas A and B.
- ▶ A four-day workshop (two days for the supervisors and two days for the grass-root workers) on Disease Surveillance, organized by the project in collaboration with MOHFW/EPI and WHO, attended by all field staff.
- ▶ A two-day workshop on "Campaigning for the Protection and Promotion of Breastfeeding," organized by UNICEF in Dhaka, attended by the Area B training coordinator.
- ▶ Dr. Iqbal Anwar, Area B Project Manager, attended the 19th conference of the National Council for International Health (NCIH) in Washington D.C., USA, June 14-17, 1992. He presented a paper, "Targeting Garment Workers to Increase TT2 Coverage in Dhaka."
- ▶ Mr. Sylvester Costa and Dr. Anwar, the Project Managers for Areas A and B respectively, served as resource persons in the Training of Trainers workshop on "Rapid Knowledge and Practice Surveys for Community Assessment and Action." The workshop was held August 26—September 10, 1992, in Phnom Penh, Cambodia, and was organized by World Vision International (WVI). Dr. Marcelo Castrillo was the workshop consultant.

1.5 Technical Support

PVO/USA and Regional Office Technical Support: The International Health Programs Department (IHPD) of WVRD in California provided excellent technical, administrative and moral support to the project. Updated information on A.I.D. guidelines and reporting requirements were relayed to the project immediately upon receipt from A.I.D./Washington. Headquarters staff also facilitated the communications between the field office and Johns Hopkins University's (JHU) PVO CS Support Program Office to implement A.I.D.-sponsored technical support for the project's baseline survey. IHPD also provided valuable comments in the development of technical papers presented at the conference sponsored by the National Council for International Health in Washington, D.C., in June 1992. During the year, over 20 CS-related technical publications were received from IHPD.

Dr. Sri Chander, World Vision Regional Health Advisor/Asia Region, based in Singapore, visited the project three times and assisted in the baseline survey, writing the Detailed Implementation Plan (DIP), annual report, and periodic revision of the project progress.

A.I.D.-Sponsored Technical Support: A standardized baseline survey was carried out following an agreement between WVRD and Johns Hopkins University's PVO CSSP office. Mr. Kenneth Sklaw, PVO CSSP staff, trained the project staff in Bangladesh and provided technical assistance to the survey.

Abdul Hye, former Monitoring and Evaluation Coordinator for Dhaka Urban Integrated Child Survival Project (DUICSP), attended an eight-day Regional Child Survival Workshop in March 1992 on "Rapid Knowledge and Practice Surveys for Community Assessment and Action" in Ahmedabad, India. The workshop was organized jointly by Johns Hopkins University PVO/CSSP and CARE India. Abdul Hye served as one of the workshop facilitators.

Local Technical Assistance: Dr. Sri Chander, along with Sylvester Costa and Dr. Iqbal Anwar, DUICSP Project Managers of Areas A and B respectively, and Dr. Kabir Ahmed, Deputy Associate Director, WVB, visited Mr. David L. Piet, Office of Population and Health, USAID, Dhaka, in April 1992 during the preparation of the Detailed Implementation Plan. Mr. Piet gave some valuable suggestions in the preparation of the DIP.

Dr. R. N. Basu, WHO Consultant for EPI in Bangladesh, provided technical back-stopping and facilitated the workshop on "Disease Surveillance," organized by the project, the first of its kind in Bangladesh. He also served as consultant for the "Neonatal Death Survey," the first neonatal death survey in urban areas of Bangladesh. A description of the workshop in Disease Surveillance is found in Appendix D.

The project also received technical assistance on the baseline and Neonatal Death Surveys, and the training for project staff and CVs from the following consultants:

- ▶ Dr. L. R. Talukder, Project Director, MOHFW/EPI
- ▶ Dr. Jehangir, Director, Institute of Public Health Nutrition
- ▶ Md. Nazrul Islam, Chief of Bureau of Health Education, MOHFW
- ▶ Dr. Ashraf, Chief Health Officer, Dhaka City Corporation

Additional technical support came from Mr. Khondker Mahfuzul Haque, part-time local health education consultant from the Bureau of Health Education, MOHFW. He assisted in developing practical health messages and IEC materials for individual and group use. He also help strengthen linkages with the MOHFW. Appendix E details the workshops/conferences availed of by CSP staff.

1.6 Community Participation

There are 87 NHCs to date. All are still active. Their major activities are to:

- ▶ Build awareness of community needs and CSP interventions to address these needs.
- ▶ Encourage the beneficiaries to patronize the project's clinics to build a financial base to support project activities.
- ▶ Arrange community meetings to identify health needs and possible solutions to those needs.
- ▶ Participate in the baseline survey and other sharing sessions/special events arranged by the project.
- ▶ Provide moral support to the CVs and FMGs.
- ▶ Help project staff in the distribution of VAC among target groups.
- ▶ Assist CVs to trace defaulters.
- ▶ Guide/supervise the activities of CVs in their areas.

- ▶ Provide feedback to communities based on the monthly activity reports submitted to them by the CVs.
- ▶ Organize a mass mosquito control program in collaboration with DCC and the project staff.

The committees met at least once a month for the last 12 months to review the progress of the work carried out jointly by the respective NHC and the project. Not a single NHC missed a meeting in the past 90 days. A study to assess the level of commitment of NHCs and CVs was conducted in March. The results are given in Appendix F.

1.7 Linkages to Other Health and Development Activities

The project implements EPI, ORT, and family planning activities in accordance with national policy. Nutrition, ARI, and safe motherhood interventions follow the guidelines established by UNICEF, WHO, and the respective departments of the government of Bangladesh.

The MOHFW/EPI plans to form a cadre of trainers at the national level to promote and sustain EPI services nationwide. World Vision CS project staff has been asked to be one of the leading trainers on the team. Very recently the national EPI headquarters requested World Vision CSP staff to conduct an EPI coverage survey in a selected district called Sylhet. This survey covered management, operational, and administrative areas, the results of which will be used to improve EPI services in Sylhet. It is a big task and a great opportunity for World Vision Bangladesh to be able to partner with the government.

The project also maintains close relationship with other NGOs working in and around the impact areas. It accessed the technical expertise of the Cooperative and Credit Union League, Bangladesh (CCULB) a local NGO in Dhaka to conduct training sessions on cooperatives, leadership, and accounts management for the board members of CVs' cooperatives and project staff's cooperative. CCULB will later assist in the registration of the coops with local government Cooperative Ministry.

The project is exploring other possibilities to tap the technical skill of local entrepreneurs and other NGOs engaged in successful microenterprise ventures.

Aga Khan Foundation and Koinonia, two NGOs working in Dhaka city, extended cooperation to train total 26 TBAS in two batches from impact areas. They are willing to continue further training programs for project health workers.

2. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

2.1 Constraints

A constant constraint to project implementation is population shift—in and out migration. In July 1991, Kamalapur CSP staff did a sample survey on population shift. About 30 percent of target households migrated in and out of the impact area during the last six months, while 13 percent of families migrated in and out during the previous 7-12 months. Hence, a good number of target families missed the services of the project.

Another constraint is a lack of health facilities for maternal health. In Area A (Kamalapur), the staff discovered that there is no health center/clinic in the area where pregnant women can get pre- and post-natal check-ups to ensure safe delivery. In July 1992, the neonatal death survey revealed that 86 percent of delivery is being carried out at the home level. In response to this, the project has started to organize TBA training programs. Plans have been drawn to initiate

and support "Community Consultancy Chamber" in the project area where basic facilities for maternal care will be available. This plan is discussed further in Section #5.1.2.

2.2 Unexpected Benefits

The project in collaboration with relevant government agencies/departments and school authorities introduced the School Health Education Program in 15 schools within the project area. The aim of the program is to disseminate health messages to the students through the teachers. These students form another cadre of health ambassadors who could potentially bring about changes in the behavioral aspect of health in the community. They will join the NHCs and CVs who have become strong exponents in the dissemination of health messages. CS "protective behaviors" hopefully will become a way of thinking and behaving in these communities.

Another unexpected benefit derived from the implementation of the project is the empowerment of CVs (men and women). Trained and functioning CVs through their own initiative and project motivation have formed a cooperative association called "Survival Association for CVs" (SAC) to raise a group fund which will be used to initiate income generation activities. It is the project's hope that this initiative will accelerate and strengthen the financial viability of the community-based health infrastructure.

Communities have taken a large chunk of health activities in their communities, e.g., the mosquito control program, cleaning of water hyacinth from derelict ponds, and the improvement of their environment and sanitation facilities.

2.3 Institutionalization of Lessons Learned

This past year is characterized by a preoccupation of project staff and NHC convenors/members with the issue of sustainability. Project staff and community-based health workers have incorporated sustainability objectives/responsibilities in the execution of their work. The plan is to form a consortium or a central committee which will network and link with different organizations to continue the activities which are being carried out by the project now. It is expected that the consortium will be able to procure vaccines from DCC, Vitamin A from the Civil Surgeon of Dhaka, and continue the implementation of other services such as outdoor treatment or family planning services from the NGO forum.

The consortium will be formed by different community representatives such as community leaders, high officials, schoolteachers, and other influential members of the community and will function as an independent organization. To run this consortium, some financial and technical support will be needed to initiate and maintain it for a considerable period of time.

3. CHANGES IN PROJECT DESIGN

3.1 Perceived Health Needs — No changes have been made since the project submitted its DIP.

3.2 Project Objectives — The objectives remain the same.

3.3 Planned Interventions — No change in the type or scope.

3.4 Change in Potential and Priority Beneficiaries — No changes in this area.

4. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

4.1 Characteristics of the Health Information System

4.1.1 The DUICSP Health Information System (HIS) is well designed to measure progress of project objectives. As stated in the DIP, the system uses population registration with a CDW and 8-12 CVs doing follow-up of a compartment of 900-1,200 families. They collect data on the family to enable them to identify and direct services especially to high-risk children. This system has been very useful. At the clinic level, relevant information about the family and the individual are contained in these records:

Master Vaccination Register. The register keeps information on infants/children and women 15-45 years including pregnant women who are immunized by DUICSP. It also serves as a source on EPI coverage.

Minor Ailment Treatment and Referral Register. This register contains information on minor ailments, and the treatment/advice provided by the Public Health Nurses (PHNs). It also tracks a number of cases such as children who are severely malnourished, dehydrated due to diarrhea and other ailments not manageable at the project level. These cases are then referred to other institutions/hospitals/organizations for proper management/treatment.

CDWs are responsible for maintaining the following records:

Domiciliary Visit Form. This is a pre-coded computerized form filled out once every six months. It contains the data about the target families during the CDWs' routine visits in the community. The form is updated by the CDWs who visit every target household every six months.

VAC Distribution Form. It records the names of the infants and children 12-71 months, the number of prophylactic doses of VAC given, the number of therapeutic doses of VAC given to children who are nightblind, the number of children 7-15 years suffering from nightblindness, and the number of therapeutic doses given. The form is used every six months during the VAC distribution.

Register for Nightblind Children. The register keeps the following information: name, age, stage of xerophthalmia, therapeutic doses of VAC given to the nightblind children 0-71 months.

Family Planning Client Register. Information about eligible couples who are on some form of modern methods of contraception is kept in this register. Sources of contraception are either from the project or from other services.

Information from the above records is used to generate statistics for monthly and quarterly reports using a prescribed format. These and periodic reports on any special events or activities are submitted to the respective supervisors. We are using three indicators—input, process, and output for all project interventions. Only the Vitamin A component makes use of the impact indicator. To improve the staff's skill in data collection, the project arranges appropriate training on HIS supplemented by refresher courses as necessary.

At the community level, CDWs collect data in two ways: (a) on an ongoing basis of the priority target families to periodically update demographic and health status using

Domiciliary Visit Form; (b) through periodic sample surveys such as KAP survey, vaccination coverage, VAC coverage, population shift, etc. These data are entered/verified and compiled by the Monitoring and Evaluation Officer (MEO).

The MEO edits, processes, and analyzes the data and prepares reports for sharing/feedback. He is also responsible for monitoring the operational activities of the field.

- 4.1.2 The system has proven useful for identifying and directing services to the high-risk women or children. From time to time, the CDWs and CVs get refresher training in identification and follow-up of the high-risk women and children. No changes were made in HIS this year.
- 4.1.3 The project reports on the activities carried out at the clinics. These include the number of immunization sessions, the treatment for the minor ailments of children and mothers, and number and reason for referral to a hospital/clinic/ Family Planning center on a monthly, quarterly, and annual basis. Project management finds these activity reports very useful both in terms of operations and logistics supply. The project did not make any refinement in the reporting system as we found it to be working well.
- 4.1.4 The project has developed monthly reporting forms for each staff category to track their monthly accomplishments and as a basis for their plan of action for the next month. At the project level, CDWs submit their monthly activity reports to the Public Health Nurse who compiles the reports of five to ten CDWs. The PHNs then submit the compiled CDWs' monthly reports, narrative and statistical, to the respective Area Coordinators (ACs) who consolidate them. The ACs submit the report to the Project Manager/Operations Coordinator for final compilation.

The Project Manager shares the results and feedbacks with the staff, WVB, WVRD, and other agencies. The project management values these data as they have been useful in decision-making, e.g., allocating resources, tracking project performance by geographic area, identifying areas which require more training or more motivation, etc.

At the community level, CVs submit their monthly reports to their respective NHCs apart from their respective CDWs. The accomplishments are discussed during monthly NHC meetings and provide an opportunity for the NHCs to take follow-up actions.

4.2 Special Capacities of the Health Information System

- 4.2.1 The project has the monthly reporting system to monitor the clinical session held, and compare it against the planned number. It attempts to project the expected number of sessions by case prevalence based on seasonality and previous years' experience. The registers maintained on different clinical sessions serve as an evidence/document of the conduct at the clinical sessions.
- 4.2.2 The project monitors the following sustainability indicators:

Indicator: *CVs Commitment* **Status:** *65 percent CVs active.*

- ▶ Visiting target families, ORT training, nutrition/FP education.
- ▶ Attending regular monthly meeting/special events.
- ▶ Participating in VAC program (six monthly).

- ▶ Organizing immunization outreach sessions.
- ▶ Participating in social mobilization campaign.
- ▶ Assisting CDWs in data collection.
- ▶ Updating neighborhood health information and submitting monthly activity report.

Indicator: *NHCs Commitment* **Status:** *100 percent NHCs active.*

- ▶ Supervising the activities of CVs and discussing them with the community during monthly meetings.
- ▶ NHC Conveyors/Coordinators are receiving monthly report of the CVs.
- ▶ Attending regular monthly meetings.
- ▶ Mobilizing communities for special activities, e.g., observance of World Health Day , EPI Week, Survey, etc.
- ▶ Joining CVs and CDWs in tracking defaulters.
- ▶ Providing space for immunization outreach session and community meetings.
- ▶ Leading and motivating communities to gradually pay or provide labor for health-related activities such as the mosquito control program, latrine construction, drainage, etc.

Indicator: *TBAs Commitment* **Status:** *100 percent TBAs still active.*

- ▶ Attending regular monthly meetings and submitting monthly activity report.
- ▶ Providing VACs to mothers within two weeks after delivery.
- ▶ Providing antenatal and prenatal care to mothers.
- ▶ Motivating women 15-45 years, especially pregnant women for TT vaccination.
- ▶ Motivating mothers for immunization of their infants.

Indicator: *Focus Group Mothers Commitment*

Status: *100 percent focus mothers active.*

- ▶ Attending regular monthly meetings and training programs.
- ▶ Maintaining liaison with local CVs and NHCs.
- ▶ Disseminating updated health messages to target beneficiaries.
- ▶ Following up target mothers/children for immunization.

Indicator: *EPI Directorates' Willingness*

Status: All vaccines, EPI logistical supplies, training materials continue to be provided by the EPI zonal office free of costs on a regular and timely basis.

Indicator: *IPHNs' Willingness*

Status: VAC teaching materials continued to be supplied by IPHN.

Indicator: *DCCs' Willingness*

Status: Participates in/supports all activities and requests made by the project.

4.2.3 In April 1992, the DUICSP, in collaboration with MOHFW/EPI project, organized an EPI Disease Surveillance Workshop, the first of its kind in Bangladesh. The workshop was facilitated by Dr. R. N. Basu, WHO Consultant for EPI, and Dr. Mary Carnell of the Cambridge Consultant Corporation.

In July 1992, the project, in cooperation with MOHFW/EPI project, Dhaka City Corporation, and other local NGOs/PVOs, conducted a Neonatal Mortality Survey (NNMS) covering all target families from all four wards in Areas A and B. All live

births and neonatal deaths over the last 12 months were tracked. Verbal autopsy forms were used by the project physician and PHN to determine the causes of listed neonatal deaths. The survey was conducted under direct technical supervision and back-up support of Dr. R. N. Basu.

From October 1992 the project will begin to correlate the EPI disease incidence/mortality with EPI coverage on an ongoing basis. Preliminary activities have been completed which include: a) preparation of forms; b) establishment of two Active Continuous Surveillance sites (ACSS), one in each impact area; and (c) establishment of five reporting units staffed by PHNs and CDWs based in five existing sub centers (two in area A and three in area B). These units will collect ongoing data from home visits on measles cases/deaths, neonatal tetanus cases/death, and cases of residual polio paralysis without history of trauma.

During home visits, the CDWs will inquire if any household member is sick and verify the nature of illness. EPI standardized case definitions will be used. Reporting units will report cases/deaths by wards/zones and compartments. These will be consolidated by the two project evaluation officers (one in each area) and submitted to their respective project managers, then to the project director, who will submit a joint monthly report directly to the EPI Surveillance Unit of the MOHFW/EPI Project.

4.2.4 The project monitors pre-service, in-service, and continuing education training of community health workers using checklists/evaluation forms.

4.2.5 In some cases, our project staff have found difficulty in collecting data on the following areas:

Weaning Food Practices: CDWs continue to teach/motivate mothers with children under one to introduce weaning foods to their infants at fourth month of age. Some mothers were afraid to acknowledge that they practice it (in the presence of their mothers-in-law) because of fear of being blamed for their infants' ailments which the mothers-in-law will attribute to the early introduction of weaning food.

Contraceptive Usage: Some women with infant/children under two years were either shy or fearful to express actual contraceptive usage. They expressed a number of fears—fear of their husbands, fear of offending religious sensitivities, fear of being blamed in case they have complications arising from the use of birth-spacing methods. Some lactating mothers are afraid to use contraceptive methods at specific times, especially since they are breastfeeding.

ORT: Our CDWs had some difficulty in defining diarrhea, which according to WHO is "four or more loose or watery stools per day." Mothers surveyed gave different definitions—"loose or watery" stools—and thus some degree of interviewer's bias on documenting case definition of diarrhea was inevitable. We have corrected this problem by emphasizing the value of standardizing definitions in data collection. The CDWs also had difficulty in overcoming the shyness of mothers to demonstrate their competence in ORT preparation.

4.3 Management of the Health Information System

4.3.1 About eight percent (8%) of the country annual budget or US\$15,278 has been spent on design, management, and strengthening of the project's HIS. Here is a gross breakdown of the expenditures:

Item	Cost
Salaries and benefits of two monitoring and evaluation officers	US\$3,783
Baseline Survey	US\$5,722
Neonatal Death Survey	US\$1,403
Local Consultants	US\$1,502
Computer supplies	US\$859
Production of health cards	US\$1,408
Data entry	US\$527
Printing of domiciliary visits forms	US\$74
TOTAL	US\$15,278

4.3.2 The project reviewed its indicators during DIP writing in April, 1992. Project management has scaled down its target for CVs and NHCs. We have scheduled another review of the DIP either at the end of September or early October 1992, to set the tone for fiscal year 1993.

4.3.3 The project believes in the exchange of findings as the basis for facilitating community "ownership" of the project. Sensitization activities which began since the inception of the project continues, and public support is maintained through regular information sharing with the project advisory committee people, neighborhood health committee people, community volunteers, etc. The project arranges meetings for sharing/presenting/feedback of the findings of the survey/data. A sharing session is also arranged for the project staff.

The project made similar arrangements for the baseline survey, carried out by the project in November 1991 and the Neonatal Death Survey, carried out in July 1992.

4.3.4 To ensure the quality of data, the Monitoring and Evaluation Officer goes to the field to spot check/cross-check data collected by the health workers with the help of a checklist. Moreover, the supervisors—ACs and PHNs—conduct regular field visits and use supervision checklists which include checking for data collection.

4.3.5 To improve the HIS and the staff's skills in data collection, the project has arranged for the staff to participate in the following training workshops:

Four-day training in October/November 1991 for the DUICSP supervisors (senior staff) and interviewers (CDWs) on "Rapid Knowledge and Practice Survey" facilitated by Kenneth Sklaw of PVO CSSP from Johns Hopkins University.

- ▶ Four-day training/workshop on "EPI Disease Surveillance"—two days for supervisors and two days for CDWs in March 1992. This was organized by DUICSP in conjunction with the EPI Directorate, and facilitated by Dr. R. N. Basu, WHO Advisor, EPI in Bangladesh and Dr. Mary Carnell, CCC Consultant.
- ▶ Seminar/workshop on the Conduct of Verbal Autopsies (design and field testing of questionnaire, interview training, and data analysis) in May 1992 by Dr. Basu attended by two project managers, five ACs, and five PHNs.
- ▶ Five day training for supervisors and CDWs in conducting/supervising the Neonatal Death Survey facilitated by Dr. Basu in June 1992.
- ▶ Training on DBASE programming for the Evaluation and Monitoring Officers from Kamalapur and Mohammadpur DUICSP.

Moreover, the project has planned to arrange the following training/orientation course in FY93:

- ▶ HKI staff will be solicited to provide training to two project managers, operations coordinator of Area B, five ACS, and five PHNs on supervision and quality control of data collection and analysis.
- ▶ Five day training of five PHNs, 38 CDWs and 20 selected CVs and Focus Mothers in the design, implementation, and evaluation of a training module on weaning foods with assistance from SCF.
- ▶ Three-day orientation for three CDWs, ten CVs, and ten Focus Mothers in pilot growth-monitoring promotion, implementation, and monitoring, including the conduct of exit interview.

5. SUSTAINABILITY

5.1 Recurrent Costs

- 5.1.1 Recurrent costs in this project include salaries, travel, office expenses, depreciation cost of equipment, training program, supply costs, and sub heads cost for basic medicine. Costs that could be phased over and costs needed to be continued after USAID grant ends were arrived at under the following assumptions:

Salary: Few technical and program staff might be withdrawn and placed under WV support program.

Interventions: Most of the service delivery in various components could be handed over to other NGOs or local infrastructure of DCC.

Support Costs: Continuation of selected training on leadership, management, community development, and social mobilization are needed and to be supported by the project.

Except supplies of ministry costs (immunization, ORT, nutrition and family planning contraceptives) and selected training programs, other recurrent costs could not be continued after the end of A.I.D. Child Survival grants, as seen in the following table. (NOTE: Exchange rate used is 1 US\$ = 38,9087 Taca.)

Line Items	Actual Expenditure	Costs that Could Be Phased Over	Costs Needed to Be Covered After A.I.D. Grant Ends
Salaries	108,884	21,777 (20%)	87,107 (80%)
Training	7,108	2,132 (30%)	4,976 (70%)
Immunization	726	726 (100%)	NIL (0%)
Nutrition	3,997	1,199 (30%)	2,798 (70%)
ORT	452	452 (100%)	NIL (0%)
Family Planning	2,857	2,286 (80%)	571 (20%)
Basic Medicine	7,246	NIL (0%)	ODA 7,246 (100%)
ARI	47	14 (30%)	33 (70%)
SHH	13	4 (30%)	9 (70%)
Social Mobilization	3,536	1,414 (40%)	2,122 (60%)
Rent & Utilities	15,777	7,888 (50%)	7,889 (50%)
Maintenance	32,147	9,644 (30%)	22,503 (70%)
TOTAL	182,890	47,356	135,254
	100%	26%	74%

5.1.2 The project is exploring the possibility of identifying costs which could be borne by or handed over to GOs/PVOs or to the community itself. At this stage, the project considers that the following costs could be borne by these key players.

Target Community: Bigger communities might be willing to patronize present services such as immunization, checkups, treatment for general ailments, contraceptives, ORT packets, etc., from the static centers of the project and pay a little more. At present, target mothers pay for the treatment of selected minor ailments. The staff is having dialogues with active NHC members who have proposed to provide a room free of cost to start "Community Consultancy Chambers." Medical doctors and nurses who are engaged with GOs/NGOs in the area will be solicited to provide part-time voluntary health care services. It needs more discussion and sharing with the community, Dhaka City Corporation and NGOs.

Government: The Dhaka City Corporation health department responsible for providing primary health care services to the city dwellers is working closely with Urban Immunization Program funded by USAID to establish community health care service centers for EPI in each Ward. The project is exploring the possibility of utilizing existing resources such as Medical Officers, Inspectors and vaccinators of DCC for the immunization program. The Chief Health Officer of DCC, the former Civil Surgeon of Dhaka, has shown interest in extending immunization activity of DCC in collaboration with World Vision of Bangladesh.

Continuing training, leadership, and management in the impact areas are costs unlikely to be continued and must be considered and paid for at least three years beyond the life of the project.

5.2 Strategies for Increasing Post-Project Sustainability:

5.2.1 A number of approaches are being explored to create a sustainable health service delivery system in the project area. One of the potential approaches other than strengthening the existing GO/NGO collaborative structure is the evolution of an integrated development program for trained and potential community volunteers through the following mechanisms:

- a) Creating part-time jobs for trained and interested community volunteers as health motivators under Family Development projects of World Vision Bangladesh in Dhaka City. Five to seven volunteers have already been engaged in these projects.
- b) Organizing a savings and cooperative society for the trained and functioning community volunteers. Last year, more than 100 volunteers have already been practicing savings regularly. In three separate groups (two in Impact Area A and one in B) volunteers raised savings up to \$US800. After obtaining leadership and management training on cooperatives and credit, groups are planning to start community entrepreneurship. They have been advised to proceed very carefully and to seek advice from the NHC members. Hopefully it will provide a very innovative strategy in formulating an integrated program for the community.
- c) Forming Ward Coordination Committees in each Ward—in process. On an ad-hoc basis, a Coordination Committee, supported by existing NHC conveners/coordinators, is being tested in Ward 51 (Impact Area A). These Ward Coordination Committees are envisioned to supervise, supply, pay or motivate volunteers after the project ends.

5.2.2 To minimize recurrent costs, the project has adopted the following policies:

- a) Reducing expensive and excessive costs for hospitality in honor of government or non-government guests/visitors to the project.
- b) Modifying the incentive scheme given to volunteers for active involvement in week-long programs such as VAC distribution.

5.3 Cost Recovery

5.3.1 One of the significant means to recover costs is the fee-for-service scheme. The project charges a minimum fee for treatment and medications for minor ailments from mothers who come at the static centers of the project. Both impact areas collected US\$888 during the last eleven months. These revenues are kept in a bank as local income. The money could be utilized when the Ward Coordination Committee would start functioning sometime in the middle of FY93 for purposes the committee deems necessary.

- 5.3.2 The community gave a positive feedback regarding a hike in fee-for-services. The project staff is now thinking of raising the rate starting second quarter of FY93. Besides this, the project is also considering supporting a "Community Consultancy Chamber" as mentioned in 5.1.2.

Services are being offered to all categories of people in the impact area. As acknowledged by the MTE team of CSPK, Sept. 1990: "Despite the heterogeneous educational and socio-economic background of the population served, services are best accepted by the community." The project continues to practice one of the tenets of sustainable family planning services—"offer the same standard of excellent service to everyone!"

- 5.3.3 Plans are underway to implement an exercise on costing services and price setting. The project managers of the impact areas have taken the initiative to introduce the costing exercise methods among finance and program people of the project.

6. PROJECT EXPENDITURES AND JUSTIFICATION FOR BUDGET CHANGES

6.1 Pipeline Analysis

Project financial statement for fiscal year 1992 covers eleven months (Oct. 91-Aug. 92). Country project Pipeline Analysis reflects the Actual Expenditure to Date (Oct. 91-Aug. 92). The remaining obligated fund for FY92 and agreement figures for actual and estimated expenditures of major line items are derived from the proposal and later adjusted with the DIP. The project pipeline analysis is given on the next page.

PROCUREMENT

Office Equipment: No major office equipment was purchased during the reporting year except a generator for Impact Area A to replace the previous one for cold chain maintenance. We also budgeted for two air conditioners, one in each area training room.

Supplies and Materials: Supplies include office and ministry supplies for immunization, ORT, Nutrition, Family Planning, ARI and Safe Motherhood.

Consultants: It covers the expenditure for local, WV Regional and International consultants' remuneration, fees, honorarium, etc. The project charged the consultancy fees for these activities: Disease Surveillance, Neonatal Death Survey, and visit of WV Regional Health Consultant.

EVALUATION

Expenditures for Baseline Survey for both impact areas and final evaluation survey for Impact Area are covered under this item. Trainer from PVO CS Support Program, Johns Hopkins University, USA helped the project to complete Baseline Survey.

PERSONNEL

All staff are national regular contract staff. Their salary and benefit package is in compliance with the WV Field Office personnel policy manual.

TRAVEL/PER DIEM

This includes local travel for project staff and international travel for staff participation in training/conferences overseas.

OTHER DIRECT COST

Expenditures for training/workshop/seminar for staff and community people, school health education program, utilities, and repair maintenance were met under this item.

6.2 Justification of Budget Changes

There have been no major changes in the line items of the budget shown in the project proposal. The DIP budget breakdown reflects the latest status of the funding allocation assured by the donors for various line items.

7. WORK SCHEDULE AND BUDGET

(See following pages.)

7.1 Plan of Action for FY92-93

MANAGEMENT/ADMINISTRATION:

SL #	ACTIVITIES	INITIATOR(S)	FACILITATOR(S)	1ST QUARTER			2ND QUARTER			3RD QUARTER			4TH QUARTER		
				OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEP.
1.	Observe World Vision Day	Training Coords.	Project Managers Project Director	X											
2.	Review and renew job contracts of project staff	Project Managers	Project Director F&A Officers	X											
3.	PVO Sharing Workshops on "Lessons Learned on Child Survival"	Project Managers	Project Director				X			X				X	
4.	Observe Christmas Day	Training Coords.	Project Managers Project Director			X									
5.	Develop Plan of Action and budget for next year	Project Managers Project Director	F&A Officers							X					
6.	Organize Midterm Evaluation	Project Managers	Reg. H/Advisors Project Director											X	

MONITORING & EVALUATION:

1.	Continue to evaluate and fine-tune all training programs	Training and Area Coords.	M&E Officers Operations Coord. Project Managers	X	X	X	X	X	X	X	X	X	X	X	X
2.	Analyze and prepare updated report on Domiciliary Visits	M&E Officers Operations Coord.	Project Managers	X	X					X	X				
3.	Assess commitment/active involvement of NHCs/CVs	M&E Officers Area Coords.	Operations Coord. Project Managers					X							

TRAINING:

1.	Arrange orientation/workshop/gathering for the Conveners/Coordinators/ Members of NHC	Training Coords.	Project Managers Project Director		X			X	X		X		X	X	X
2.	Arrange training/orientation for Focus Group Mothers	Training Coords.	Area Coords. Project Managers	X			X				X				
3.	Arrange training on common disease/treatment for staff/selected CVs	Training Coords.	Project Managers		X			X		X					
4.	Train new CVs	Training Coords.	Project Managers				X			X		X	X		

SL #	ACTIVITIES	INITIATOR(S)	FACILITATOR(S)	1ST QUARTER			2ND QUARTER			3RD QUARTER			4TH QUARTER		
				OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEP.
5.	Arrange orientation on ARI/SM for trained Focus Group Mothers and NHC	Training Coords.	Area Coords. Project Managers		X			X	X		X		X	X	X
6.	Organize training for TBAs	Training Coords.	Project Managers				X			X					
7.	Training NHCs/WCCs on Leadership and Management	Training Coords.	Project Managers					X		X			X		
8.	Conduct costing exercise workshop for project staff	Training Coords.	Project Managers Project Director							X					
9.	Arrange exposure trip/learning events for project staff	Training Coords.	Project Managers Project Director		X			X							
10.	Arrange foreign exposure/workshop for project staff	Project Managers	Project Director Exec. Director				X						X		
11.	Organize refresher courses for NHCs/CVs	Training Coords.	Project Managers				X		X		X				
12.	Organize "TOT" for project staff/CVs and school teachers	Training Coords.	Project Managers				X			X		X			
13.	Organize skills development training for CVs	Training Coords.	Project Managers						X			X			
14.	Arrange exposure trip for NHCs/CVs	Training Coords.	Project Managers Project Director			X		X							

INTERVENTIONS:

1.	Continue project interventions	Area Coords.	Project Managers	X	X	X	X	X	X	X	X	X	X	X	X
2.	Administer VAC for the mothers who delivered within last two weeks	Area Coords.	Project Managers	X	X	X	X	X	X	X	X	X	X	X	X
3.	Administer high potency VACs with the help of CVs/NHCs	Area Coords.	Project Managers		X						X				

COMMUNITY PARTICIPATION:

1.	Keep contact with GOs/NGOs	Project Managers	Project Director In-cont/Consultant	X	X	X	X	X	X	X	X	X	X	X	X
2.	Continue Social Mobilization/Communications for all interventions	Area Coords. Operations Coord.	Project Managers In-cont/Consultant	X	X	X	X	X	X	X	X	X	X	X	X
3.	Observe National Immunization Week	Area Coords. Training Coords.	Project Managers In-cont/Consultant	X										X	X
4.	Continue to publish Quarterly CSP Newsletter	Area Coords. Project Managers	Project Director In-cont/Consultant	X			X			X			X		

SL #	ACTIVITIES	INITIATOR(S)	FACILITATOR(S)	1ST QUARTER			2ND QUARTER			3RD QUARTER			4TH QUARTER		
				OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEP.
5.	Continue and follow-up NHCs/CVs/Focus Group Mothers monthly/quarterly/ special meetings	Area Coords. Operations Coord.	Project Managers	X	X	X	X	X	X	X	X	X	X	X	X
6.	Continue School Health Education Program	Area Coords.	Project Managers In-cont/Consultant	X	X	X	X	X	X	X	X	X	X	X	X
7.	Initiate income-generation activities for CVs	Area Coords.	Project Managers					X	X	X	X	X	X	X	X
8.	Continue NGO coordination meeting/gathering	Project Managers	Project Director	X		X		X		X		X		X	
9.	Organize annual gathering for CVs and NHCs	Area Coords. Training Coords.	Project Managers Project Director					X							X
10.	Form Central Neighborhood Health Committee (Consortium)	Project Managers	Area Coords. Project Director		X				X			X			
11.	Observe World Health Day (April 7, 1993)	Area Coords. Training Coords.	Project Managers Project Director							X					

7.2 FY93/FY94 Budget

COST ELEMENTS	A.I.D.	WVRD	TOTAL
I. PROCUREMENT			
A. Supplies	13,962	36,688	50,650
B. Equipment	-0-	4,097	4,097
C. Services/Consultants	21,337	(1,428)	19,909
SUB-TOTAL I	35,299	39,357	74,656
II. EVALUATION SUB-TOTAL II	20,777	5,331	26,108
III. INDIRECT COSTS			
Overhead on Field %	75,200	181,653	256,853
SUB-TOTAL III	75,200	181,653	256,853
IV. OTHER PROGRAM COSTS			
A. Personnel	240,690	72,681	313,371
B. Travel/Per diem	28,068	7,579	35,647
C. Other Direct Costs	51,164	46,705	97,869
SUB-TOTAL IV	319,922	126,965	446,887
TOTAL	451,198	353,306	804,504

**NEONATAL DEATH SURVEY REPORT
IN WARD NOS. 12, 13, 14 & 51
OF DHAKA CITY CORPORATION**

JULY 1992



DUICSP

DHAKA URBAN INTEGRATED CHILD SURVIVAL PROJECT

WORLD VISION OF BANGLADESH

ACKNOWLEDGEMENT

The Dhaka Urban Integrated Child Survival Project (DUICSP) is an endeavor of World Vision Relief and Development (WVRD) working in partnership with the Ministry of Health & Family Welfare and Dhaka City Corporation through World Vision Bangladesh.

The Neonatal Death Survey carried-out by DUICSP is the result of joint efforts of several individuals. It is a great pleasure to recall the enormous contributions made by Dr. R.N. Basu, WHO Consultant for EPI in Bangladesh who is popularly known as an unmatched personality with an ocean load of patience and understanding. His expertise, interest, encouragement and help were the sources of energy for us to do it effectively & flawlessly within a short stipulated time. Without his active involvement this survey would not have seen the light of the day.

As always, James Hilton, Executive Director, WVB, Dr. Sri Chander, Regional PHC/CS Advisor, Asia Region, WVI and Dr. Kabir Ahmed, Deputy Associate Director, WVB have been the sources of inspiration and enthusiasm which we gratefully acknowledge.

I would like to take the cognition of the excellent leadership provided by Dr. Iqbal Anwar and Sylvester Costa, the Project Managers of two Impact Areas of DUICSP in carrying-out this survey.

Also, I gratefully acknowledge the commendable works done by Md. M.R. Chowdhury & Louis Rozario of Monitoring & Evaluation Units of the Impact Areas of both the project both in the field & in the office to conduct this survey.

A list of the people without whom it would not have been possible to conduct the survey smoothly and successfully is given in Appendix - 4. We gratefully acknowledge their contributions.

My sincere appreciation and thanks to the Community Volunteers who during the survey did their jobs admirably well.

Finally, it is to the respondents of the survey who spared their time and shared their information with us. We are grateful to them.

This survey is a diagnosis, no treatment. If we have been able to sensitize the concerned people to the need of appropriate treatment we will consider that our efforts have not gone in vain.

August 16, 1992

Simon P. Munshi
Project Director, DUICSP &
Associate Director
World Vision of Bangladesh.

PREFACE

The goals to be attained by the year 2000, adopted by the World Summit for children held in 1990, relate to protection of girls and women, education, nutrition and child health. The targets for survival of children include a) one third reduction in under - five deaths by 2000, b) eradication of poliomyelitis by 2000, c) elimination of neonatal tetanus by 1995 and d) 90% reduction of measles incidence by 1995.

Government of Bangladesh is a signatory to the above declaration and has incorporated these objectives in their Five-year Plan activities.

The under 5 mortality rate in Bangladesh in 1990 was 180 per thousand live births. The annual rate of its reduction during last ten years was 1.6% . To achieve the target by the end of decade, it is required to reduce this rate by 9.4% every year during 1990-2000. The infant mortality rate was estimated as 114 per thousand live births in 1990. This shows that more than 63% of childhood deaths occurred before first birth day. Majority of the infant deaths in Bangladesh take place during neonatal period (within first 28 days of birth) and various surveys have estimated that neonatal mortality rate was about half of infant deaths. A survey to estimate the incidence of neonatal tetanus conducted in 1986 by EPI project, in collaboration with WHO, revealed that, Tetanus was the single major cause of neonatal death. The above data draws attention to the fact that, elimination of neonatal tetanus, will play an important role in reduction of infant and thereby under 5 mortality.

During 1983-90, the percentage of births attended by trained health personnel in the country as whole, was 5% . The ratio is higher in the urban area, especially in metropolitan cities. Bangladesh EPI, has taken up a programme of immunization of all women of child bearing age (15-44), with emphasis on pregnant women. The national vaccination coverage survey in 1992, has shown that 78% of women (mother of 0-11 months child) had received two doses of tetanus toxoid. Close to 100% protection, will be required to eliminate the disease. The increased vaccination coverage has commenced to produce impact in the reduction of incidence of neonatal tetanus. The surveys conducted by National Institute of Preventive and Social Medicine and Global 2000 in 1990, estimated neonatal tetanus mortality rate in various divisions between 16 and 10 per thousand live births, as against 41 in 1986 national survey. The present challenge is to begin monitoring not just immunization level but the decline of the disease.

Surveillance has to be strengthened to detect each case occurring in the community. This information collected along with immunization services, will help in identification of high risk areas and chalk out specific plan for control. The routine disease reporting system in the country is very much deficient and non-existent in the cities. There are many limitations of the data collected from few Infectious Disease Hospitals, which admit tetanus cases. People do not report neonatal morbidity, especially tetanus, to a health facility. Considering this situation, active surveillance has to be depended on, at this point of time. The health workers during their routine visits can ask about neonatal deaths occurring since last visit. The reported deaths have to be investigated, taking retrospective history of sickness (verbal autopsy) to ascertain the probable cause. This has to be followed by appropriate action.

World Vision, Bangladesh, through Dhaka Urban Integrated Child Survival Project provides selected child health services in four wards out of 75 in Dhaka City Corporation. The specialty of their programme is that the project monitors the usefulness and significance of various activities undertaken. They have collected valuable data on health and socio-economic conditions during initiation of the project through sample base line surveys. They have conducted periodic vaccination coverage surveys using WHO recommended technique. The first half of 1992 may be considered as the period of application of innovative measures for Dhaka Urban Integrated Child Survival Project. In March, all the staff of the project were provided orientation in surveillance. In June-July, they completed a neonatal mortality survey - a follow up of the training. The report of this survey is presented here.

It is hoped that, this report will be useful to those who are interested in child survival programme and disease surveillance. It is proposed to discuss the report with government officials (MCH, EPI, HIU, PHC etc.), other NGOs and international organizations (WHO, UNICEF, USAID, World Bank). These joint discussions will bring out the lessons learnt and suitability of using this procedure in health programme in other areas. All components of the task, planning, training, interviewing, supervision, report writing etc. have been done by various categories of staff of DUICSP, like Community Health Workers, Area Coordinators, Public Health Nurses, Monitoring & Evaluation Officers, Medical Officers. Special mention has to be made of the Community Volunteers, who spared one week's time in collecting data from the field.

July 1992

**Dr. R.N.Basu
WHO Advisor
EPI in Bangladesh**

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1. INTRODUCTION :

Dhaka Urban Integrated Child Survival Project (DUICSP) has been in operation in ward 12, 13, 14 (i.e. Impact Area B, Mohammadpur) & 51 (i.e. Impact Area A, Kamalapur) of Dhaka City Corporation with the revised objectives for the extended period of 3 years since October, 1991. The population of the project area is about 197,000. Approximately 35% of the population live in the slums situated in the project area. The project since its inception has been implementing immunization, as one of the most important and integral component of project's Child Survival (CS) package program. Within the last few years, the project has been able to increase its immunization coverage among priority age group from 15% (Baseline) to 85% (Annual Survey 1991). The immunization of women with two doses of TT has been found to be 85% during the year 1992. During the extended period (Second Phase), the project would go ahead to comply with the National EPI efforts of elimination of neonatal tetanus by 1995 and eradication of poliomyelitis by 2000.

The disease reduction targets can be achieved through adaptation of the twin support of high immunization coverage plus disease surveillance. Disease Surveillance means, i) to look for the case of the mentioned diseases ii) to report the case(s) iii) to analyze history of the case(s) iv) to respond to the cases for appropriate action (Containment activities) and v) to provide feedback.

Considering these, project will initiate disease surveillance from the 2nd half of FY-92 specially on poliomyelitis and neonatal tetanus. To perform this task the project operations staff and some of the members of Community (CVs/NHCs) have received necessary training/orientation on the subject.

It is needless to say that the project since its inception has aimed to reduce infant mortality rate by implementing the major child health activities. In this regard, the project has been using necessary monitoring tools to have the picture of deaths of the children under five on an ongoing basis.

In the existing reporting system, the CHWs collect the information on births & deaths during the period since last visit (generally at the interval of six months). In case of information on deaths the Public Health Nurses (PHNs) collect data by using verbal autopsy form to ascertain the cause. In addition to that the CVs collect the information on births/deaths from his/her assigned area or population on a monthly basis. But the project never carried-out any special study by which the deaths of group like infants, neonates or even child could be found-out. The reason for not doing this is obvious. The project by its all out efforts wanted to implement the CS interventions first, with the hope that they will obviously put positive impacts in reducing the death of the said age groups. Time has now matured to assess the impact of the program on the death rates of the neonates/infants.

To the best of our knowledge none in Bangladesh has carried-out any study to find out the death of neonates in the past in the urban area. EPI project in collaboration with WHO and National Institute of Preventive and Social Medicine in collaboration with global 2000, have conducted surveys to estimate the incidence of neonatal tetanus in the rural area, in 1986 and 1990 respectively.

2. OBJECTIVES :

In Dhaka City Corporation (DCC) there is no system of reporting disease incidence to assess the magnitude of the problem or evaluate the program. The purpose of the survey was to identify the extent of neonatal deaths in the community.

- a. To find-out the neonatal death rate & its causes among all live births in the four months age group.
- b. To estimate the incidence of neonatal tetanus in the areas & measure the impact of the TT immunization program.
- c. To compare the findings with national & project statistics.
- d. To use the findings in modifying the project's strategy in reducing the infant mortality rate.
- e. To disseminate the findings to other partners (Govt./Nongovt. agencies) for the improvement of the child survival program.

3. METHODOLOGY :

The Survey was conducted by using the methodology of complete enumeration of all the families residing in the project areas. This allowed to overcome the problem of sampling as the total area was covered. CHWs & CVs were engaged in data collection. Senior officers of the project supervised field level data collection. Groups were formed for data collection (two members for each group). Through visiting each & every household, the interviewers found-out how many live births were there in the prescribed period and among them how many died. Any reported cause of neonatal death was investigated through using a Verbal Autopsy Form by PHN/Project Physician. The survey was conducted from June 27 - July 2, 1992.

- Study Universe : Wards 12,13,14 & 51 of Dhaka City Corporation.
- Survey Procedures : Each & every household of the project areas were covered by the interviewers.
- Population Size : Total estimated population was about 197,000 (36,000 households), according to Project.

The period of recall used was four months, from 1 February to 31, May, 1992. A four-month recall period increased the accuracy of the data collected. Well known festivals were identified in a local Bangla calendar, so that vital events could be precisely placed in time.

4. IMPLEMENTATION :

The steps of implementation of survey consisted of designing of form, training of interviewers, ensuring supervision, arranging cross checking and analysis of data.

4.1 SURVEY INSTRUMENTS :

The information was collected through a pre-coded questionnaire. The questionnaire was finalized after getting valuable inputs from an internationally reputed person like Dr. R. N. Basu, WHO Advisor for EPI in Bangladesh, who was involved in many important and special events of the project (Project proposal writing, DIP writing and Disease Surveillance workshop) & also from Dr. Sri Chander, WVI South Asia Regional Health Director.

The interviewers used one/two form in each day to collect information on live births during designated period, child alive or dead, if dead date of death and TT immunization of the mothers. Cause of death was later investigated by PHN/Physician by using verbal autopsy form.

4.2 FIELD TEST/FEEDBACK SESSION :

A day-long orientation was arranged for selected number of workers for field testing of the survey instruments. After completion of the field test a feedback session was arranged on June 22, 1992.

4.3 ORIENTATION OF THE INTERVIEWERS/INVESTIGATORS :

A half-day-long orientation for all the interviewers/ investigators was arranged on the day preceding the survey in three batches. These briefing sessions were attended by WHO Advisor. In these sessions, the following tasks were undertaken :

- Discussion on importance of the survey.
- Information to be collected during the interview.
- Explanation of the forms to be used.

4.4 SUPERVISION :

The area to be visited, was handed over to the interviewers in the morning daily. The interviewers submitted the filled up forms to the supervisors in the afternoon who checked it. Any form with mistakes was returned to the interviewers for necessary correction. A list of neonatal deaths detected was prepared daily and handed over to PHN/Medical Officer for investigation. The investigator visited the particular household and enquired from the mother of the dead child, the clinical manifestations during the sickness. He also noted other particulars like the place of delivery, attendant at delivery, use of tetanus toxoid etc. The supervisor also visited certain number of households to confirm the findings of the interviewers.

4.5 CROSS CHECKING :

To see the consistency of the data collected during the survey cross checking was in-built with the program. In addition to supervisor's visits, comparison with secondary data were made to identify missing of information.

4.6 DATA ANALYSIS :

The survey data was edited and then banked into the computer for analysis. Analytical work was done by using the package SAS (Statistical Analytical Software).

5. SURVEY FINDINGS :

With a view to collect information of live births (who were born from February 1 to May 31, 1992) and their deaths, interviewers visited each and every household in the Project area during the survey period.

5.1 DEMOGRAPHY :

A total of 1693 live births and 64 deaths among those live births were found through visiting a total of 44,531 households. Among the total deaths, 36 deaths were neonatal which is about 56.2% of the total reported deaths.

On the basis of number of households surveyed the population of the project is estimated about 2,26,279. The estimated crude birth rate per 1000 population is 22 and neonatal death rate per 1000 live births is 21.

5.2 TT IMMUNIZATION :

In terms of immunization status of the mothers with live births 71.7% were found to be immunized with two or more doses of TT. But only 47.5% of total mothers had immunization card.

Among the mothers with neonatal death 69.4% were found to be immunized with TT2 or above and 38.9% were with cards.

5.3 NEONATAL DEATH (Age & Cause) :

It should be mentioned here that 36 neonatal deaths were reported by the interviewers. But during the death investigation carried-out by PHNs/Physician by using Death Investigation (Verbal Autopsy) Forms, 4 of the 36 cases could not be found-out because of their absence (left the project area).

Out of the 32 neonatal deaths, 53.1.% died within the first 3 days of their birth & 15.6% died within 4-7 days, 12.5% died within 8-14 days & same % died within 15-21 days of their birth . The rest 6.3% died within 22-28 days of their birth.

Out of 32 neonatal deaths investigated, 6.2% child died due to Diarrhoea, 9.4% due to Neonatal Tetanus, 6.2% due to ARI, 18.8% due to Birth Asphyxia, 12.5% due to Prematurity, 6.2% due to Congenital Disease, 3.1% due to Difficult Labor and the rest 37.6% died due to Birth Trauma, Dyspnoea, & Neonatal Jaundice etc..

3 of the deaths in Ward 51 took place due to neonatal tetanus. Out of 2 mothers of 3 neonatal deaths (one mother had twin babies) one mother was fully immunized with TT.

5.4 PLACE OF DELIVERY/SOURCE OF TREATMENT :

During the illnesses of the child before death , only 15.6% received treatment from the Hospitals/Health Centres. Another 15.6% of the child were treated by the MBBS Doctor and 9.4 % were under the treatment of Local Healer. A significant numbers of children were died without any treatment which is about 59.4% of the total neonatal deaths.

53.1% mothers were delivered at home by the TBAs, 25% mothers were delivered by the relative/Neighbor at home & 18.8% of mothers were conducted in the Hospitals/Health centres/Clinics. One of the interesting finding of the study was that a mother was delivered in a Motor Launch by a relative.

6. DISCUSSION :

The estimated crude birth rate has been found to be lower in Ward 13 (17 per thousand population) as against 23 to 24 per thousand population in other Wards. The neonatal death rate has been found to be very low (5 per thousand live births) in Ward 12, low in Ward 13 and 14, and high in Ward 51 (38 per thousand live births). The Ward No.12, 13 and 14 are located in Mohammadpur area and Ward 51 belongs to Kamalapur. No neonatal death due to tetanus has been detected in

Mohammadpur area, where as 3 neonatal tetanus deaths have been recorded in Kamalapur. The difference in neonatal mortality rate in these two areas can be explained by two factors.

- a. Low socio-economic status in Kamalapur area - according to base line survey, literacy rate in Kamalapur is 46% as compared to 61% in Mohammadpur and 47% of population in Kamalapur belong to low economic group as against 37% in Mohammadpur area. In Mohammadpur area, the biggest government children hospital of the city is situated. There are other seven health centre/clinics run by NGO or private sector in the area. In Kamalapur there is no government health care service delivery centre.
- b. Child Survival Project has started functioning, in Kamalapur area, about two years later than Mohammadpur Project. Time for demonstration of impact of services on disease incidence is yet to be reached in Kamalapur.

Retention of TT immunization card was found to be low especially in Ward 13. To implement five doses of TT schedule for women to attain life long protection, card retention is necessary for follow up. The zero death from neonatal tetanus in Ward 12, 13, 14 and less than 10% of neonatal deaths due to tetanus in Ward 51, tells about the effect of high TT immunization coverage of women in the area.

53.1% of child died within first days of life and 68.7% of within first week of birth. Proper antenatal care will prevent many of these early neonatal deaths. 78.1% of the deliveries were conducted at home. There is need for training of probable birth attendants on clean delivery practices.

7. CROSS-CHECKING :

Independent visit of the supervisors to the household, project data on domiciliary visit and immunization session, secondary data from local hospitals and traditional birth attendants were examined to ensure that no live birth during the period under review is missed. These are mentioned here and in table-6, as these may be used as source of surveillance data in the area.

7.1 SUPERVISOR'S REVISITS :

Revisits of 2097 (4.7%) families of the total (44,531) families were made by the Supervisors. The data of 71 live births were collected by the supervisors. Out of 71 live births 68 (95.8%) confirmed the findings of the survey. The information of 3 (4.2%) live births were added later as they were excluded or missed because of the absence of the families during survey.

7.2 HOSPITAL/MATERNITY CLINIC :

7.2.1 AZIMPUR MATERNITY CLINIC : Information/data of the 49 mothers with live birth (resident of the project area) were collected from Azimpur Maternity Clinic. Out of those 49 live births 27 were found to be included in the data collected during the survey. Addresses of the 17 mothers with live birth could not be traced as the addresses given in the maternity clinic were incomplete. The information of rest 5 mothers could not be found as they have migrated out of the area.

7.2.2 AL-FALAH MODEL CLINIC : Information of 38 live birth were collected from Al-Falah Model Clinic. Out of these 38 live births 21 were found to be included in the survey data. But the rest 17 cases could not be traced because of incomplete addresses given at the clinic register during delivery.

7.3 DOMICILIARY VISIT FORM :

As per the information of the domiciliary visit forms of CHWs of the Project 547 live births took place between February 1 and May 31, 1992. Out of these 547 live births 441 (80.6%) were found to be included in the survey data. The families with the rest 106 live birth data were found to be migrated out or absent for a longer period.

7.4 IMMUNIZATION REGISTER :

Information on 598 live births were collected from immunization registers. Out of those 598 live births 465 (77.8) were found to be included in the survey data. The rest 133 live births could not be found for the following reasons :

- a. Some times mothers come from outside the project areas just to get the vaccines.
- b. The addresses given by the mothers during immunization are not always complete or perfect.

7.5 TRADITIONAL BIRTH ATTENDANTS (TBAs) :

Information of 33 live births were also collected from 18 TBAs. Out of 33 live births 27 (81.8%) were found to be included in the data collected during the survey. During the field level cross-checking carried-out by the PHN on these information, it was revealed that 6 of the reported live births could not be traced because of out-migration or absence from the project area for a long period.

TABLE - 1

FINDINGS OF NEONATAL DEATH SURVEY
(Valid : Child born from February 1 to May 31, 1992)

Variables	Ward 12 No. & (%)	Ward 13 No. & (%)	Ward 14 No. & (%)	Ward 51 No. & (%)	Project No. & (%)
Households visited	10,910	8,017	7,483	18,121	44,531
Live births	422	226	288	757	1,693
Deaths	9	4	5	46	64
Neonatal Deaths	2	3	3	28	36
Mother's immunization status with TT2 or above					
A) Mother's with Live birth					
With Card	233 (55.2)	61 (27.0)	142 (49.3)	368 (48.6)	804 (47.5)
Without Card	60 (14.2)	110 (48.7)	72 (25.0)	167 (22.1)	409 (24.2)
With + Without Card	293 (69.4)	171 (75.7)	214 (74.3)	535 (70.7)	1,213 (71.7)
B) Mother's with Neonatal deaths					
With Card	0	0	1 (33.3)	13 (46.4)	14 (38.9)
Without Card	2 (100)	0	2 (66.7)	7 (25.0)	11 (36.5)
With + Without Card	2 (100)	0	3 (100)	20 (71.4)	25 (69.4)
Crude Birth Rate (per 1000 population) approx.	23	17	23	24	22
Neonatal Death Rate (per 1000 live births) approx.	5	13	14	38	21

N.B. : Total Population in the Project area = 2,26,279.

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TABLE - 2

FINDINGS OF NEONATAL DEATH INVESTIGATION
(Valid : Child born from February 1 to May 31, 1992)

Variables		Ward 12 No.&(%)	Ward 13 No.&(%)	Ward 14 No.&(%)	Ward 51 No.&(%)	Project No.&(%)
Age at death	0-3 days	1 (50.0)	1 (33.3)	2 (66.7)	13 (54.1)	17 (53.1)
	4-7 days	0	0	0	5 (20.8)	5 (15.6)
	8-14 days	0	0	0	4 (16.7)	4 (12.5)
	15-21 days	1 (50.0)	1 (33.3)	1 (33.3)	1 (4.2)	4 (12.5)
	22-28 days	0	1 (33.4)	0	1 (4.2)	2 (6.3)
	Total	2 (100)	3 (100)	3 (100)	24 (100)	32 (100)
Place of delivery at	Home by TBA	0	0	0	17 (70.8)	17 (53.1)
	Home by Relative/Neighbour	0	2 (66.7)	3 (100)	3 (12.5)	8 (25.0)
	Hospital/Health Centre/Clinic	2 (100)	1 (33.3)	0	3 (12.5)	6 (18.8)
	Others (Motor Launch by Relative)	0	0	0	1 (4.2)	1 (3.1)
	Total	2 (100)	3 (100)	3 (100)	24 (100)	32 (100)
Sources of Treatment during illness	Hospital/Health Centre	1 (50.0)	1 (33.3)	0	3 (12.5)	5 (15.6)
	MBBS Doctor	1 (50.0)	0	0	4 (16.7)	5 (15.6)
	Local Healer	0	0	0	3 (12.5)	3 (9.4)
	No Treatment	0	2 (66.7)	3 (100)	14 (58.3)	19 (59.4)
	Total	2 (100)	3 (100)	3 (100)	24 (100)	32 (100)

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TABLE - 3

FINDINGS OF CAUSES OF NEONATAL DEATH
 (Valid : Child born from February 1 to May 31, 1992)

Variables		Ward 12 No.&(%)	Ward 13 No.&(%)	Ward 14 No.&(%)	Ward 51 No.&(%)	Project No.&(%)
Causes of death	Diarrhoea	0	0	0	2 (8.3)	2 (6.2)
	Neonatal Tetanus	0	0	0	3 (12.5)	3 (9.4)
	Acute Respiratory Infection (ARI)	0	0	1 (33.3)	1 (4.2)	2 (6.2)
	Birth Asphyxia	0	0	1 (33.3)	5 (20.8)	6 (18.8)
	Prematurity	1 (50.0)	1 (33.3)	0	2 (8.3)	4 (12.5)
	Congenital Disease	0	0	0	2 (8.3)	2 (6.2)
	Difficult Labour	0	0	1 (33.4)	0	1 (3.1)
	Other	1 (50.0)	2 (66.7)	0	9 (37.6)	12 (37.6)
	Total	2 (100)	3 (100)	3 (100)	24 (100)	32 (100)

Sources of Information : Neonatal Death Investigation (Verbal Autopsy) Forms.

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TABLE - 4 (a)

DISTRIBUTION OF RISK/PRE-DISPOSING FACTORS OF NEONATAL DEATH

Delivered at	Children were protected against Tetanus as the mother had appropriate no. of doses of TT at appropriate time			Total No. & (%)
	Yes With Card No. & (%)	Yes Without Card No. & (%)	No No. & (%)	
Home by TBA	10 (76.9)	3 (30.0)	4 (44.5)	17 (53.1)
Home by Relative/Neighbour	2 (15.4)	3 (30.0)	3 (33.3)	8 (25.0)
Hospital/Health Centre/Clinic	1 (7.7)	4 (40.0)	1 (11.1)	6 (18.8)
Others (Motor Launch by Relative)	0	0	1 (11.1)	1 (3.1)
Total	13 (100)	10 (100)	***9 (100)	32 (100)

TABLE - 4 (b)

DISTRIBUTION OF RISK/PRE-DISPOSING FACTORS OF NEONATAL DEATH

Sources of treatment during illness of Child	Children were protected against Tetanus as the mother had appropriate no. of doses of TT at appropriate time			Total No. & (%)
	Yes With Card No. & (%)	Yes Without Card No. & (%)	No No. & (%)	
Health Centre/ Hospital	1 (7.7)	3 (30.0)	1 (11.1)	5 (15.6)
MBBS Doctor	3 (23.1)	1 (10.0)	1 (11.1)	5 (15.6)
Local Healer	2 (15.4)	0	1 (11.1)	3 (9.4)
No treatment	7 (53.8)	6 (60.0)	6 (66.7)	19 (59.4)
Total	13 (100)	10 (100)	***9 (100)	32 (100)

*** 2 out of 9 mothers had 2 doses of TT but the neonates were not protected against Tetanus as the mothers did not take those as per the EPI protocol.

Sources of Information : Neonatal Death Investigation (Verbal Autopsy) Forms.

TABLE - 4 (c)

DISTRIBUTION OF RISK/PRE-DISPOSING FACTORS OF NEONATAL DEATH

Delivered at	Sources of treatment during illness of child				Total No. & (%)
	Health Centre/ Hospital No. & (%)	MBBS Doctor No. & (%)	Local Healer No. & (%)	No Treatment No. & (%)	
Home by TBA	0	2 (40.0)	3 (100)	12 (63.1)	17 (53.1)
Home by Relative/Neighbour	2 (40.0)	1 (20.0)	0	5 (26.3)	8 (25.0)
Hospital/Health Centre/Clinic	3 (60.0)	2 (40.0)	0	1 (5.3)	6 (18.8)
Others (Motor Launch by Relative)	0	0	0	1 (5.3)	1 (3.1)
Total	5 (100)	5 (100)	3 (100)	19 (100)	32 (100)

TABLE - 5

DISTRIBUTION OF MAXIMUM RISK/PRE-DISPOSING FACTORS OF NEONATES (OUT OF 9) WHOSE MOTHERS WERE NOT IMMUNIZED WITH APPROPRIATE DOSE OF TT

Delivered at	Sources of treatment during illness of child				Total No. & (%)
	Health Centre/ Hospital No. & (%)	MBBS Doctor No. & (%)	Local Healer No. & (%)	No Treatment No. & (%)	
Home by TBA	0	0	1 (100)	2 (33.3)	3 (33.3)
Home by Relative/Neighbour	1 (100)	1 (100)	0	3 (50.0)	5 (55.6)
Hospital/Health Centre/Clinic	0	0	0	0	0
Others (Motor Launch by Relative)	0	0	0	1 (16.7)	1 (11.1)
Total	1 (100)	1 (100)	1 (100)	6 (100)	***9 (100)

*** 2 out of 9 mothers had 2 doses of TT but the neonates were not protected against Tetanus as the mothers did not take those as per the EPI protocol.

Sources of Information : Neonatal Death Investigation (Verbal Autopsy) Forms.

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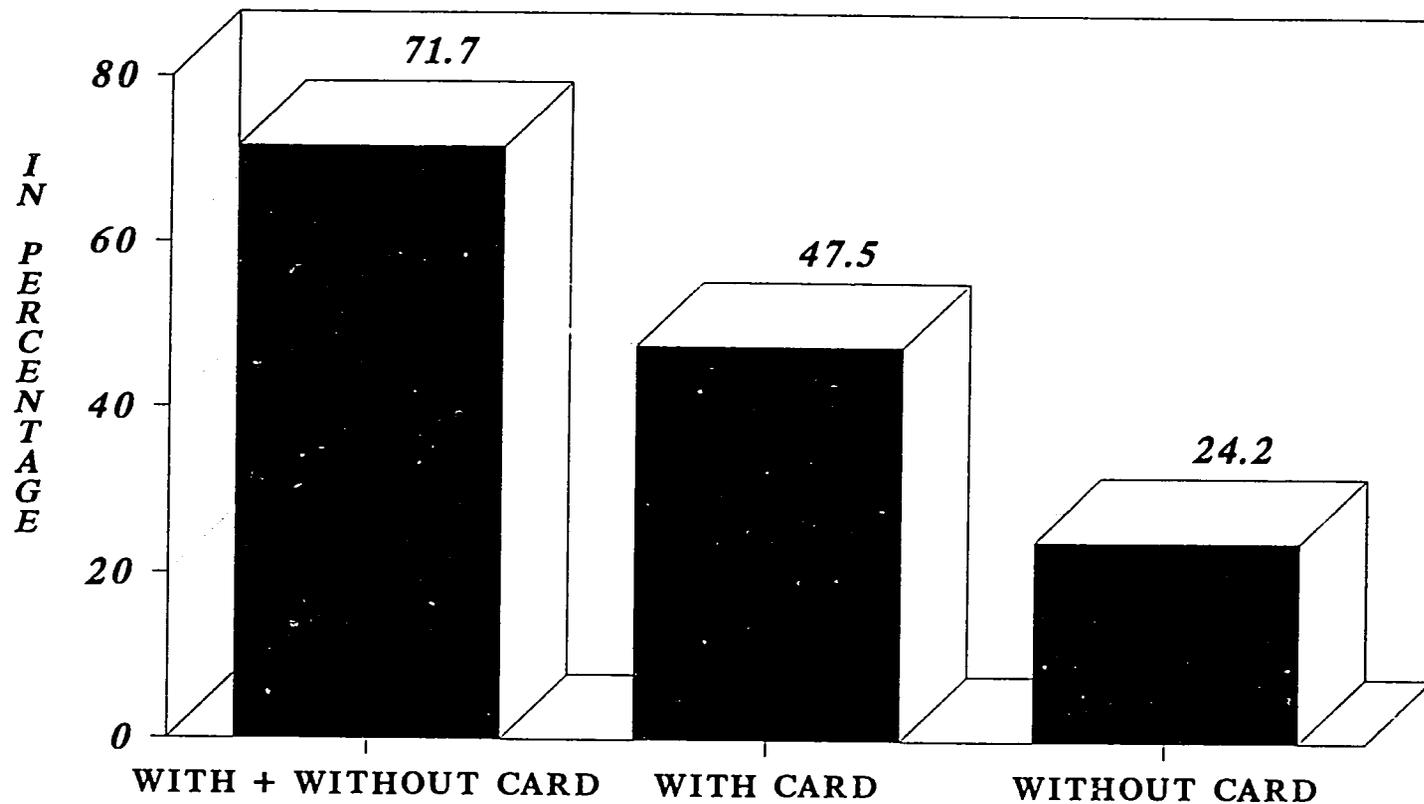
TABLE - 6

CROSS CHECKING OF SURVEY DATA WITH DIFFERENT SOURCES
OF INFORMATION/DATA COLLECTED BY/FROM THE PROJECT

Sources		Ward 12 No.&(%)	Ward 13 No.&(%)	Ward 14 No.&(%)	Ward 51 No.&(%)	Project No.&(%)
Revisits of families (4.7%, 2,097) by the Supervisors	Birth found by the Supervisors	20 (100)	6 (100)	8 (100)	37 (100)	71 (100)
	Compared with the Survey	20 (100)	6 (100)	8 (100)	34 (91.9)	68 (95.8)
	Not compared (because family was absent during the Survey period)	0	0	0	3 (8.1)	3 (4.2)
Hospital (H)/ Maternity Clinic (MC)	Birth found in H/MC	24 (100)	15 (100)	48 (100)	No H/MC facility in & around the Ward	87 (100)
	Compared with the Survey	14 (58.3)	9 (60.0)	25 (52.1)		48 (55.2)
	Not compared (because family absent for long period/left the Project Area).	10 (41.7)	6 (40.0)	23 (47.9)		39 (44.8)
Domiciliary Visit (DV) by CIW	Birth found in DV	149 (100)	48 (100)	77 (100)	273 (100)	547 (100)
	Compared with the Survey	119 (79.9)	41 (85.4)	62 (80.5)	219 (80.2)	441 (80.6)
	Not compared (because family absent for long period/left the Project Area).	30 (20.1)	7 (14.6)	15 (19.5)	54 (19.8)	106 (19.4)
Immunization Registered (IR)	Birth found in IR	121 (100)	50 (100)	118 (100)	309 (100)	598 (100)
	Compared with the Survey	103 (85.1)	43 (86.0)	103 (87.3)	216 (69.9)	465 (77.8)
	Not compared (because family absent for long period/left the Project Area).	18 (14.9)	7 (14.0)	15 (12.7)	93 (30.1)	133 (22.2)
Traditional Birth Attendant (TBA)	Birth found by TBA	10 (100)	0	1 (100)	22 (100)	33 (100)
	Compared with the Survey	10 (100)	0	1 (100)	16 (72.7)	27 (81.8)
	Not compared (because family absent for long period/left the Project Area).	0	0	0	6 (27.3)	6 (18.2)

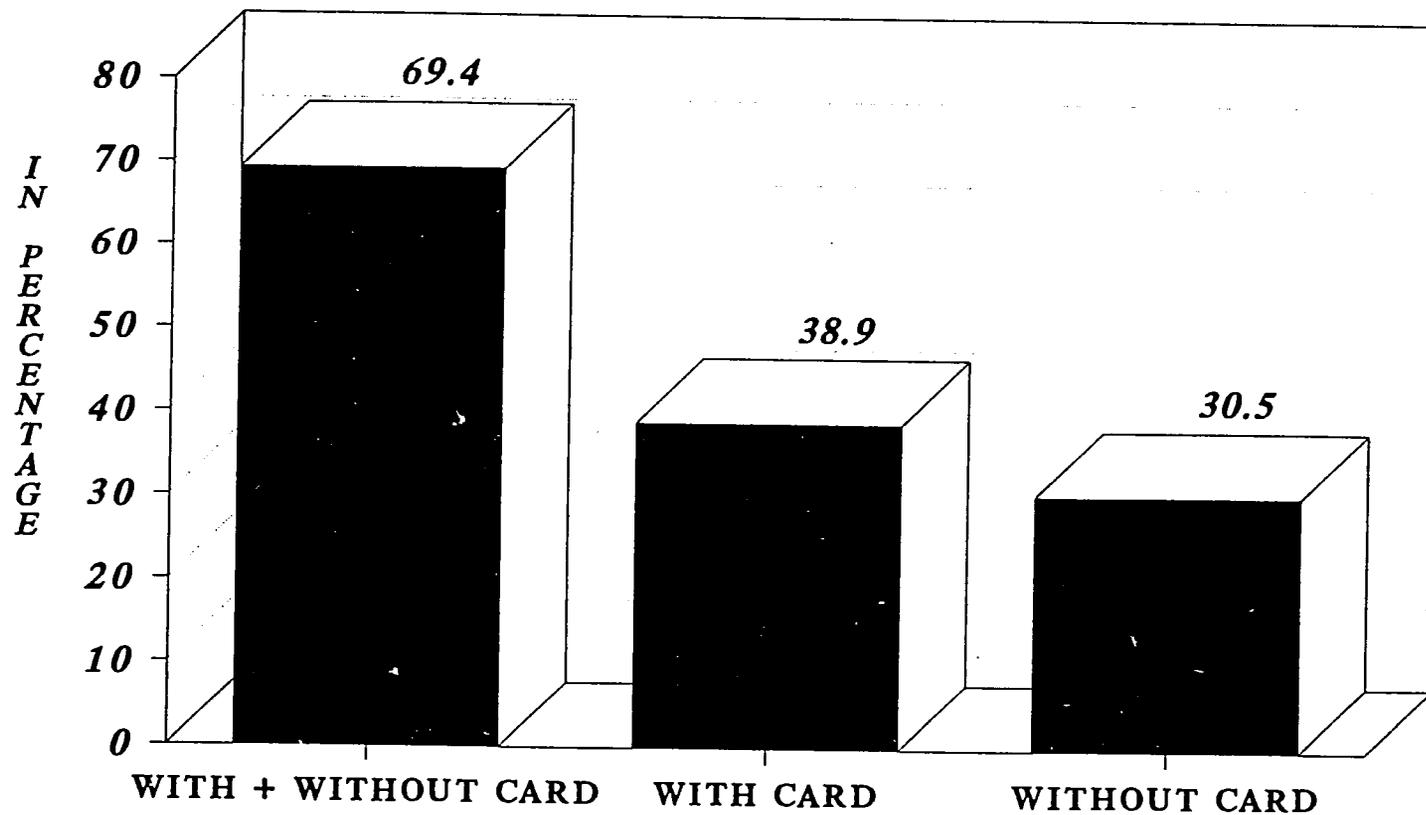
HP

**MOTHER'S WITH LIVE BIRTH
IMMUNIZED WITH TT2/TT2+
CHILD BORN BETWEEN FEB. 1 TO MAY 31,'92**



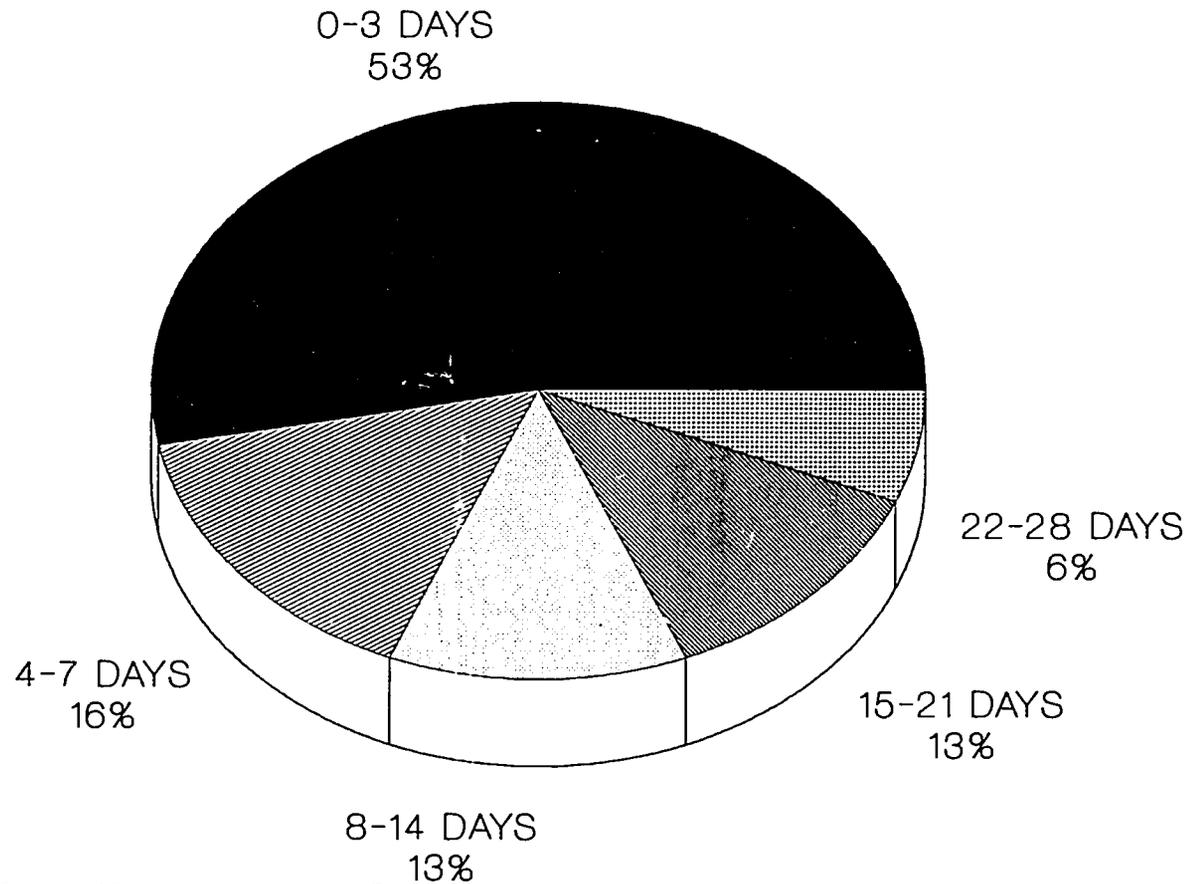
Sources of Information : Neonatal Death
Survey Questionnaires.

**MOTHER'S WITH NEONATAL DEATHS
IMMUNIZED WITH TT2/TT2+
CHILD BORN BETWEEN FEB. 1 TO MAY 31,'92**



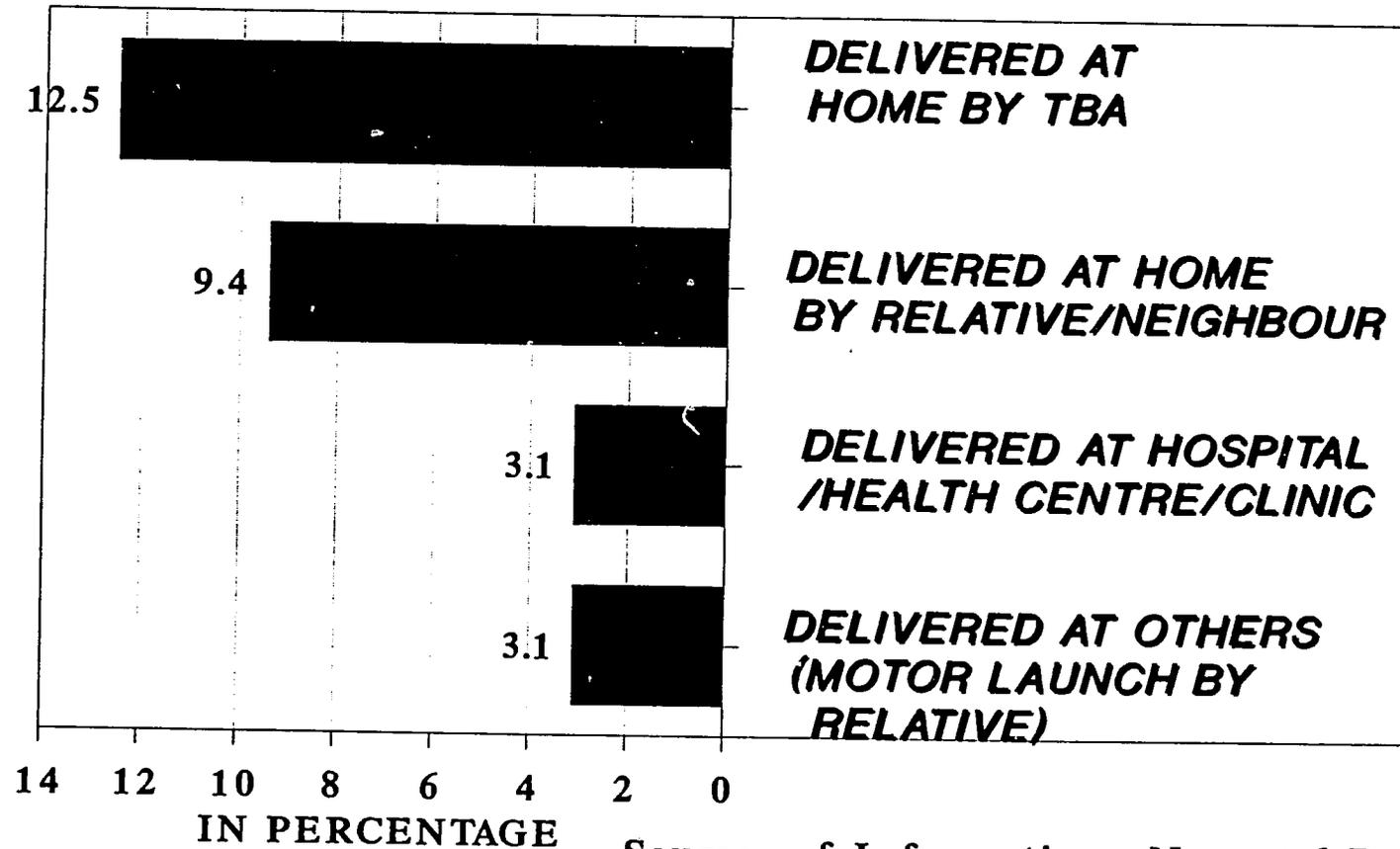
Sources of Information : Neonatal Death
Survey Questionnaires.

**CHILD AGE AT DEATH (NEONATAL)
CHILD BORN BETWEEN FEB. 1 TO MAY 31,'92
DUICSP**



**Sources of Information : Neonatal Death
Investigation (Verbal Autopsy) Forms.**

**NEONATES AT RISK (9 OUT OF 32 DEATHS)
WHOSE MOTHERS WERE NOT FULLY IMMUNIZED
WITH TT VACCINES**



Sources of Information : Neonatal Death Investigation (Verbal Autopsy) Forms.

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NEONATAL DEATH SURVEY QUESTIONNAIRE
 Valid : (Child born February 1 to May 31, 1992 in the Family)
 DHAKA URBAN INTEGRATED CHILD SURVIVAL PROJECT, 1992

(HOUSEHOLD VISIT TO LIST LIVE-BIRTHS AND THEIR OUTCOME ALIVE OR DEAD)

Impact Area (A/B) : []
 Ward/Zone [(12/13/14/1 (=Northern)/2(=Southern))] : []
 Comp # (1 22) : []
 Group No. : []

1. No. of households visited (Circle each star for each household)

* * * * * * * * * * * * * * * * * * * * * * * * * Total : _____
 * * * * * * * * * * * * * * * * * * * * * * * * *
 * * * * * * * * * * * * * * * * * * * * * * * * *
 * * * * * * * * * * * * * * * * * * * * * * * * *
 * * * * * * * * * * * * * * * * * * * * * * * * *

2. No. of live births (Circle each star for each live birth) :

* * * * * * * * * * * * * * * * * * * * * * * * * Total : _____

3. Record of live birth

Sl. No.	Name of infant	Name of household head	Address	Date of Birth	Is he or she alive	If dead, Date of Death	TT vaccination status of mother	
							Card seen or not	No. of doses
1				/0 — 92				
2				/0 — 92				
3				/0 — 92				
4				/0 — 92				
5				/0 — 92				

** Supervisor's remark including no. of Neonatal Death _____

Name of Interviewer : _____ Date _____
Name of Supervisor : _____

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**DEATH INVESTIGATION (VERBAL AUTOPSY) FORM
DHAKA URBAN INTEGRATED CHILD SURVIVAL PROJECT, 1992**

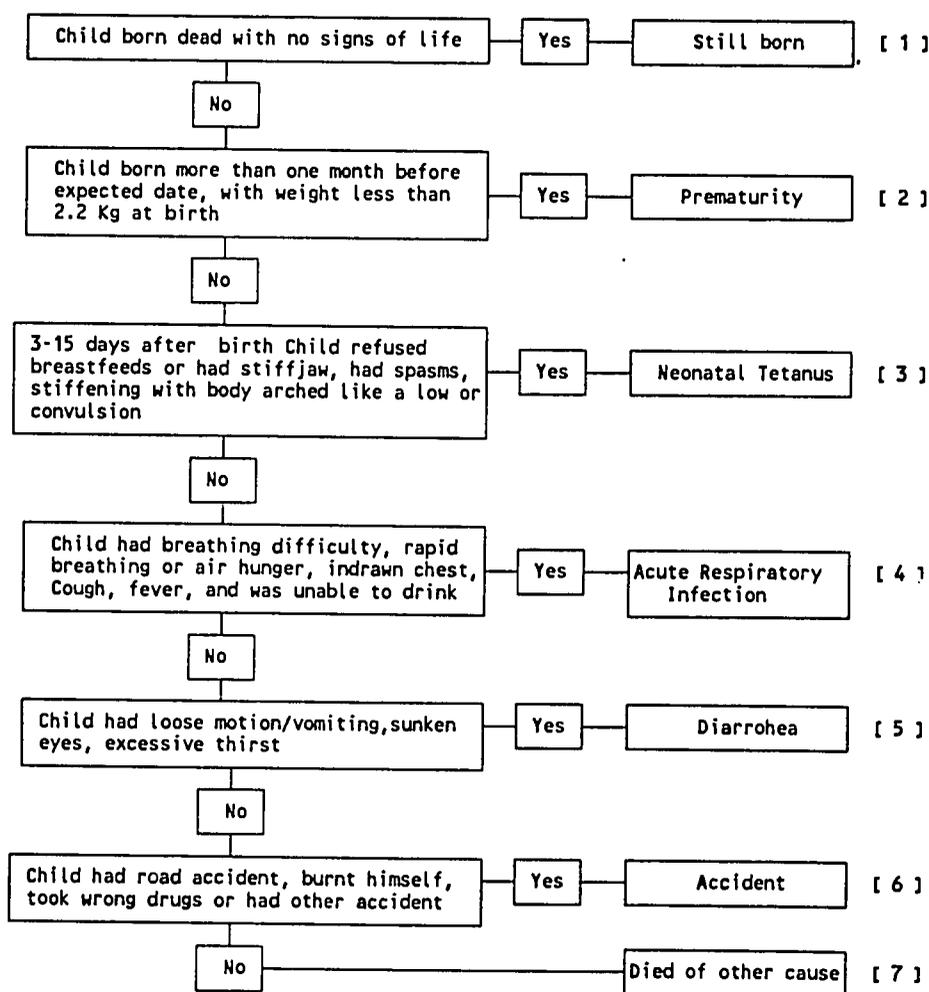
Name of Investigator : _____	Date : __/__/92
Reported date by CHW/CV(s) : __/__/92	Group No. : _____
Comp.# (1....22) : ____	Ward/Zone (12/13/14/01(=Northern/02(=Southern)) : ____
Impact Area (A/B) : ____	
Name of head of the household : _____	
Address : _____	

Name of the Child died : _____ Sex : Male [] Female []

Date of death __/__/92

Date of birth __/__/92

Cause of death (as reported by the family) _____



1/6

INFANTS CARE SINCE BIRTH (TICK APPROPRIATE BOX) :

1. Child delivered at
- a) Home with the help of TBA [1]
 - b) Home with the help of relatives/Neighbour [2]
 - c) Home with the private nurse/HW [3]
 - d) Hospital/Clinic/Health centre [4]
3. With what type of equipment the cord was cut? _____
4. How was the stump dressed? _____
5. When the child became ill, who treated the child?
- a) Health Centre [1]
 - b) Registered Physician [2]
 - c) Local Healer [3]
 - d) No Treatment [4]

MOTHER'S IMMUNIZATION HISTORY (TICK APPROPRIATE BOX)

1) Was mother immunized against tetanus?

- a) Yes [1]
- b) No [2]

2) Was the immunization card seen?

- a) Yes [1]
- b) No [2]

3) No. of doses

TT1	__ / __ / __
TT2	__ / __ / __
TT3	__ / __ / __
TT4	__ / __ / __
TT5	__ / __ / __
N/A	00/00/00

CALENDER FOR IDENTIFICATION OF DATE

1 FEBRUARY - 31 MAY, 1992/ ১৮ই মাঘ ১৮ সাল - ১৭ ই জ্যৈষ্ঠ ১১ সাল

MONTH	SAT	SUN	MON	TUE	WED	THUS	FRI
FEBRUARY মাঘ - ফালগুন	1 ১৮	2 ১৯	3 ২০	4 ২১	5 ২২	6 ২৩	7 ২৪
	8 ২৫	9 ২৬	10 ২৭	11 ২৮	12 ২৯	13 ৩০	14 ফালগুন ১
	15	16	17	18	19	20	21
	২	৩	৪	৫	৬	৭	৮
	22	23	24	25	26	27	28
	৯	১০	১১	১২	১৩	১৪	১৫
	29 ১৬						
MONTH	SAT	SUN	MON	TUE	WED	THUS	FRI
MARCH ফালগুন - চৈত্র		1 ১৭	2 ১৮	3 ১৯	4 ২০	5 ২১	6 ২২
	7 ২৩	8 ২৪	9 ২৫	10 ২৬	11 ২৭	12 ২৮	13 ২৯
	14 ৩০	15 ১	16 ২	17 ৩	18 ৪	19 ৫	20 ৬
	২১	২২	২৩	২৪	২৫	২৬	২৭
	২৮	২৯	৩০	৩১			
	১৭	১৮	১৯	২০	২১	২২	২৩
	28 ১৪	29 ১৫	30 ১৬	31 ১৭			
MONTH	SAT	SUN	MON	TUE	WED	THUS	FRI
APRIL চৈত্র - বৈশাখ					1 ১৮	2 ১৯	3 ২০
	4 ২১	5 ২২	6 ২৩	7 ২৪	8 ২৫	9 ২৬	10 ২৭
	11 ২৮	12 ২৯	13 ৩০	14 ১	15 ২	16 ৩	17 ৪
	১৮	১৯	২০	২১	২২	২৩	২৪
	২৫	২৬	২৭	২৮	২৯	৩০	৩১
	১১	১২	১৩	১৪	১৫	১৬	১৭
	২৪ ১০	২৫ ১১	২৬ ১২	২৭ ১৩	২৮ ১৪	২৯ ১৫	৩০ ১৬
MONTH	SAT	SUN	MON	TUE	WED	THUS	FRI
MAY বৈশাখ - জ্যৈষ্ঠ							1 ১৮
	2 ১৯	3 ২০	4 ২১	5 ২২	6 ২৩	7 ২৪	8 ২৫
	9 ২৬	10 ২৭	11 ২৮	12 ২৯	13 ৩০	14 ৩১	15 জ্যৈষ্ঠ ১
	১৬	১৭	১৮	১৯	২০	২১	২২
	২	৩	৪	৫	৬	৭	৮
	23	24	25	26	27	28	29
	৯	১০	১১	১২	১৩	১৪	১৫
30 ২৬	31 ২৭						

২১শে ফেব্রুয়ারী
(৮ই ফালগুন) - শহীদ দিবস

৭ই মার্চ
(২৩শে ফালগুন) - ১লা শ্রমদিবস
২৬শে মার্চ
(১২ই চৈত্র) - স্বাধীনতা ও
জাতীয় দিবস।

৩রা এপ্রিল
(২০শে চৈত্র) - ছায়াপুতন - দিবস
৫ই এপ্রিল
(২২শে চৈত্র) - বৈশাখ-১৩০০
১৪ই এপ্রিল
(১লা বৈশাখ) - নব্বাথ

১লা মে
(১৮ই বৈশাখ) - মে দিবস
১৬ই মে
(২৩রা জ্যৈষ্ঠ) - ব্রহ্ম গুণিমা

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APPENDIX - 1

SOURCES OF CROSS-CHECKING

1. Azimpur Maternity Clinic :

It is only maternity centre in the city being run by the government exclusively for deliveries and maternal care. It is about 5 Km from the project office.

2. Al-Falah Model Clinic :

It is a clinic being run by one NGO (Al-Falah of Bangladesh) within the project area to provide clinic based health care services exclusively for the standred Pakistanis.

3. TBAs :

They are women who usually after getting either some formal or informal training conduct delivery of the low income group of people of the community. As one of the important and integral part of the Safe Motherhood component of the project, periodic contact is made with them.

4. Supervisors' Cross-Check :

The key people of the project's Operations including the Monitoring & Evaluation department played the role of the supervision. 13 supervisors were involved during the survey.

5. Domiciliary Visit Form :

It is one of the most important monitoring tools of the project which are used to up-date the demographic information the priority target population of the project area in every six months on-going basis. 21 CHWs in Mohammadpur and 12 CHWs in Kamalapur area are engaged in routine visit to collect data on birth and death.

6. Immunization Register :

This is the register keeping all the necessary information/ particulars of the infants immunized at the project level, including data of birth.

APPENDIX - 2

FEEDBACK FROM SUPERVISORS AND INTERVIEWERS

IMPORTANT POINTS DETECTED DURING SUPERVISION :

The following problems were faced when the supervisors revisited.

1. Before starting the survey, publicity or importance of the survey should be disseminated among the community people.
2. The rate of out migration/absent families is high.
3. Method of survey looks very easy but the collection of information on birth and death is very difficult.
4. This type of survey needs time as each household has to be enquired. But we do it within a very short time.
5. We can achieve our goal " To reduce child mortality" through this type of survey. The total picture births and their survival can be followed up.

Problem faced by Interviewers :

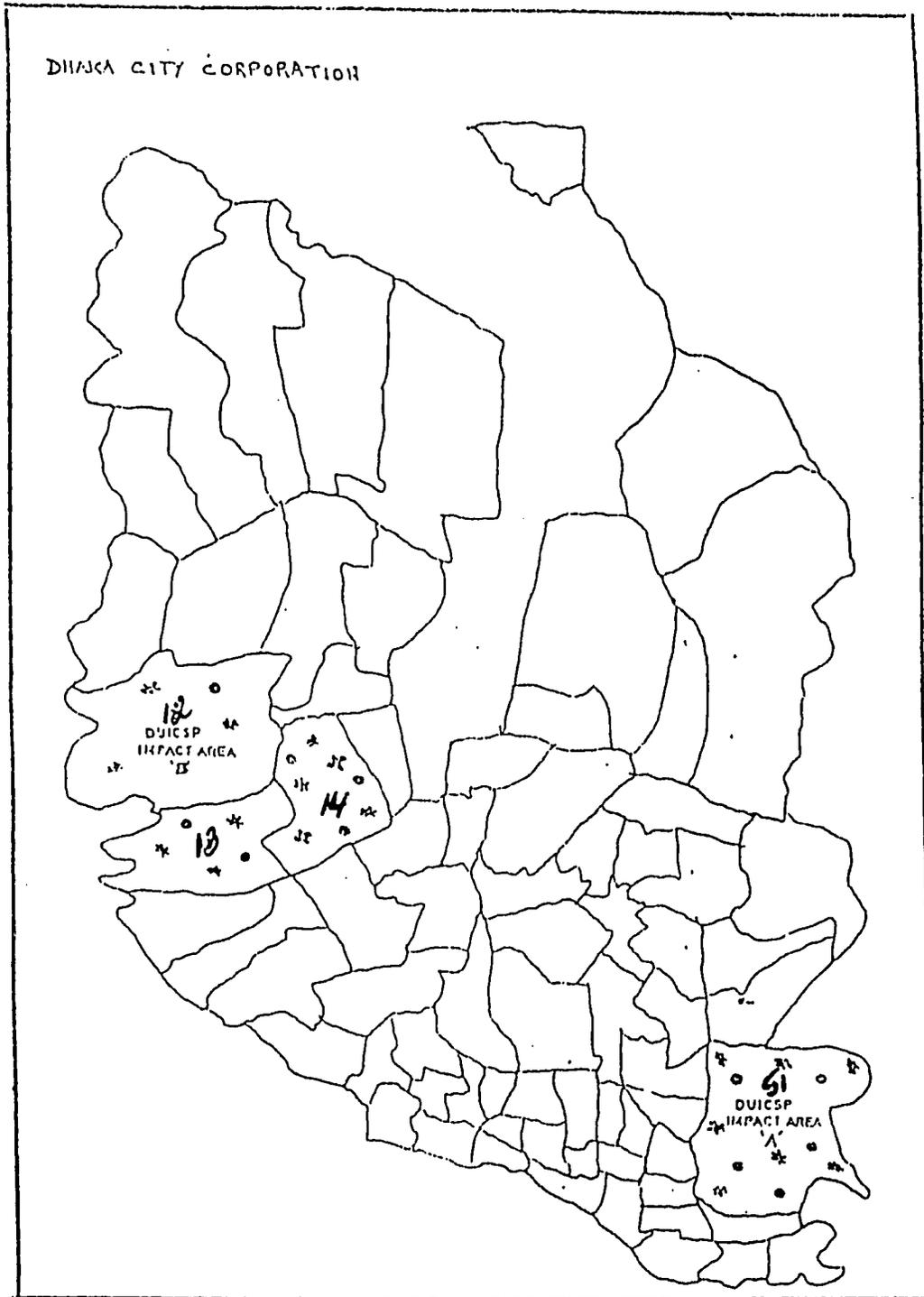
The following problems were faced by interviewers :

1. Lack of community awareness specially of the middle & high class family on the health program.
2. Out migration/Absent family
3. This type of survey needs only one person for each compartment, to collect the information. More than one compartment was allocated.
4. Time should be more flexible. Some families could be contacted in the afternoon.
5. Too much hard job, as it required knocking every door and introduction.
6. Method is very simple, needs less time for filling-up of the forms.
7. Collection of data is not appreciated by the community.

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Appendix - 3

Map of Dhaka City Corporation showing the Wards surveyed



- ⌘ Hospital — Gov't / Non Gov't (Indoor + OPD)
- ☆ Health Clinic — Private (Indoor + OPD)
- Health Post — PVOs / NGOs (OPD)

Appendix - 4

LIST OF THE CONTRIBUTORS

SURVEY DESIGN

- | | |
|------------------------|--|
| 1. Dr. R. N. Basu | WHO Advisor, EPI in Bangladesh |
| 2. Dr. Sri Chander | Asia Regional PHC/CS Adviser, WVI, Singapore |
| 3. Dr. Kabir U. Ahmed | Deputy Associate Director, WVB |
| 4. Dr. Iqbal Anwar | Project Manager, Impact Area B |
| 5. Sylvester S. Costa | Project Manager, Impact Area A |
| 6. Dr. A.T.M. Faruq | Operations Coordinator, Impact Area A |
| 7. Md. M. R. Chowdhury | Monitoring & Evaluation Officer, Impact Area A |
| 8. Louis Rozario | Monitoring & Evaluation Officer, Impact Area B |

DATA CONSISTENCY CHECK/FIELD LEVEL SUPERVISION

- | | |
|--------------------------|------------------------------------|
| 1. Dr. A.T.M. Faruq | |
| 2. Md. M. R. Chowdhury | |
| 3. Louis Rozario | |
| 4. M.R. Howlader | Area Coordinator, Impact Area A |
| 5. Samina Rashid | Area Coordinator, Impact Area A |
| 6. Syed Aleya Nayeem | Area Coordinator, Impact Area B |
| 7. Monowara Sultana | Area Coordinator, Impact Area B |
| 8. Monju Maria Palma | Area Coordinator, Impact Area B |
| 9. Mary Margaret Rozario | Public Health Nurse, Impact Area B |
| 10. Nilu Rani Halder | Public Health Nurse, Impact Area B |
| 11. Muksuda Begum | Public Health Nurse, Impact Area B |
| 12. Bani Roy | Public Health Nurse, Impact Area A |
| 13. Piale Boidya | Public Health Nurse, Impact Area A |

DATA COLLECTION

Community Health Workers (CHWs) :

IMPACT AREA A

Mansura Akter	Gloria M.
Sabita Gomes	Poly D' Costa
Rabi A. Palma	Abdur Rob
Nazmun Nahar	Shamsun Nahar
Ahsan Munir	Suchitra R.
Jakia Khanam	Aktarun Nahar

IMPACT AREA B

Samir Gomes
Delwara
Rokeya
Ismail
Jhunu
Jesmin
Mary Majee
Jannat
Nomita
Sheema
Fredousi Mohal

Cicilia
Arifur Rahman
Mahbub
Bedana
Shokina
Barnadett Adhikary
Moin Chowdhury
Jogodish Karmakar
Rownak Ara
Smreeti Howlader

&

97 Community Volunteers from both the Impact Areas of DUICSP
(Impact Area A = 43 & Impact Area B = 54)

DATA ANALYSIS

1. Md. M. R. Chowdhury
2. Louis Rozario

REPORT WRITING

1. Dr. R. N. Basu
2. Dr. Iqbal Anwar
3. Md. M. R. Chowdhury
4. Louis Rozario

**DHAKA URBAN INTEGRATED CHILD SURVIVAL PROJECT (DUICSP)
NUTRITIONAL DEFICIENCY NIGHTBLINDNESS PREVENTION PROGRAM
THE EIGHTH ROUND OF VITAMIN A CAPSULE (VAC) DISTRIBUTION**

Introduction

The eighth round of Vitamin A Capsule (VAC) distribution was conducted from May 10-21, 1992. Children 1-6 years old numbering 13,802 were given VACs in accordance with the national policy.

A routine half-day orientation session was held in the south and north zones on May 7 and 10, 1992, respectively. The orientation has proven to be effective prior to each round of VAC distribution. It serves as a good time to review and to renew acquaintances with CVs, and it keeps CVs motivated in the absence of remuneration.

World Vision Bangladesh provided 20,000 VACs while the Civil Surgeon's Office in Dhaka gave 5,000 VACs and 400 forms to record information regarding the VAC distribution and findings, i.e., cases of nightblindness, diarrhea, measles, etc.

VAC Distribution and Identification of Cases of Nightblindness

CVs distributed VACs among the target children according to this work schedule:

Zone	No. of CVs	No. of CV Groups (1 Group: 3 CVs)	Duration (Date)
South	38	07	May 10-20, 1992
North	31	06	May 11-21, 1992
Project	69	13	May 10-21, 1992

After the CVs administered VACs to the children, they recorded information in the government—supplied formats. CVs also disseminated messages by showing flash cards regarding prevention of nightblindness. CHWs supervised the CVs to ensure full and appropriate VAC coverage. CHWs also helped CVs to detect nightblindness cases correctly. All 69 CVs worked in groups on a rotation basis to diminish the workload. This technique was adopted by the Area Coordinators.

Results

1. Nightblindness

Since 1988, DUICSP has already distributed VACs semiannually in the project area. Messages are continuously communicated to the community regarding consumption of low cost, indigenous Vitamin A-containing food. Still, we find few cases with nightblindness at each round. In this eighth round, the rate of nightblindness was 0.18 percent. All are new cases. These cases did not reside in the project area

during the previous round—six months ago. It is safe to assume that there are no nightblindness cases among the target children who have been residing in the project area for more than six months. It also implies that for behavioral change in dietary habits to occur, prolonged education and sustained education is necessary.

2. Coverage

Zone	Total Target Families	VAC Target Families	Children 12-71 Months						Therapeutic Dose for 7-15 Yrs. Children		Absent Cases		Total VAC Distribution	Families with Kitchen Gardens
			Total Children	Pro-phylactic Dose	Therapeutic Dose			Extra Doses	New	Old	Family	Children		
					New	Old	Total							
North	7,584	4,035	5,638 (98.93%)	5,628	09	NIL	09	39	11	01	57	61	5,730	1,892 (24.95%)
South	8,697	5,671	8,165 (98.2%)	8,149 (98%)	16	NIL	16	21	22	02	206	150	8,335	1,726 (19.85%)
Total	16,201	9,700	13,802 (98.49%)	13,777 (98.31%)	25 (0.18%)	NIL	25	60	33	03	263	211	14,000	3,610 (22.22%)

The rate of nightblindness was 0.18 percent. These cases were given therapeutic doses of Vitamin A. High VAC coverage among target children continues to be maintained.

NOTE:

Extra doses were given for children with diarrhea and measles; new children are those who came to reside in the project area between the seventh and eighth round.

3. Kitchen Gardens

Some Vitamin A-rich plants can be grown very easily at the household level. Plants such as pui and Kachu, a kind of spinach, are very common in Bangladesh. We are encouraging families to grow these plants which require very small land space and less care. These kinds of gardens also serve as demonstration points for the community.

We found that 22.22 percent of all registered families have kitchen gardens containing Vitamin A-rich plants. Many families do not have any/sufficient land to grow gardens.

JOB DESCRIPTION PROFILE
DHAKA URBAN INTEGRATED CHILD SURVIVAL PROJECT, DUICSP
AREA B (MOHAMMADPUR)

JOB TITLE: DUICSP Area Coordinator

JOB PURPOSE: To organize, lead and control the operations and manual staff for accomplishing the goals and objectives of the project.

RESPONSIBILITIES:

1. To be responsible as the team leader on administrative and operational aspects of the project in his/her assigned Ward/Zone with the following people reporting to him/her:
 - ▶ Public Health Nurse (PHN)
 - ▶ Community Health Workers (CHWs)

2. To be responsible to work with the Ward Commissioner, Ward Coordination Committees, Neighborhood Health Committees (NHCs) and Committee Volunteers (CVs) to accomplish the project's objectives for his/her Ward/Zone viz:
 - ▶ To increase immunization coverage of children under one with six EPI vaccines, and of women of childbearing age with tetanus toxoid to 85 percent.
 - ▶ To train one person per household in 60 percent of registered households on correct ORT usage.
 - ▶ To train 80 percent of mothers with children 0-23 months on correct weaning and infant feeding practices.
 - ▶ To increase the practice rate of modern methods of contraception among the eligible couples with children under two to 60 percent.
 - ▶ To train 50 percent of mothers with children 0-59 months on the recognition of major pneumonia signs which indicate a need for treatment or referral.
 - ▶ To increase the rate of at least three checkups (two ANC and one PNC) among the women (15-45 years) who delivered in 12 months by a trained person to 50 percent.
 - ▶ To provide Vitamin A Capsules (VAC) to 90 percent of children under six years semiannually and women (15-45 years) within two weeks after delivery.
 - ▶ To help select and train the targeted number of community volunteers.

- ▶ To work with the concerned people in establishing targeted numbers of NHCs — one for each neighborhood of 250-500 families and Ward Coordination Committee — one for each Ward.
 - ▶ To strengthen the linkages with the City Corporation Health staff and adjacent health institutions within a three-year period.
3. To work with the Ward Commissioner and NHCs to select at least two CVs for each neighborhood.
- ▶ To discuss sustainability issues with the community.
 - ▶ To discuss with/help the CVs/community on initiating/running IGP.
4. To be responsible for the logistical arrangements and inventory records needed to accomplish the objectives listed in No. 2.
5. To be responsible to help plan and implement the pre-service training and on-the-job training of the following personnel in cooperation with the training coordinator:
- ▶ PHN
 - ▶ CHWs
 - ▶ CVs
 - ▶ Neighborhood Committee members
 - ▶ Focus Group Mothers
6. To assist the project manager in the issue and regular review of job descriptions/ performance of all personnel under his/her jurisdiction.
7. To work with the Ward/Zone Unit Team (PHN, CHWs) to do regular sample checks with the volunteers to:
- ▶ Ensure that at least one person demonstrates competence in treating childhood diarrhea in the home (by prompt increase of fluids, continued feeding, proper mixture and administration of ORS to prevent dehydration, and to make a referral where there are signs of severe dehydration).
 - ▶ Ensure at least 85 percent immunization coverage of children under one and women of childbearing age.
 - ▶ Ensure legislation of all target families.
 - ▶ Ensure 90 percent coverage of children under six with VACs and women (15-45 years) within two weeks after delivery.
 - ▶ Growth monitoring of targeted groups of children.

8. To be responsible to the project manager for maintenance of proper discipline and security measures in the project/sub-center of the Wards/Zones.
9. To be responsible for any other duties assigned by the project manager or project director.

REPORTING RESPONSIBILITIES:

Reports directly to the project manager of Dhaka Urban Integrated Child Survival Project, Impact Area B, and World Vision of Bangladesh.

REQUIRED QUALIFICATIONS:

- ▶ Masters Degree in Social Science
- ▶ Fluency in English, written and oral
- ▶ Preferably several years' experience with PVOs in the fields of community health/organization as supervisor.

APPENDIX D

WORKSHOP ON DISEASE SURVEILLANCE DHAKA URBAN INTEGRATED CHILD SURVIVAL PROJECT FY92 - FY94

INTRODUCTION

Immunization is one of the most important and integral part of the project's Child Survival (CS) program. In the last three-years (first phase), the Kamalapur Child Survival Project area has maintained about 85 percent coverage. During the extended phase, the project will comply with the national EPI efforts of setting targets on disease reduction for measles, neonatal tetanus, and poliomyelitis.

These are:

- Reduce by 90 percent measles cases, compared to pre-immunization level, by 1995.
- Eliminate neonatal tetanus by 1995.
- Eradicate poliomyelitis by the year 2000.

The project will overcome difficulties in reaching these targets by adapting the twin support for immunization: *coverage* and *disease surveillance*. Disease surveillance means (a) to look for the case, (b) to report it, (c) to analyze the case history, (d) to act on the case with appropriate instructions (containment activities), and (e) to provide feedback.

The DUICSP will initiate disease surveillance, especially on poliomyelitis and neonatal tetanus, throughout the life of the project.

OBJECTIVE

1. To understand the surveillance concept, approaches, and methods.
2. To formulate measurable objectives and monitoring indicators for disease surveillance.
3. To share and observe different approaches and actions of EPI which impact on the high immunization coverage among children and women.
4. To strengthen operational linkages with other institutions/organizations by introducing disease surveillance approaches and method.

EXPECTED OUTCOME

1. Enhanced knowledge/skills of the participants to detect, report, and respond to EPI cases.
2. Strengthened ability of the project to liaise and to network with respective government health institutions.

3. Enhanced involvement of relevant and active NGOs in the impact areas with project activities.
4. Development of a working strategy by participating agencies.

METHODS/DESIGN

1. Lecture/Discussion
Plenary Session
Group Discussion and Group Presentation
2. Session Review
3. Report/Documentation

TIME AND DURATION

The workshop will be held in two phases:

- Phase I: 16, 17 March 1992 for supervisors
Phase II: 18, 19 March 1992 for grassroots workers

VENUE

- 16, 17 March 1992: Conference room of EPI HQ, Mohakhali, Dhaka
18, 19 March 1992: Training room of Dhaka Urban Integrated Child Survival Project

PARTICIPANTS

Phase I (Days 1 and 2)

1.	Project managers, mid-level managers/supervisors of DUICSP	18
2.	Health coordinators of WVB Field Office and project managers and M&E coordinator of CSPC	5
3.	Managers/supervisors of the active and potential NGOs working in and around the project area	6
4.	Representatives from the leading NGOs working in Dhaka City	<u>3</u>
	Total	32

Phase II (Days 3 and 4)

1.	Community health workers (grassroots workers) of DUICSP	38
2.	Representatives (grassroots workers) from the NGOs working in and around the project area	6
3.	Representatives of capable community volunteers from DUICSP area	<u>5</u>
	Total	49

ORGANIZER/COORDINATOR/FACILITATOR

Organizer

Dhaka Urban Integrated Child Survival Project, World Vision of Bangladesh with administrative/management support from Simon P. Munshi, Associate Director, Central Division, WVB and technical expertise from Dr. R. N. Basu, WHO Consultant in Bangladesh and active support and cooperation from Dr. A. K. M. Lutfar Rahman Talukder, Director EPI, MOHFW.

Coordinator

Dr. Kabir U. Ahmed, Deputy Associate Director, World Vision of Bangladesh.

Facilitator

Chief Facilitator: Dr. R. N. Basu
(Honorary) WHO Consultant for EPI in Bangladesh

Co-Facilitator: Three to four experts in EPI

SCHEDULE

Please see attachment.

PERSONS RESPONSIBLE

1. Sylvester Costa, Project Manager
DUICSP, Impact Area - A (Kamalapur)
24/B/4 Golapbagh, Demra, Dhaka
Phone - 230757
2. Dr. Iqbal Anwar, Project Manager
DUISCP, Impact Area - B (Mohammadpur)
5/5 Gaznabi Road, Mohammadpur
Phone - 314731

Schedule on Disease Surveillance Workshop
Dhaka Urban Integrated Child Survival Project
World Vision Bangladesh
March 16, 1992 (Monday)
Day 1

Time	Events	Person(s) Responsible/Facilitator
08:30 a.m.	Inaugural Session	Dr. Kabir U. Ahmed
09:45 a.m.	Tea Break	
10:00 a.m.	Plenary Session: <ul style="list-style-type: none"> · Concept of Surveillance · Needs of Surveillance · Methods of Surveillance 	Dr. R. N. Basu, WHO
11:15 a.m.	Break	
11:30 a.m.	Conduct Disease Surveillance: <ul style="list-style-type: none"> · WHO Module 	Dr. R. N. Basu, WHO
01:00 p.m.	Lunch Break	Ajit K./Paul Baroi
01:30 p.m.	Disease Surveillance (Cont.): <ul style="list-style-type: none"> · WHO Module 	Dr. R. N. Basu, WHO
03:00 p.m.	Review	Dr. Basu/Dr. Kabir
03:30 p.m.	Close	Dr. Basu/Dr. Kabir

Schedule on Disease Surveillance Workshop
Dhaka Urban Integrated Child Survival Project
World Vision Bangladesh
March 17, 1992 (Tuesday)
Day 2

Time	Events	Person(s) Responsible/Facilitator
08:30 a.m.	Plenary Session: <ul style="list-style-type: none"> · Tasks of Polio Eradication · Neo-natal Tetanus Elimination Tea Break	Dr. R. N. Basu
09:45 a.m.	Group Discussion:	Group Facilitator
10:00 a.m.	<ul style="list-style-type: none"> · Group A: Training of Grassroots Workers on Disease Surveillance · Group B: Planning for Surveillance in Project Area · Group C: Linkages with GO, NGO, and DCC · Group D: Case Definitions · Group E: Involvement of Community 	Dr. Arun Patel, UNICEF Dr. Mary Carnell, CCC Dr. Ashrafuddin, DCC Dr. Hanif Kh. Mahfuzul Haque
12:00 Noon	Presentation	Dr. Basu/Dr. Kabir
01:00 p.m.	Lunch Break	Ajit K./Paul Baroi
01:30 p.m.	Monitoring Indicators of Recommendations	Dr. R. N. Basu/Dr. Kabir U. Ahmed
03:30 p.m.	Close	

Schedule on Disease Surveillance Workshop
Dhaka Urban Integrated Child Survival Project
World Vision of Bangladesh
March 18 & 19, 1992 (Wednesday & Thursday)
Days 3 & 4

Time	Events	Person(s) Responsible/Facilitator
08:30 a.m.	<ul style="list-style-type: none"> · Concept of Surveillance · Needs of Surveillance 	Dr. Iqbal Anwar/Md. Abdul Hye
10:00 a.m.	Tea Break	
10:15 a.m.	<ul style="list-style-type: none"> · Case Definitions · Six EPI Diseases · Diarrhoea · Phenomena 	Prof. N. Naher
12:00 Noon	Community Awareness on Disease Surveillance	Kh. Mahfuzul Haque
01:00 p.m.	Lunch Break	Ajit K./Paul Baroi
01:30 p.m.	Reporting Procedures	Dr. Faruq/Abdul Hye
02:15 p.m.	Response to the Report for Appropriate Action	Dr. Faruq/M. Howlader/- Aleya Nayeem
03:00 p.m.	Review	Dr. Basu/Dr. Kabir
03:30 p.m.	Close	

**WORKSHOP/CONFERENCE/SHARING SESSIONS
FROM OCTOBER 1, 1991 — SEPTEMBER 20, 1992**

SL. #	NAME OF THE WORKSHOP	DATE	DURATION	TOPIC COVERED	FACILITATORS
1	Workshop on Communications for the Control of Diarrhea Disease (CDD) organized by the National CDD program (NCDDP), Directorate General of Health Services (DGHS).	14-16 October 1991	3 Days	<ul style="list-style-type: none"> ▶ Analysis and identification of problems and issues regarding communications for CDD. ▶ Goals and objective setting for communication components of the National program. ▶ Communication strategies for CDD. ▶ Action planning 	Operations Coordinator of Impact Area A
2	Workshop on National EPI Workplan for 1992 — organized by EPI and DGHS.	02-05 December 1991	4 Days	<ul style="list-style-type: none"> ▶ Presentation of findings of the Need Assessment Study. ▶ Clarification and interpretation of results and problems identified in the Needs Assessment Study. ▶ EPI overall objectives and goals for 1992. ▶ Analysis and categorization of issues and identification of problems from the Associates for Community and Population Research study and issues emerged during the 1991 implementation. 	Operations Coordinator of Impact Area A
3	5th Sentinel Surveillance Workshop — organized by EPI and DGHS.	30-31 December 1991	2 Days	Develop effective disease surveillance system, correcting the present situation of under-reporting. Use surveillance data to identify high-risk areas for appropriate action.	Operations Coordinator of Impact Area A and Project Manager of Impact Area B
4	Working Group Retreat on Communication for the Control of Diarrhea Diseases — organized by NCDDP and DGHS.	15-18 February 1992	4 Days	<ul style="list-style-type: none"> ▶ Health Facility Survey findings ▶ Household Case Management Survey findings ▶ Folk Terminology for Diarrhea in Rural Bangladesh ▶ Formulation of a national theme for communications of CDD in the country. 	Operations Coordinator of Impact Area A

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SL. #	NAME OF THE WORKSHOP	DATE	DURATION	TOPIC COVERED	FACILITATORS
5	NGOs Workshop On Prevention of AIDS in Bangladesh organized by DGHS and WHO.	12-13 May 1992	2 Days	<ul style="list-style-type: none"> ▶ Involvement of the NGOs in Bangladesh for prevention and control program for AIDS. ▶ Formulation of projects 	Project Managers of Impact Areas A and B and Operations Coordinator of Impact Area A
6	Training of Trainers Workshop on Rapid Knowledge and Practice Surveys for Community Assessment and Action.	August 23- September 11, 1992	20 Days	<ul style="list-style-type: none"> ▶ Need for surveys ▶ Selection of 30 Clusters ▶ Survey supervision ▶ Project management and sustainability ▶ Data collection ▶ Data Entry in to EPI INFO ▶ Data analysis and implications for the project ▶ Feedback to project partners ▶ Evaluations 	Project Managers of Impact Areas A and B

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APPENDIX F

**STUDY TO ASSESS LEVEL OF COMMITMENT
OF NHC MEMBERS AND CVs**

**Dhaka Urban Integrated Child Survival Project
March, 1992**

Since its inception, the Dhaka Urban Integrated Child Survival Project has recognized the importance of addressing the issue of sustainability, a key component of which is community participation. This project has promoted community participation largely through the development of Neighborhood Health Committees (NHCs). The NHCs are responsible for selecting Community Volunteers (CVs) who after a period of training are then involved in providing a variety of project services to 50-60 families in their communities. There are currently 28 NHCs and 140 active CVs.

In order to assess the commitment and quality of work of the NHCs and CVs and to monitor the progress of community involvement in the project, a survey was conducted from February 1-5, 1992, on a systematic sampling of NHC members and CVs. A total of 46 NHC members and 29 CVs were interviewed for this survey, the major findings of which are presented below:

A. NHC Members

1. Those NHC members interviewed attended an average of 3.7 meetings in the six-month period preceding the survey.
2. Twenty-nine of the 46 respondents understood correctly their responsibilities and activities, whereas 17 had only partially correct knowledge of these responsibilities.
3. Three was the average number of CVs for which each NHC was responsible among those NHCs represented.
4. Twenty-six of the respondents reported that they were totally aware of the activities of the CVs, 16 were partially aware, and 4 were unaware of these activities. Twenty-one respondents never met with the CVs to discuss the progress of their work.
5. All of the NHC members believed that their communities were aware of the NHC activities and that these committees were important for improving the health status of the communities.

B. CVs

1. The 29 CVs interviewed were responsible for an average of 51 families each. All CVs reported that they knew their working areas well and were regularly visiting their assigned families to provide information, education, and motivation regarding the health of mothers and children. They spent an average of 16.3 hours per month performing their project-related duties.
2. The CVs attended an average of 2.7 out of the previous three monthly meetings, but only 12 of the 46 NHC members interviewed indicated that the CVs regularly submitted their monthly reports.
3. Twenty-three of the CVs had correct knowledge of their responsibilities, five had partially correct knowledge, and one had incorrect knowledge.
4. All those interviewed believed that their work was an important component of the process of improving the health status of the community.