

AI-ABP-407  
21

**SAVE THE CHILDREN (USA)**

**WORKSHOP ON**

**"LESSONS LEARNED IN PRACTICAL NUTRITION:  
APPROACHES & ACTIONS IN BANGLADESH"**

**MAY 13-17, 1990**

**DHAKA, BANGLADESH**

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This workshop was organized by Save the Children (USA), and hosted by SCF's Bangladesh Field Office. Funding support was provided by the Office of Private Voluntary Cooperation at USAID/Washington. Workshop development support was provided by USAID/Bangladesh and the PVO Child Survival Support Program at Johns Hopkins University.

The workshop report was compiled and edited by Donna Sillan. Photo credits: Donna Sillan and Taheerah Haq

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## BACKGROUND:

According to UNICEF (1985) fifty percent of children born in Bangladesh are underweight (low birth weight: less than 2.5 kgs.), and seventy percent of under-five children are malnourished (less than 80% weight/age: 1st, 2nd and 3rd degree).

It was therefore appropriate to hold a workshop on practical lessons learned in nutrition in Bangladesh, in order to address various implementation strategies which have been tried and further refine nutritional action. It was an unique opportunity to crystallize a list of lessons learned from Bangladesh's wealth of experience. The outcomes of the workshop impact on programs within Bangladesh, and also reach beyond to other countries which can learn through Bangladesh's experience.

Through the Agency for International Development's Bureau for Food for Peace and Voluntary Assistance, Office of Private Voluntary Cooperation (AID/FVA/PVC) competitive grants program, Save the Children/Bangladesh was given authorization to host a nutrition workshop in Bangladesh with the collaboration of the PVO Child Survival Support Program for PVOs carrying out child survival programs with nutrition interventions in Bangladesh. The workshop was attended by a large number of Bangladeshi PVOs not receiving central child survival PVC funding as well. Local AID Mission concurrence was sought for the workshop. Both USAID/Bangladesh and Johns Hopkins University provided workshop development support.

Twenty four participants representing a wide gamut of PVOs involved in nutrition programming, as well as MOH and UNICEF, attended a five day workshop conducted May 13-17, 1990 in Dhaka. The organizing committee met for preliminary planning in Baltimore on March 12-14, 1990 to assure that USAID/Washington as well as PVO Child Survival Support Program input would be incorporated into the workshop design.

## ORGANIZATION:

The workshop organizing committee consisted of a workshop coordinator/facilitator (Donna Sillan, SCF/Indonesia), a logistics coordinator (Dr. Amin, SCF/Bangladesh), session coordinators/facilitators (Cynthia Carter, PVO Child Survival Support Program and Mohammed Mansour, SCF/Headquarters), technical specialist (Dr. Mohammed Mansour/HQ, and SCF home office coordinator (Karen LeBan/HQ).

The organizing committee convened in Baltimore on March 12-14, 1990 to plan a practical and program-oriented workshop. Dr. Dory Storms of PVO Child Survival Support Program, Ms. Sally Jones of AID/FVA/PVC and Karen LeBan, from SCF headquarters provided assistance during this meeting. Dr. Amin returned to Dhaka to set the entire stage for the workshop, to liaison with USAID local mission, and to contact participants.

The core organizing committee, consisting of Dr. Amin, Ms. Sillan, Ms. Carter and Dr. Mansour, met one week prior to the workshop in Dhaka to prepare for the workshop. A recorder (Taheerah Haq) was hired and assisted in logistical support prior to the workshop. Job descriptions were formulated for each member of the team, and responsibilities divided accordingly. See appendix 1 for assignment of sessions.

A preliminary PVO needs assessment was forwarded from PVO Child Survival Support Program and PVC to SCF/Bangladesh in early March which formed the basis of the Baltimore planning meeting. An additional, more thorough needs assessment was sent from SCF/Bangladesh to participants in April to complement the first one. The workshop was planned and designed according to the needs of the participating agencies. The two questionnaires and a compilation of the needs assessments are found in appendix 2 .

In summary, agencies are experiencing difficulty in growth monitoring implementation and follow-up, sustainability and inter-agency coordination. From the nutritional objectives submitted it was also clear that objective formulation is weak. From the needs assessments, a project profile matrix was produced and provided to each participant outlining information about each of the participating organizations (see appendix 3).

The WORKSHOP GOALS were formulated upon analysis of the needs assessments. The goals identified were:

1. Synthesize and **compile PVO experiences** to date in nutritional interventions (approaches and action) and identify implications for broader national policy and future PVO activities in Bangladesh.
2. **Improve skills** of PVO staff responsible for nutritional interventions in identifying nutritional problem areas, developing a plan of action, implementing and monitoring it.
3. Encourage **networking** among PVOs with child survival projects and their collaborating agencies.

**DATES AND LOCATION:**

The workshop was held on May 13-17, 1990. The venue was the Hotel Abokash, Bangladesh Prajatan Cooperation located in Mohakhali area of Dhaka. A large meeting room comfortably accommodated the PVO group in a large horseshoe seating arrangement. Two smaller "breakout" rooms were available for small group discussions and a Resource Room was set up to display PVO project materials. Dining facilities were available and reasonable.

**PARTICIPANTS:**

Workshop participants invited to attend included representatives from organizations that are currently engaged in implementing practical nutrition activities at the community level in Bangladesh, preferably as part of child survival type programs. Persons responsible for implementation and/or technical backstopping of programs were requested to attend. The initial roster of participants consisted of 28 participants; however 24 participants actually attended. The following agencies attended:

**A. Bangladesh government agencies directly involved in nutritional policy making:**

- 1) National Nutritional Council
- 2) Institute of Public Health and Nutrition

**B. PVOs with nutrition programs:**

Aga Khan, ADRA, BRAC, CSS/World Relief Canada, HKI, ICDDR,B, ODA: with two funded agencies Nari Maitree and Shasthya Kallyan Sangstha, Ghash-Fool, Radda Barnen, SCF (USA), VHSS, and World Vision. (Two PVOs invited but unable to attend were SCF (UK) and Salvation Army.)

**C. UNICEF: one representative.**

The participants held a variety of administrative and technical positions, ranging from medical directors to program officers to nutritionists. The degree of experience varied greatly as well, with some PVOs working in nutritional programs for years and others just beginning to implement nutrition activities. A list of workshop participants and organizers can be found in appendix 4.

Resource persons included Dr. Mohamed Mansour, a nutritionist, available during all sessions. He also facilitated particular technical sessions. Cynthia Carter, reviewed the quality of the PVOs nutritional objectives and organized a session on objective formulation. Dr. Afzal, of SCF/Bangladesh, an active participant, also served as resource person assisting the organizing team. Dr. Mahmud Khan of Tulane University and UNICEF presented the results of the Nutritional Modules of the national level survey conducted in 1985-86 and 1989 by the Bangladesh Bureau of Statistics. All participants were considered resource persons to each other.

#### THEME:

The theme of the workshop was to document lessons learned and transfer them within the participant group, as there were varying degrees of experience among participants. It was also an important event for networking among agencies, which is one of the significant outcomes expressed during the final workshop evaluation. Transferring implementation skills such as objective writing, choosing an appropriate monitoring method and developing a decision tree for growth monitoring was also a goal.

#### METHODOLOGY:

The workshop was designed to be action-oriented so that each participant would create and leave with materials relevant to her/his work in her/his organization. The process was facilitated using adult, participatory training techniques although it was a workshop, not a training. This method depends on the active communication and learning by all participants. One participant exclaimed during the final evaluation that this was the most participatory workshop he had ever attended.

#### AGENDA:

Numerous methods of training were used to increase participation and add variety. Fishbowls (panel discussions with observers), round robins, role plays, small group discussions, games and brainstorming were techniques used during the workshop to elicit active participation.

During the five day workshop, one day was spent in the

field, which provided a rich opportunity to interact with child survival beneficiaries directly. Four groups split between four villages and focussed on one of four major issues: a) growth monitoring and promotion, b) program integration, c) child survival activities, d) pregnancy monitoring.

The days began at 9am and ended by 6pm, with a one hour lunch break and two 15 minute tea breaks. The resource room was open during lunch break and between 5:30pm and 6:30pm. At the beginning of each day, WAWA (where are we at?) and the day's schedule was reviewed. Next, feedback on the previous day's evaluations was presented daily. At the end of each day participants filled in a daily evaluation which was compiled by Ms. Carter, the evaluation coordinator.

The logic of the scheduled sessions/activities followed the sequence below:

- Day I:     **WHAT and WHY? HOW MUCH? (extent of problem)**  
           \* Identifying the nutritional problem and it's causes and extent  
           \* Monitoring methods for measuring the problem (nutritional and growth status)
- Day II:     **HOW? (to address problem)**  
           \* Nutritional interventions: approaches and action
- Day III:    **FIELD TRIP: meet directly with beneficiaries**
- Day IV:     **WHO? (targeting your population) WHEN? HOW LONG?**  
           \* Identifying priority nutritional interventions/  
           HIGH RISK  
           \* Sustainability  
           \* Objective formulation
- Day V:     **WHAT WILL BE DONE FOR WHO? WHAT WORKS?**  
           \* Decision tree  
           \* Priority nutritional messages on child and maternal nutrition  
           \* Lessons Learned

A RESOURCE ROOM displayed nutrition education materials useful for child survival projects. Although not all PVOs brought materials from their child survival projects, the resource collection did include samples of health education materials, growth charts, and a selection of weighing and measuring equipment. A complete list of materials displayed during the workshop is included after the daily schedule.

SCHEDULE OF ACTIVITIES

NOTE:  
 WAWA = Where Are We

TIME:	May 13, Sunday	May 14, Monday	May 15, Tuesday	May 16, Wednesday	May 17, Thursday
8:00			DEPARTURE FROM DHAKA		
9:00	<ul style="list-style-type: none"> <li>* Introduction</li> <li>* Goals/Objectives</li> <li>* Schedule Review</li> </ul>	WAWA & evaluation feedback		WAWA & evaluation feedback (Mon & Tue)	WAWA & evaluation feedback
9:15		DIFFERENT APPROACHES OF INTERVENTIONS & FOLLOW-UP (OBJECTIVE C)	**FIELD TRIP**	DEFINING PRIORITY INTERVENTIONS & HIGH-RISK (OBJECTIVE D)	TASK FORCE PRESENT (OBJECTIVE B)
9:45	WHY ARE WE HERE? (OBJECTIVE A)		to		DECISION TREES (OBJECTIVE G)
10:45	OPENING CEREMONY		GHIOR Impact area SCF/B		
11:00		Snack		Snack	
11:15		Cont... OBJ. C			Snack
11:30	Snack			Intro to DECISION TREE (OBJECTIVE G)	LESSONS LEARNED IN SUSTAINABILITY (OBJECTIVE E)
1:00	Lunch Resource Room	Lunch Resource Room	Lunch in field	Lunch Resource Room	Lunch Resource Room
2:00	MONITORING METHODS OF NUTRITIONAL/ GROWTH STATUS (OBJECTIVE B)	Cont... OBJ. C		OBJECTIVE FORMULATION (OBJECTIVE F)	IEC: IDENTIFYING PRIORITY MESSAGES (OBJECTIVE H)
3:30		Tea			
4:00	Tea	UNICEF presentation		Tea	Tea
4:15	Cont...OBJ. B		DEBRIEFING IN FIELD Reflection	Cont...OBJ. F	LESSONS LEARNED at CLOSURE (GOAL # 1)
5:00			Depart to Dhaka		
5:15	Reflection	FIELD TRIP PREPARATION		Reflection	
5:30-6:30	Resource Room	Resource Room	Resource Room	Resource Rm	Final Evaluation CLOSING DINNER

**IEC INVENTORY**  
(from materials used and brought to the Workshop by participant-organizations)

Sl.No.	Kind of Materials	Title	Produced By	Contents	Usefulness for
1.	Poster	Diarrhea Protirodn Korun (Prevent Diarrhea)	Shasthya Adhidoptor	3 messages: a. Use Latrine b. Dispose of child's stool c. Wash hand after defecation with soap/ash	* Mass awareness raising * Training of parents
2.	Poster	Patla Paikhana Hole..... (in case of diarrhea ..)	BRAC	3 messages: a. Prepare salt molasses solution b. Start ORT c. Continue normal food	* Mass awareness raising * Training of parents
3.	Poster	Khola Paikhana Rog-jibanu Chharai (Open Latrine is the source of pathogenic microorganism)	Shasthya Adhidoptor	2 messages: a. Destroy open latrine b. Use safe latrine	Mass awareness raising
4.	Hand out	Seven points on diarrhea-management and prevention	BRAC	Different aspects of diarrhea management and prevention	Mass awareness raising
5.	Flip-chart	Diarrhea Protirodn Korun (Prevent diarrhea)	BRAC	Different aspects of diarrhea management and prevention	Teaching parents BRAC's seven points on diarrhea management and prevention.
6.	Flip-chart	Shasthya Shikkha:Diarrhea (Health Education:Diarrhea)	MOHFP & GTZ	ORT & ways of diarrhea prevention	Parents training
7.	Flip-chart	Shishuder Dasto Ba Patla Paikhana O Tar Protikar (Diarrhea of the Children and its Management)	Jonosonkhya Niontron O Foribar Porikolpona Kormosuchi	Ways of diarrhea management	Parents training
8.	Flip-chart	Khokar Goipo (The Story of Khoka)	ICDDR,B	ORT and diarrhea prevention	Parents training
9.	Poster	Sustho Bachcha Sustho Chokh  (Healthy Child Healthy Eyes)	HKI	3 messages on 1. Colostrum and breast feeding 2. Vitamin A reach food 3. VAC	Mass awareness raising and training parents.

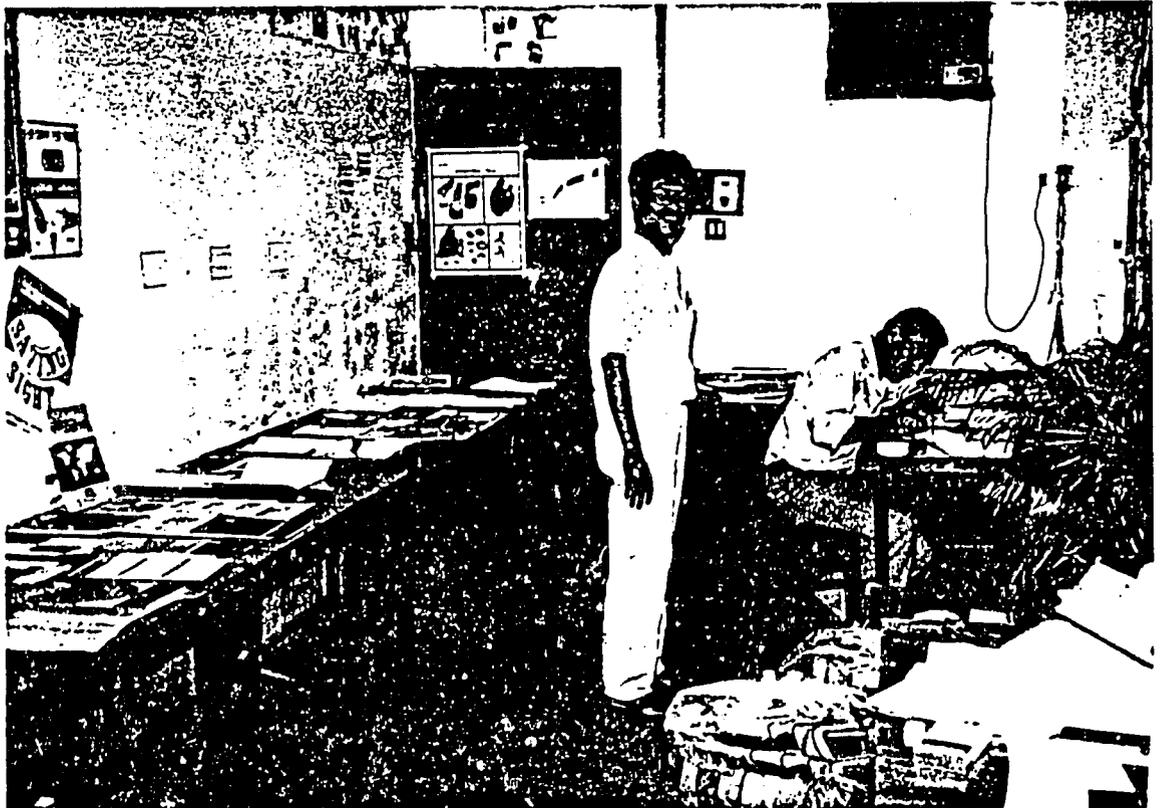
Sl.No.	Kind of Materials	Title	Produced By	Contents	Usefulness for
10.	Poster	Protidin Khete Din..... (Feed every day.....)	IPHN, HKI	Vitamin A reach foods	Mass awareness raising and training parents
11.	Poster	Andhotter Avishap Theke Choknke Rokkha Korun  (Protect Eyes From Blindness)	WIF	Advises to eat vitamin A reach food	Mass awareness raising and training parents
12.	Poster	Chokkhu Andho Hobar Pathe  (About To Be Blind)	IPHN	Says that if vitamin A reach foods would be given to the child, blindness could be prevented	Mass awareness raising and training parents
13.	Folder	Amader Shishuder Chokh Bachan (Save the Eyes of Our Children)	HKI, UNICEF, PIACT/PATH	Symptoms of night- blindness, prevention and treatment	Health Worker's training
14.	Flip-chart	Nutrition Strategy (English & Bangla)	UVP/ICDDR,B	Messages for mothers on vitamin A deficiency prevention and treatment	Training of parents
15.	Flip-chart	Apustijonito Andhotto Nibaron Chitramala (Malnutritional Blind- ness prevention pictures)	WIF	As obvious from the title	Training of parents
16.	Folder	Booker Doodh Shishur Jibone Shrestha Suchona (Breast-milk--great introduction in Child's life)	VMSS	5 messages on breast- feeding	Mass awareness raising
17.	Poster	Booker Doodh Shishur Jibone Shrestha Suchona (Breast-milk--great introduction in Child's life)	ICDDR,B	Call to breastfeed	Mass awareness raising

Sl.No.	Kind of Materials	Title	Produced By	Contents	Usefulness for
18.	Poster	Apnar Shishuke Booker Doodh Din (Breastfeed your child)	IPHN	2 messages: a. No baby-food is better than breast-milk b. Start food-supplementation from 4th month	Mass awareness raising
19.	Poster	Apnar shishuke Apusti Theke Bachan (Save your child from malnutrition)	PIACT/PATH	5 messages on child feeding	Mass awareness raising
20.	Poster	Poribarar Prapto Khabarer Susthu Bonton (Proper Intrafamily Food Distribution)	IPHN	Who should get what food, if there is not enough of everything not enough of	Mass awareness raising and training of parents
21.	Poster	Ajker Shishu Bhobishyater Samriddhir Sopan (Today's Child is The Staircase To Future)	IPHN	1 message: Proper food for the child can be prepared from foods, available in the household.	Mass awareness raising and training of parents
22.	Hand-out	Prebriddhi Anusoron O Unnoyan Somporkito Nitimala (Growth Monitoring And Promotion Guideline)	Save the Children (USA)	Implementation guideline of a GMP Program	Health Workers' Orientation/ training
23.	Book	Shishur Tola (Barti) Khabar (Supplementary food for Children)	VHSS	All important aspects of food supplementation to children	Health Workers' Orientation/ training
24.	Book	Apnar Shishur Jotno : Koekti Profojonio Kotha (Care of Your Child : Few Necessary Points)	IFSN Population Control Division, USAID, UNICEF, UNFPA	All important aspects of child nutrition	Health Workers' Orientation/ training
25.	Poster	Urbor Jomite Jemon..... (As In Fertile Soil.....)	IPHN	Nutritional need of pregnant women	Mass awareness raising.

Sl.No.	Kind of Materials	Title	Produced By	Contents	Usefulness for
26.	Flipchart	Gorvokalin Sebjotno O Nirapod Prosob (Care During Pregnancy And Safe Delivery)	PIACT	As obvious from the name of the materials.	For pregnant womens training
27.	Hand-out	Mohilader Gorvokalin Poricharja Sonkranto Nitimala (Guidelines on Pregnancy Care)	Save the Children (USA)	As obvious from the name of the materials.	For Orientation/ training of health workers.
28.	Book	Dhatree Proshikkhon PustiKa (TBA- Training Booklet)	NIPORT	As obvious from the name of the materials.	Planning and conducting of TBA training
29.	Flipchart	Dhatree Proshikkhan (TBA-Training)	UNICEF	Pictorial messages on pregnancy care and safe delivery	TBA - training
30.	Flash Card	Apnar Shishuke Tika Din (Immunize Your Child)	UNICEF	Pictures, symptoms of 6 immunizable diseases and immunization schedule	Training of parents
31.	Poster	Prosobkale Ma O Shishur Dhanustankar Hote Pare (Mother And Child May Be Infected By Tetanus During Child Birth)	Shasthya Adhidoptor (EPI)	Call for IT Vaccination	Mass awareness raising.
32.	Poster	" Jahadul Bala " (Birth-spacing message)		Saying by the Holy Prophet on birth spacing	Mass awareness raising
33.	Poster	Jahara Bibahe Asomortno (Those Who Are Not Yet Financially Solvent to Marry)	Birth-Spacing Message	Saying from the Holy Quran on birth spacing	Mass awareness raising
34.	Sticker	Bishuddho Pani Pan Korun (Drink Safe Water)	VHSS	Call to drink tube-well water	Mass awareness raising
35.	Booklet	Iodiner Avab: Samosya O Somadhan (Iodine-deficiency : Problem & Solution)	NNC	IDD prevention and treatment	Training of program managers & health workers.

Sl.No.	Kind of Materials	Title	Produced By	Contents	Usefulness for
36.	Folder	Gologondo Samosya O Iodinukto Lobon (Problem of Goitre And Iodised Salt)	DAC, UNICEF	Use of iodised salt to prevent goitre	Mass awareness raising
37.	Poster-set	Poster-set on Nutrition	WVB	3 types of food, food for pregnant and lactating mother, personal hygiene	Training of parents
38.	Book	Pusti Somondhe Jene Rakha Bhalo (Better To Learn About Nutrition)	NMC	Nutritional requirements and needs of all ages.	Training of midlevel managers and health workers.
39.	Book	Ki Upaye Sundor Shasthyaban Poribar Gore Tola Jai (How can we build A Beautiful Healthy Family)	WVB	On primary health care	Mass awareness raising, orientation of health worker.
40.	Book	Ki Bhabe Rog Charai (How Diseases Are Transmitted)	WVB	As obvious from the title	Mass awareness raising, orientation of health worker.
41.	Poster	Prathomic Shasthya Porichorja (Primary Health Care)	VHSS	Components of primary health care	Orientation of health workers.
42.	Poster	Shishu Poricharjai Adoshya Koronio (Compulsory Elements of Child Care)	UNICEF	5 messages on a. Colostrum b. Timely supplementation c. EPI d. VAC e. ORT	Mass awareness raising
43.	Folder	Prathomic Shasthya Porichorja (Primary Health Care)	BRAC	Short narrative on elements of primary health care	Health Worker's Orientation.
44.	Flip-chart	Ma O Shishu Shasthya Flip-chart (Flip-chart On Maternal And Child Health)	Jonosonkhya Niontron O Poribar Porikolpona Koramosuchi	MCHFP - messages	Training of mothers.

Si.No.	Kind of Materials	Title	Produced By	Contents	Usefulness for
45.	Flip-chart	Grameen Shasthya Shikkha- Prothom O Ditio Khondo (Rural Health Education- Part I & II)	GTZ	MCHFP - messages	Training of mothers.
46.	Leaflets	Joruri Shasthyabarta (Emergency Health Messages)	Health Education Bureau, WIF, VHSS, CSI, UNICEF	Set of leaflets, each containing a single health education message.	Post-flood awareness raising.



## THE WORKSHOP

### Introductory Session:

After a review of the day's schedule, Donna Sillan began the workshop by welcoming participants. An ice breaker, which served the purpose of introductions, began by participants pairing up with a person they did not yet know. Participants introduced themselves by interviewing their partner, asking a set of questions. Each participant wrote the information about their partner on large newsprint and posted it on the wall. Individual's photos were taken during registration and the photos were attached to each participant's newsprint the following day and kept posted the duration of the workshop (see Appendix 5).

This method allowed for reinforcement of names with faces, and was both entertaining and revealing. It was preparatory for the amount of written newsprint to be produced by the participants during the workshop. Participant and facilitator/organizer alike participated in this exercise so that there was not a separation between the organizers and participants.

The opening ceremony began with an opening address by Ms. Angela Van Rynbach, Director SCF/Bangladesh (Appendix 6). Next, the special guest, Mr. Gary Cook, Office of Health and Population, USAID/Bangladesh spoke of the health relationship between NGOs and government in Bangladesh. His three main points were: 1) nutrition is an outcome of a complex network of factors, requiring inter-sectoral development approaches; 2) nutrition is a wide spectrum ranging from famine to over-nutrition. NGO's must examine different interventions and decide which holds the greatest potential for impact; 3) PVOs provide the greatest laboratory in which to operationalize ideas, which are pioneering new approaches to be replicated on a national scale.

The Chief Guest, Mr. Tashimur Rahman, Joint Secretary, Ministry of Health and Family Welfare, provided an encouraging opening to the participants, emphasizing the worth of the workshop in aiding the Ministry to plan for future interventions. He cited the present weaknesses in IEC, emphasizing National Nutrition Council's important and positive role it is playing in developing a national nutrition "consciousness." He wished us all good luck.

Documentation of sessions follow, which outlines the process, the results and a process critique for each session.

## Session 1

## WHY ARE WE HERE?

**Objective:** To explore nutritional problems of women and children in Bangladesh and their causes as experienced by workshop participants.

**Timing:** Day 1, 9:45-10:45 am

**Process:**

- \* Individual brainstorming
- \* Round robin: each participant stating the nutritional problems faced
- \* Group facilitated to categorize causes.

**Summary:** The large group produced the following results:

5 Major Categories of Causes of Malnutrition

1. **POVERTY :** Lack of employment, underemployment, low income and productivity, low purchasing power, insufficient food availability.
2. **LACK OF KNOWLEDGE:** Ignorance, low family education, lack of mothers/fathers awareness about child and maternal nutrition, feeding and weaning practices, colostrum/breastfeeding, hygiene, Vitamin A, low birth weight. Insufficient nutrition counselling, education, and motivation.
3. **UNDERLYING ILLNESSES:** TB, ARI, IDD, anemia, other micronutrient deficiencies, anorexia, diarrhea, worms, PEM
4. **LACK OF OR INSUFFICIENT SERVICES:** insufficient health facilities/coverage, lack of manpower, untrained manpower, irregular supplies, lack of follow-up, lack of referral system, lack of integration of health and development services, lack of supplementation, lack of intensive care for high risk groups
5. **SOCIO-CULTURAL:** sex discrimination/preference, intra-family food distribution: bread-winner eats first and vulnerable groups last, superstitions, food taboos

**Process Critique:**

Rather than break the newly formed participant group into smaller groups, the first exercise entailed a whole group effort. This proved to work well, as it provided group cohesion and guaranteed everyone's participation (round robin around the room). Time use was efficient.

**Session 2 MONITORING METHODS OF NUTRITIONAL STATUS/GROWTH**

**Objective:** To share PVO experiences in monitoring nutritional and growth status for intervention on an ongoing basis.

**Timing:** Day 1, 12:30-5:30 pm

**Process:**

- \* Fish Bowl exercise (30')
- \* Small group discussions (45')
- \* Large group presentations (60')
- \* Summary (30')

**Summary:**

This session began by inquiring what monitoring methods the participating agencies used in their field projects. The breakdown is as follows:

**WEIGHT/AGE:**

- a) For intervention: World Vision, SCF, Radda Barna, Nari Maitree, CSS, AKCHP, Ghash-Fool, BRAC, ICDDR/B, IPHN
- b) For survey/database: HKI, NNC, VHSS

**MUAC:**

- a) For intervention: World Vision, IPNH, ODA, ICDDR, B
- b) For survey/database: NNC, VHSS, HKI

**WT/HEIGHT:**

- a) For intervention: ICDDR, B
- b) For survey/database: HKI, NNC, VHSS

Three participants were pre-selected to join in a fish bowl discussion to be interviewed by the facilitator, while other participants observed the discussion. Interviews of three participants using three different types of monitoring methods were conducted in the center of the fish bowl.

**Interviews:**

**1. WEIGHT FOR AGE:**

a) BRAC: Rafiqul Haider  
BRAC measures growth/nutritional status to identify high-risk children and advise mothers on changes in weight. High-risk cases are referred to curative services and followed-up. Children are weighed once a month. The method was chosen because it is easily used and understood by mothers. BRAC is satisfied with this method.

b) SCF: Dr. Amin  
SCF measures growth/nutritional status to find out who are the needy childrer. The objective is for intervention. Growth & nutritional status is measured in terms of age group of target population. Growth is measured in terms of:

For children 0-12 months: weight gain within 30 days  
For children 1-3 years; weight gain within 60 days

This method was chosen since it is the most sensitive method and allows for early detection of malnutrition. Other methods find malnourished children only after they are already malnourished. This method tells the mother her child is in danger before the child is actually at-risk through tracking growth faltering and worry weights.

SCF is not satisfied with the measuring tools since both the Salter and CMS hanging scales are expensive, delicate, and difficult to read (500 gram graduation). Other methods may supplement this method, but certainly not replace it.

## 2. MUAC ODA funded NGO:

Nari Maitree and ODA Drs. Faroque & Samad

Growth/nutritional status are measured for intervention, supplementation and prevention purposes. ODA chose this method for screening purposes. Children who measure less than 12 cm are directly referred for treatment in the nutrition center since it is the cut-off point of severely malnourished.

Using the baseline household registration, MUAC is used to initially screen the project areas. Children who are between 12.5 and 13.5 cm are considered in the danger level (yellow). There are differences in color, red, yellow, and green. The variation between 1-5 year old is only 1 centimeter so the same tape is used for all ages.

This method was chosen since it is the easiest and most convenient. Home-based measuring and rehabilitation is preferred to clinic-based, to avoid disrupting the family life.

ODA is satisfied with this tool and has recently developed a chart to plot the arm measurements, on a monthly basis. This chart is currently being field tested.

### 3. Weight for Height ICDDR,B: Dr. Selina

ICDDR,B measures the nutritional/growth status of children at their clinic-based project to monitor the children (in the field, MUAC is used). Once the patients reach 80% weight/height they are discharged from the nutrition rehabilitation center. The children in the center are monitored twice a week.

This method is used since it can detect acute malnutrition well. Age is often hard to guess, time consuming, and many mothers do not know the age of their children. This method also detects change quickly. Within 3-8 weeks, you can easily measure growth change from 60-80%, which weight/age can not do.

The tools used are 500 gram graduated Salter scales and home made measuring boards for height. The weighing scales are expensive. ICDDR,B makes their own height boards.

#### Participants question the Fishes in the Bowl:

Question: What charts do you use? (HKI)

SCF : The chart produced by BRAC.  
 ICDDR,B : Developed our own monitoring card (wt/ht)  
 ODA : Developed our own card, now field-testing

Question: What is the average frequency for measuring?

ICDDR,B: twice a week for weight/height  
 ODA : monthly for MUAC if between 12.5-13.5 cm  
 SCF : monthly for wt/age

Question: 70% of children are malnourished in Bangladesh.  
 If 70% are below weight, can follow-up be done?

BRAC : Yes; workers are able to conduct home visits.  
 ODA : Yes, field workers visit once a month.  
 SCF : No, follow-up of all malnourished children is not possible; children for follow-up should be prioritized.

After the fish bowl discussion, four groups were formed in accordance with the methods they used or were thinking of using. Each group (average 6 persons) was asked to answer a set of guided questions provided on a sheet to find out who is using what monitoring method and their lessons learned in monitoring. The following results were presented by each group. See next page.

Session 2: Monitoring Methods

	WEIGHT/AGE	WEIGHT/AGE	MUAC	WEIGHT/HEIGHT
Group members	SCF, BRAC, NM, CSS, ICDDR,B, GF, AKCHP	AKCHP, CSS, SCF, RB CSP-WV, BRAC, ADRA	ODA, CSP-WV, IPNH NNC, SKS	ICDDR,B, UNICEF, NNC, HKI, VHSS, WV
Definition of Growth	Weight gain with no consensus regarding time period.	Weight gain within 2-3 successive weighings, frequency of weighing monthly.	arm circumference	At a given time, the increase in height & weight of a child in accordance with standard
Why this method?	Sensitive and manageable	* Sensitive tool to assess immediate nutritional changes. * Able to detect both acute & chronic * Pre-designed growth card available * Helpful for early detection * Method recommended by WHO	Cheap and easily implemented (mobile)	* Easy to work with trained volunteers * Measures nutritional status accurately * Easy to deal with the status of a floating population
Standards applied	WHO/NCHS	NCHS	Harvard standard	Waterlow
Measurement tools	Salter: England (4,000 tk) Secca: India Spring: England	Salter: England (4,000 taka) Local scale: (2,500 taka)	MUAC tapes, locally manufactured & purchased (5-6 taka)	Salter scale, height boards locally made
Recording tools	Growth charts, rosters, and malnourished forms	BRAC printers: charts (6-7 tk)	MUAC chart is 10 taka	Card developed and printed locally (5 tk)
Frequency of weighing	1-3 month intervals	monthly, bimonthly, quarterly depending on age	used specifically for screening purposes	Time a week
Time to measure 1 child	5 minutes	10-15 minutes	5 minutes	5-10 minutes
Where to measure:	community centralized/home	house-to-house, fixed outreach center or clinic	Anywhere	Community-based nutrition center
Opportunity for education?	Yes	Yes	Yes	Yes
Manpower to measure:	1-2 persons	2-3 workers & community volunteers	1 person	2 workers
Socio-cultural aspects	At 1st cultural resistance to weighing, but overcome with education. In urban areas: absence of mother from home (work) and/or absence of child (work/school)	* Children are not "goods" to be weighed * "Weighing reduces weight" * "Child may fall sick" * expectation for assistance to rehabilitate child * mothers are not willing to spend more time for weighing	None	Age determination, beliefs about weighing and measuring children.
Strengths	sensitive, manageable	mothers are made the judges to see the growth of their children	Easy to implement/mother can be taught It is home-based. Larger coverage at minimum time/cost	* Easy to work with trained volunteers * Measures nutritional status accurately * Easy to deal with the status of a floating population
Constraints	* age determination * support to hang scales * classification may be inappropriate for Bangladesh	* actual age is difficult * immediate impact not visible * socio-cultural resistance	* Not suitable for under-ones * Not suitable for monitoring * Difficult to measure MID upper arm * Risk of improper measurement * suitable for nut. status, but not growth * local standards are needed	* non-availability in local market * mobility of tools, cost, trained manpower * tools are heavy * children bend their legs
Overcoming constraints	* Use of events calendars	* Provide IEC * Integrate with other activities * Develop grass-roots infrastructure	* Develop standards for 7-12 mos. children * Used only for screening one point in time, so don't use for monitoring * Training/supervisor follow-up for measuring accuracy	Development of low-cost, simple locally produced equipment.
Change method?	No, not now.	No, but want to include other methods for research	Appropriate for status, not growth	Want to add Weight/Age to make the program age specific
Discussion	* Standards: better to use Indian standard. Matlab has developed a standard which is not internationally	* Need to address sustainability * Feasibility cost and accuracy of instrument must be considered. * The time a mother is willing to	* Matlab experience has shown that 12.5-13.5 is too high for Bangladesh. * Bangladeshi children are thinner once they are six months old.	* Is manageable in a community-based center.

The following sum-up was facilitated by Dr. Amin:

- \* To assess growth status we need to define growth in measurable terms.
- \* Frequency of measuring should be decided according to priority of the organization; it usually varies from once every month to quarterly.
- \* None of the methods are perfect nor are they exclusive. They are all useful under different situations.
- \* MUAC is good for measuring nutritional status, others can be used for measuring both nutritional status and growth
- \* Problems with wt/age is age, wt/height is that it is difficult to measure height.
- \* Salter Scales are the best at this moment.
- \* Factors to consider for choosing a method are:  
1) feasibility 2) sensitivity 3) cost 4) availability
- \* The reasons for measuring are to:
  - 1) Find out the children that are not yet at-risk but are about to be at-risk.
  - 2) Find out those that are at-risk now.
  - 3) Intervene to improve the status, develop the child.
- \* Recommendation to NNC: Design a scale which will be light and convenient to use.

#### CONCLUSIONS of SESSION:

The session required more clarity to clearly delineate the different methods used to monitor growth/nutritional status. The objective was to share PVO experiences in monitoring nutritional and growth status for intervention on an ongoing basis. Although this was accomplished in a sense, there was a need for more distinction between methods. Partially due to limited time during the session, the objective was not fully reached. Hence, a TASK FORCE was formed to work on an in-depth analysis of the various methods and to make recommendations on the use of these methods by program goals for workshop participants to be presented on Day 5.

#### Process Critique

The structured guideline provided during the small group discussions was too long for the time allotted to discussion. More detailed interviewing during the fish bowl discussion rather than in small groups would improve the session and leave more time for the large group presentation and discussion.

**TASK FORCE FINDINGS: MONITORING METHODS OF  
NUTRITIONAL AND GROWTH STATUS**

**Task force members:**

Dr. Aminul Islam,	ICDDR,B
Dr. Celal Samad,	ODA
Dr. Iqbal Anwar	WVB
Mr. Fazlul Karim,	BRAC
Dr. Mohamed Mansour,	Resource person.

**Working Procedure**

- (1) The task force first identified 3 major program goals for which the anthropometric indicators may be applied:
  - Growth monitoring
  - Screening nutritional status for intervention
  - Measuring immediate change in nutritional status.
  
- (2) Task force members agreed to examine different anthropometric method by looking at the following criteria:
  - Feasibility, including portability, time needed for measurement;
  - Sensitivity;
  - Cost; and
  - Socio-cultural barriers.

It was fortunate that objective data on these criteria were available in the literature.

These criteria were ranked from 0 to 4 according to their appropriateness (for example, if the criteria is cost, 0 = very high cost, 4 = cheapest). The task force preferred to use these values than to propose new values which can only be subjective.

The task force felt however that an additional criteria should be added which is the appropriateness of the anthropometric methods for each program goal. The following assumptions were made:

- weight for age is generally accepted as more appropriate for growth monitoring.
- arm circumference more appropriate for screening acute malnutrition among children between age 1 to 4 years.
- weight for height more appropriate to measure rapid and immediate change in health status in a clinical

center based setup.

- height for age more appropriate for screening chronic malnutrition or past history of nutrition.

Because values of appropriateness of these methods for different program goals were not available, task force members had to make up these figures based on their experience and current knowledge.

- (3) The following tables present the final results of the task force:

Recommendation for selection of anthropometric methods by program goal

Program goal: Growth monitoring

Criteria	Wt/Age	Wt/Ht	MUAC	Ht/Age
Feasibility	3	1	3	2
Sensitivity	4	3	3	2
Cost	2	1	4	3
Socio-cultural	3	3	4	3
Appropriateness	4	1	0	0
TOTAL	16	9	--	--

Actually, only two methods are appropriate for growth monitoring: Wt/Age and Wt/Ht. Results show that when these two methods are compared according to the above criteria, Wt/Age ranks much higher.

Program goal: Screening nutritional status for intervention

Criteria	Wt/Age	Wt/Ht	MUAC	Ht/Age
Feasibility	3	1	3	2
Sensitivity	4	3	3	2
Cost	2	1	4	3
Socio-cultural	3	3	4	3
Appropriateness	3	2	4	0
TOTAL	15	10	18	-

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Actually, only 3 anthropometric methods can be realistically compared for screening given that height for age is an improper indicator of current nutritional status. Results show that when all criteria are taken together, MUAC seems to be more appropriate for screening than the other three.

Program goal: Measuring rapid and immediate change in nutritional status

Criteria	Wt/Age	Wt/Ht	MUAC	Ht/Age
Feasibility	3	1	3	2
Sensitivity	4	3	3	2
Cost	2	1	4	3
Socio-cultural	3	3	4	3
Appropriateness	3	4	2	0
TOTAL	15	12	16	-

The three anthropometric methods considered appropriate for this intervention are Wt/Age, Wt/Ht and MUAC. Under field conditions (the figures borrowed from the Indonesian studies apply to community based interventions), MUAC seems to rank higher, followed by weight for age and weight for height.

When this intervention takes place in clinical/center based setting as it generally does, then some of the criteria as cost and socio-cultural barriers cannot apply and the values for the other criteria should be modified (the feasibility measuring weight for height in a health center is not the same than in the community; the cost of measuring weight for height in a health center is one-time investment; socio-cultural barriers are not applicable when a child is weighed by health professionals). The revised table shows the following result:

Criteria	Wt/Age	Wt/Ht	MUAC	Ht/Age
Feasibility	3	3	3	3
Sensitivity	3	4	2	1
Cost	N O T	A P P L I C A B L E		
Socio-cultural	N O T	A P P L I C A B L E		
Appropriateness	3	4	2	0
TOTAL	9	11	7	-

After corrections were made with regard to the intervention site, weight for height ranks higher than the other two followed immediately by weight for age and then by MUAC.

### Conclusions

With regard to three major nutrition intervention goals, growth monitoring, screening nutritional status and measuring immediate and rapid change in nutritional status, the task force recommends the use of weight for age for growth monitoring, MUAC for screening nutritional status at the community level and weight for height as a measure of rapid and immediate change in nutritional status in center-based nutrition rehabilitation interventions. Height for age is the only appropriate method for measuring chronic malnutrition.

SESSION 3      DIFFERENT APPROACHES OF INTERVENTIONS  
AND FOLLOW-UP

Objective: To share and observe PVO experiences with different approaches and actions/interventions having an impact on the nutritional status of women and children.

Timing: Day 2 May 14 - 5 hours 45 minutes  
9:00-11:00 am; 11:15-1:00; 2:00 - 4:00pm

Process: **Part A: Three approaches**  
Role plays (3) (30')  
Fish Bowl Discussion (45')  
Summary/Closure (15')

**Part B: Ideal Interventions**  
Small group discussion (60')  
Large group presentation (30')  
Summary/Closure (15')

**Part C: Prioritize Interventions**  
Small group discussion (45')  
Large group discussion (45')  
Summary/Closure (30')

Results:

1. Warm-up: Three role plays illustrating three different approaches of nutrition interventions were performed in front of the group by participants.

- Clinic based health approach: One participant played a doctor, another a father with a sick child. The doctor, sitting in his chamber at the clinic, looks exhausted after examining a great number of sick children. He sees the child, prescribes medicines and rebukes the father for bringing the child so late. With all good intentions the doctor did not have enough time to address the cause of the problem and he only sees the child once he already has a nutritional problem.
- Community-Based Primary Health Care Approach  
One participant plays a health supervisor doing a home visit to spot check the work of a community health worker. A mother shows the latest weight of her child on the growth curve. The supervision asks probing questions to see whether the mother understands the growth curve. He also checks the immunization records.

He asks questions about family planning and encourages the mother to follow it. The mother asks him to help.

in getting potable water to the village which does not have a tube well. The supervisor says they have provision only for health services and they can not help the villages to get a tube-well.

- Community based integrated development approach:

A participant plays a role of a CHW doing a home visit to invite a mother to come to the next EPI event. He inquires about the literacy course the mother is attending. The mother brings to his attention the lack of potable water in the village and the desire of the community to have a tube well. The CHW asks the mother if she had discussed this issue with the rest of the community. He shows willingness to help if this is what that the community wants and if it is willing to contribute to it.

All these role plays were in Bangla. A script was prepared in advance. Participants were chosen for the role plays and rehearsal conducted done one day before.

At the end of the role play, Dr. Afzal summarized the main features of each approach as follows:

- In the clinic setting, services are provided to those who leave within a manageable distance and those who usually come for treatment. Because the demand for health and medical services is so important and the clinic facilities are limited and sometimes understaffed, the interaction between mothers/caretakers and health or medical personnel is very short. Most often, interventions in the health clinics are curative and fail to address the real causes of child malnutrition.
- In the PHC approach, there is better reach through a community based health delivery system. Preventive and curative services are possible to reach the community through a network of village health workers. This sectoral approach deals with direct health problems and is less effective in dealing with causes of malnutrition, particularly those of economic nature. When the only solution for a malnourished child is to provide more food, VHW's are usually helpless.
- The integrated development approach attempts to address the various causes of malnutrition through the provision of a service package for groups identified at high-risk. Here, all the causative factors are considered and interventions are planned to address those factors as much as possible.

2. Fish bowl exercise:

3 participants were pre-selected to join in a fish

bowl discussion conducted by the facilitator. Other participants observed the discussion. The three participants represented each of the approaches mentioned above.

The facilitator asked each of the speakers two questions in two rounds:

- What do you do to prevent and cure malnutrition in your area?
- What are the things you think you really need to improve your services.

#### Community Based Integrated Development Approach

SCF: This approach focuses on the prevention of problems. Major thrusts:

- pregnancy monitoring
- growth monitoring and promotion
- economic rehabilitation, income generating projects.

Results obtained so far are encouraging but long-term sustainability remains an issue.

#### Community Based PHC Approach

BRAC: In terms of PHC program, BRAC focuses on:

- prenatal care: a trained TBA for 40-50 households
- growth monitoring and promotion
- mothers' clubs formation.

These interventions have proven to be successful but interventions regarding "high-risk" children are left to desire because they rely on the GOB infrastructure and services.

#### Clinic Based Intervention Approach .

ICDDR,B: This approach is based on the concept of "missed opportunities". ICDDR,B has developed a packaged program focusing on mothers while they are present for treatment. Mothers are being trained and educated on protective child behaviors in a participatory fashion.

The Nutrition Rehabilitation Center calls for an active participation of mothers in the rehabilitation of their children. After discharge mothers are followed up after six months.

Since it is backed by a broad-based research group, ICDDR,B can continuously modify its services.

## Discussion

- SCF:** Discussion focused on SCF's Women Saving Groups (WSG). These groups of 8 to 12 women engaged in economic activities are in a stage of developing a revolving fund to sustain activities. WSG created a forum to share problems and experiences among women. Tangible results are already obtained:
- less sex discrimination
  - better nutritional status
  - decreased fertility
- WV:** A question addressed to all three is how to motivate the fathers? Both SCF and BRAC have included fathers in their activities of awareness building and community involvement.
- BRAC:** The question of program cost was raised. Some attempts are being made but cost analysis is difficult and expertise is lacking.
- ICDDR,B:** Focusing on mothers brings far reaching results.

### PART B

Identifying and discussing the ideal interventions to address the 5 major categories of causes of malnutrition identified earlier during the workshop was facilitated with an exercise to imagine "ideally". A single question was asked to each small group:

- Ideally, what interventions would you recommend to address these specific problems?

The following five lists of interventions are the ideal interventions selected by workshop participants to address the major causes of malnutrition:

#### IDEAL INTERVENTIONS TO ADDRESS PROBLEMS OF POVERTY (Group 1)

- \* Vulnerable group identification
- \* Credit for income generation
- \* Improved literacy status : formal and non-formal
- \* Skill development training
- \* Controlled market price
- \* Changed agricultural and food habit
- \* Proper utilization of available resources at all levels
- \* Employment creation
- \* Communication development
- \* Provision for (low-cost) housing
- \* Improvement of health service
- \* Inter-sectoral collaboration

IDEAL INTERVENTIONS TO ADDRESS  
PROBLEMS OF LACK OF KNOWLEDGE

- \* Nutrition education through mass-media
  - \* Nutrition counselling (one to one)
  - \* Nutrition training, orientation and demonstration
  - \* Nutrition education through service centers
  - \* Mass literacy
  - \* Integration of nutrition education with all services
- NOTE: Cause-specific relevant message will be developed for specific target groups to address specific problems.
- \* Awareness raising in socio-economic context.

IDEAL INTERVENTIONS TO ADDRESS  
INSUFFICIENT OR LACK HEALTH SERVICES

- \* Identify the degree of insufficiency of health facilities in the area.
- \* Establishing of adequate no. of sub-centers/satellite clinics per union/10,000 population.
- \* Equip or establish close liaison between upazila/health center and sub-center/satellites i.e. proper referral system.
- \* Linkage between upazila, H.C. & District level hospitals etc. must be strengthened.
- \* Develop strong supervision or supportive supervision from top level to field level.
- \* Proper of sufficient training, improved salary & other benefits should be looked into for better services by staff, especially the field staff.
- \* Adequate supply of commodities/medicines according to the needs with proper supervision for distribution.
- \* Better coordination between existing health facilities of gov't, NGOs, etc. and regular communication between these facilities.
- \* Linkage to be set up among other facilities present in the area: such as livestock, fisheries, agriculture, public health (sanitation) depts.
- \* Involvement of the Educational Institutions in the promotion of P.H.C.:
  - i) Development of curriculum
  - ii) Educating students re: PHC
  - iii) Promotion of female education; i.e. Increase the ration of female/male students.
- \* Organizing the community to identify and solve their own problems through active community participation which may include small regular fund-raising methods.
- \* Set up of a volunteer service in the community for improvement of the P.H.C. and other facilities in the area and reward system set up for good volunteer service.

IDEAL INTERVENTIONS TO ADDRESS  
UNDERLYING ILLNESSES

GROUPS of DISEASES: A) Diarrhea B) ARI  
C) Vaccine-preventable  
D) Deficiency disease: anemia, VAD, IDD  
E) Intestinal parasites

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\* PREVENTIVE, EDUCATIONAL INTERVENTION

1. Group education
2. Focus group discussion
3. Home visit
4. Schools
5. Imams-Mosques

education forums

EDUCATORS: Paid community  
health workers  
(1,2,3)

MOTIVATORS/REINFORCES:

- \* volunteers from community
- \* imams
- \* school teachers

Health Education Materials Development: Pamphlets - pictures for illiterates

CURATIVE SERVICES BACK-UP for effective referral system.

HEALTH EDUCATION TOPICS:

Diarrhea: ORT, environmental & personal hygiene, dietary management, when to refer.

ARI : Signs + Symptoms of ARI, referral

VACCINE : Immunization <==

Under-1's

==> promotion

Woman 15-45

Social mobilization : demand creation

Def. Dis: Nutritional components : breastfeeding/weaning

\* VIT A Cap distribution + VIT rich food  
(short-term) promotion plus  
home gardens  
(long-term)

for mothers soon after  
delivery

- \* IDD : awareness of fortified salt
- \* Anemia : iron-rich foods + tabs for ANC fortified salt.

Intestinal: Deworming, personal hygiene promotion & chemical purification of water.

=====

PEM : The disease + ANOREXIA a symptom of ALL  
PLUS : ANC + Maternal nutrition education.

### IDEAL INTERVENTIONS TO ADDRESS SOCIO-CULTURAL CAUSES

- Non formal nutrition education to all strata of the family/community through the most dominating members. Stressing the nutritional needs by mentioning the priorities of the pre school children and mothers!
- Low cost diets with high nutrition value e.g. mixture of rice and pulses
- Real life food display in the community in every month, properly supervised.
- Nutrition counselling about more nutritious foods e.g. during pregnancy, after birth, diarrhoea and other common diseases

### PART C

After Part B's "idealization", Part C focussed on prioritizing the interventions according to the three types of intervention approaches. Three groups were formed according to agencies implementing similar interventions.

- Clinic based nutrition intervention:  
IPHN, NNC, ICDDR, B, Radda Barnen, AKCHP.
- Community based primary health care approach:  
WV, BRAC, SKS, HKI, GHASH-FOOL.
- Community based integrated development approach:  
SCF, ODA, VHSS, ADRA.

The question discussed by the groups was:

- According to your own approach and strategy, prioritize these interventions so that they will be presented as recommendations to your organization.

The following lists of interventions are priority interventions chosen by workshop participants:

### CLINIC-BASED NUTRITION INTERVENTIONS

#### A. TO ADDRESS UNDERLYING ILLNESSES:

- Prevention Treatment, and Supplementation
- Improvement of referral system
- Strong follow-up system

- B. TO ADDRESS LACK OF KNOWLEDGE:  
 - To deliver health education  
 - To deliver nutrition education
- C. TO ADDRESS LACK OF SERVICES:  
 - To develop inter-sectoral collaboration  
 - Improvement of referral system  
 - Home visit and strong follow-up system  
 - Ante-natal service and TBA kit.
- D. TO ADDRESS POVERTY:  
 - Supplementary food.  
 - Compensations <-- | daily wage  
                               | transport  
 - Health insurance to the beneficiaries.
- E. TO ADDRESS SOCIO-CULTURAL CAUSES (food taboos, superstition, etc.):  
 - Nutrition Counselling  
 - Low cost nutritious food demonstration.

PRIORITY INTERVENTIONS: COMMUNITY-BASED PHC

A. TO ADDRESS INSUFFICIENT/LACK OF KNOWLEDGE

HEALTH AND NUTRITIONAL EDUCATION

- (a) Hygiene and sanitation
- (b) Control of Diarrheal Diseases
- (c) Colostrum/Breast feeding promotion
- (d) Immunization promotion/coverage.
- (e) Supplementary/Weaning Food
- (f) Promotion of Micro-nutrients
- (g) Dietary Advice during pregnancy/lactation, during and after illness.
- (h) Growth Monitoring & Promotion.
- (i) Promotion of kitchen-gardening.

B. TO ADDRESS INSUFFICIENT/LACK OF SERVICES

INTEGRATION OF EXISTING SERVICES

- (a) Formulate policies for integrating existing services such as:
  - (i) Health & Family Planning
  - (ii) DPHE
  - (iii) Agriculture
  - (iv) Co-operatives
  - (v) Social Welfare
  - (vi) NGO's etc.
- Iron for pregnant/lactating women

C. TO ADDRESS UNDERLYING ILLNESS:  
PROVISION OF SERVICES (all necessary health services)

D. TO ADDRESS SOCIO-CULTURAL CAUSES:  
REMOVAL OF SOCIO-CULTURAL BARRIERS THROUGH IEC

E. TO ADDRESS POVERTY:  
VILLAGE-LEVEL INFRA-STRUCTURE DEVELOPMENT  
(a) TBA Training  
(b) Village health committee formation  
(c) Mother's club formation  
(d) Community health workers' training.

PRIORITY INTERVENTIONS: COMMUNITY-BASED INTEGRATED DEVELOPMENT

- A. To address poverty:
1. Income generation credit with proper follow-up for poorest of the poor.
  2. Skill development training on agriculture, poultry, fishery and livestock.
  3. Awareness raising on human rights.
  4. Awareness raising on proper utilization of available public resources at all level.
- B. To address lack of nutritional knowledge and socio-cultural constraints:
1. a) to contribute to government efforts of compulsory primary education.  
b) to reinforce nutritional education through primary schools.
  2. to launch nutrition education (one to one, group, mass media; for fathers & mothers) through coordinated efforts of existing government and non-government field workers without duplicating: 3 things must be included:  
(a) colostrum; (b) proper weaning practice; and  
(c) "Eat for two" during pregnancy and lactation.
- C. To address insufficient or lack of services:
1. To strengthen the management of existing government health services through training and support (equipment, treatments, drugs)
  2. To assist government to organize health infrastructure where it is lacking, if impossible build community health infrastructure.
  3. Fee for services ?
- D. To address underlying illnesses:
1. Continue promoting EPI program

2. CDD through ORT promotion, provision of tube-well, and popularization of low-cost latrine.
3. a) Promotion of home-gardening specially for Vit. A reach foods.  
b) Routine VAC distribution.
4. ARI program: <- | education  
                          | referral linkage

#### Process Critique:

This session was very long and could have been better structured. First, the role play and the fish bowl exercise illustrating the three different approaches should be followed by a large group discussion to highlight strengths and weaknesses of each approach and make recommendations for improvements. Participants involved in role plays and fish bowl exercise should be prepared well in advance, particularly on the specific aspects to be stressed or highlighted during the presentation. The facilitator should be very familiar with the topic and prepared to ask questions.

The identification of interventions with regard to major causes of malnutrition should be treated as a separate session (or with the session on identification of nutritional problems in Bangladesh) and not included in "intervention approaches". Inclusion of this part had somehow broken the continuity of a logical process of thinking going from definition of three approaches to the prioritization of interventions within each approach.

Finally, priority interventions should be more closely linked to the type of approach. For this purpose, the instructions should be clearly stated and written and small group discussions should be facilitated. Output format should be decided and prepared in advance to ensure comparability between groups.

Session 4

SPECIAL SESSION: Bangladesh Nutrition Module of 1985/89  
Time: Day 2, 4:00-4:30

A special session was offered by UNICEF to present the results of the Bangladesh Nutrition Module of 1985/86 and 1989. The presentation by Dr. Mahmud Khan of Tulane University provided the participants with the more recent relevant findings in Bangladesh.

The data for the nutrition module has been collected by the Bangladesh Bureau of Statistics (BBS) to determine the nutritional status of children 6-71 months of age. The base was unique in the sense that it linked the nutritional data set with the expenditure level of the household. Dr. Khan was requested by BBS to analyze the database, which he recently completed. The report has not yet been produced, but he kindly shared his preliminary findings with the workshop participants. Major findings from both modules are almost similar:

1. Poverty is found to be the main cause of malnutrition; with increase of household expenditure, nutritional status of children improves.
2. Age of the children in months is related to malnutrition. In the 1989 module the lowest rate of stunting (-3SD of NCHS) was observed in the age group 6-11 months (14.4%) and highest in 12-23 months (40.5%). Severe wasting (-3SD of NCHS) was prevalent in the age group 12-23 months and 24-35 months, which are 38.5% and 28.3% respectively.
3. Area of Residence: Prevalence of malnutrition is a little more in rural areas than in urban areas. As per the 1989 module in the rural areas, prevalence of severe stunting and wasting were found to be 36.1% and 26.4% respectively in comparison to 28.6% and 21.9% respectively in the urban areas.
4. Sex of Children: Prevalence of severe stunting among girls (36.1%) is slightly more than among boys (34.5%). However, prevalence of severe wasting among girls is significantly higher than among boys 28.3% and 23.7% respectively.

Dr. Khan has found that education of the mothers plays a significant role on nutritional status of their children. He found after controlling for income that children's nutrition status improves with mother's education. The data show that toilet facilities has significant effect on nutrition.

NOTE: Any one interested to know more about the details of the study should contact Ms. Riti Ibrahim of BBS.

## Session 5

FIELD TRIP: Ghior Impact Area (SCF)

Day 3: 8:00am-5:00pm

On day 2, a preparatory session was held to explain the purpose of the field trip on the following day. After a briefing by Dr. Amin (SCF) about SCF's program, growth monitoring and pregnancy monitoring guidelines developed by SCF were distributed in Bangla. Participants were asked to sign up for the topic they were most interested in as the field trip was focused on particular issues.

Growth Monitoring and Promotion: Md. Eshaque Ali (NNC), Dr. Celal Samad (ODA), Ms. Farkhunda (IPHN), Dr. Monuara (Radda Barnen), Dr. Islam (ICDDR,B), Dr. Masud (WV), Dr. Amin (SCF)

Program Integration: F. Karim (BRAC), Naheed (Ghash-Fool), Dr. Hasib (Aga Khan), Baten (CSS), Dr. Iqbal (WV), Ms. Carter (JHU)

Child Survival activities: Mir (HKI), Hussain (CSS), Rashid (VHSS), Shabita (SCF), Dr. Afzal (SCF)

Pregnancy Monitoring: Dr. Ishtiaq (Aga Khan), Dr. Mizan (SKS), Haider (BRAC), Anjona (ADRA), Dr. Faroque (NM), Ms. Sillan (SCF)

Each group visited separate villages, held discussions with health workers, observed specific activities, and conducted home visits to interview direct beneficiaries. The group used the structured questions to gather information regarding their topic area. See the structured field visit questions in Appendix 7.

The groups met after their scheduled activity to compare notes and discuss the results of their home visits. Each group prepared a presentation to the full group, providing recommendations to the Bangladesh SCF field office. The discussion focussed on observed strengths and weaknesses, and recommendations for action for SCF.

GROUP 1:

GROWTH MONITORING AND PROMOTION

**STRENGTHS:**

1. Monitoring and Recording System is excellent.
2. Nutritional interventions, specially the intervention on weaning food is excellent.
3. Field Staff are well informed regarding the program and very efficient in motivation.
4. Well accepted by the community.
5. Family planning activities are very appreciable -  
CPR = 66%.

**WEAKNESSES:**

1. Population/Staff ratio seemed to be very high  
1 Staff : 125 families
2. Sustainability of the Project : Community organization seems to be weak giving rise to the question of sustainability of the project in future.
3. Education on Intra-family food distribution seems to be negligible.
4. Feedback system from the organization to the community seems to be poor.

**RECOMMENDATIONS:**

1. More emphasis should be given on community organization to ensure sustainability of the project.
2. Intra family food distribution should be looked into more thoroughly.
3. Improvement and communication of the result of monitoring system to the community.

**GROUP 2:****OTHER CHILD SURVIVAL INTERVENTIONS****STRENGTHS:**

1. Recording and data collection
2. Rapport
3. Participation of the community
4. Awareness of the target group.
5. Success of the family planning programme.
6. Well organized.

**WEAKNESSES:**

1. Feedback
2. Vitamin A information
3. Sponsorship Programme.
4. No achievement evaluation.
5. No analysis on cost effectiveness.
6. Village workers are not very well informed.
7. Less interest of the committee members.

**RECOMMENDATIONS:**

1. More emphasis should be given on health/nutrition education.
2. A clear decision should be taken regarding sponsorship program.
3. Measure should be taken to replicate the proof.
4. Revolving loan program should be more organized.
5. Motivation for kitchen gardening.
6. Sectoral and village committees should be reorganized and more new focus indicated.

## GROUP 3:

## INTEGRATION

**STRENGTHS:**

- Integrated approach
- Participation W.S.G. is spontaneous
- Simple, well-designed record keeping system
- Appropriate knowledge on weaning food e.g. chatu.
- Women's Savings Groups seems to be sustainable.
- Male section allows their counterparts to participate in programs.

**WEAKNESSES:**

- Lack of follow-up on the basis of EPI target group
- Little knowledge on Growth chart
- Gap of knowledge on TT schedule of F.S.
- Maternal nutritional status unchanged
- Inadequate medicine facilities

**RECOMMENDATIONS:**

- EPI follow-up needs to be strengthened.
- Mothers should be properly educated on growth chart.
- Necessary steps to be taken to improve maternal nutritional status.
- Sufficient medicine facilities need to be ensured.

## GROUP - 4

## PREGNANCY MONITORING

**STRENGTHS:**

1. Pregnancy monitoring was found to be very satisfactory. The record-keeping says so.
2. Good number of TBA's were found who had been trained by the SCF (We've interviewed 6).
3. Interviewing the pregnant mothers, our experience was :
  - (i) We've found good response from mothers who were present in the class.

**WEAKNESSES:**

- Knowledge is satisfactory, although we've found some inhibition in practising them.
- Over weighted influence by other family members.

**RECOMMENDATIONS:**

1. Father's have to be also included in the counselling, before a child birth.
2. More TBA training.

\*\*\*\*\*

Many of the recommendations are extremely insightful and helpful, however, it must be kept in mind that the recommendations were made in a very short time frame, which limited the breadth of information which was able to be viewed and shared. This exercise was not meant to be a

program evaluation in any way, rather it provided an opportunity for participants to provide their cursory feedback and first impressions to SCF, of which SCF was appreciative and thankful. The field trip went smoothly, except for a few slippery descents walking through villages.

A large number of participants showed interest in Save the Children's Women's Savings Groups, and were interested in initiating this activity in their programs. They can obtain guidelines and other documents on WSG from SCF/Bangladesh.



## SESSION 6 PRIORITY NUTRITIONAL INTERVENTIONS AND TARGETS

**Objective:** On the basis of shared experiences to facilitate/assist participants in identifying priority nutritional interventions and intervention targets (including "high-risk") in the context of organizations approaches, strategies and limitations.

**Time:** Day 4 - 2 hours 30 minutes

**Method:**

- \* Large group discussion of interventions (45')
  - Presentation of the three lists of priority interventions prepared during the session on Interventions (May 14).
  - Discussion: Agreement on a list of priority interventions.
- \* Small group discussion (45')
  - a) For each priority intervention chosen, what is the target population (target population means the population to whom the intervention is primarily addressed, directed, meant for).
  - b) Among the target population, do you focus on a particular group that you consider as your high-risk group? How do you define your high-risk categories?

Example: target population = pre-school children  
 high-risk group = under 2 years severely malnourished orphans, etc.

- \* Large group discussion (45')
  - Presentation of "high-risk" categories: each group presented its list of "high-risk" categories.
  - Discussion focussed on the relevance of the "high-risk" categories for each intervention, criteria for identification, feasibility, cost, etc.

**Results:**

### A. Introduction

1. What is your target population for a given intervention?

A target population is the population to which the intervention is primarily addressed, directed, meant for. Target population varies with types of intervention. Target population for an EPI program is children under-five or children under-two. The target population for TT vaccine is women at child-bearing age (15-45 years).

2. Can you reach all your target population? What do you do if you cannot?

Here you need to prioritize among your target population.

Need for prioritizing target population is necessary for many reasons:

- funding constraints/agency's capability
- agency goals, approach and strategy
- commitment to the donor
- accountability for quick/demonstrable results
- urgent need of the community to address
- pressure from government officials/government policy.

### 3. How can you prioritize?

There is no standard or specific rules or recipes for choosing priority target populations. It is a highly agency/ project specific decision making process. "High-risk" groups may be a method used for prioritization but it is not the only one. Other factors, budgetary, institutional, , technical, etc. may also be used.

"High-risk" group is a physiological/epidemiological concept. For instance, children of LBW are at "high-risk" of perinatal and infant mortality. New born babies of rural pregnant mothers (usually delivering at home) are at "high-risk" of neonatal tetanus. Families of a malnourished child are at "high-risk" of having malnutrition problem with the next child, etc..

Based on your experience and your current projects, what are your priority target population or your "high-risk" groups?

### B. Output

The following three tables list the priority interventions, target populations and priority target populations/"high-risk" groups according to the three intervention approaches.

- clinic-based health approach
- community-based PHC approach
- community-based integrated development approach.

**GROUP 1: Community-Based Integrated Development Approach**

Priority Interventions /Components	Target Population	Priority-target "High-Risk"group(s)
1. To contribute to govt. efforts of compulsory primary and secondary education & reinforce nutrition education through schools.	M + F 5 to 15 years Age group	Poorest of the poor families.
2. Income generation credit free of interest/creation of employment opportunities.	16 to 45 years age group farmers	Family of Sev.Mal. children/Widows Divorced Destitute
3. Continue promoting EPI program.	Under 1 Child. and 15-45 years women.	Pregnant women & children of floating people
4. Control of diarrheal diseases through ORT promotion, provision of tubewell, and popularization of low-cost latrines.	Urban Slum dwellers Rural: All population	14-45 years women poorest of poor families.
5. Promotion of a) Home-gardening for Vit A rich foods & b) routine VAC distribution.	a) Women & school children. b) U6 children women within 1 month of delivery.	a. Poor families b. Recurrent episodes of diarrhea, Measles, ARI
6. To launch nutrition education (one to one, group, mass media for fathers & mothers) through co-ordinated effort of Govt & NGOs on - colostrum, child feeding, weaning - feeding of pregnant and lactating women.	All Parents	Pregnant mothers, Lactating mothers.

7. To strengthen the management of existing Govt. health services through training and support (equipment, transport drugs)	a. Municipal health staff in urban areas. b. Upazila health complex staff in rural area.	Remote area and where facilities are not adequate.
8. Skill development training on agriculture, poultry, fishery, and Live-stock.	16 to 45 years age groups of both sex.	- Widow - Divorced - Destitute women
9. To assist Govt. to organize health infrastructure.	a) Municipal health structure in urban areas. b) Upazila health infrastructure in rural areas.	Remote areas and where facilities are not adequate.

**GROUP 2: Community Based PHC Approach**

**1. Lack of Knowledge**

i) Hygiene and sanitation	Families	Parents
ii) Control of diarrhoea diseases	Parents	Women
iii) Colostrum/Breast-feeding promotion	Women 15-45 yrs	Pregnant mothers
iv) Immunization	Parents	Women 15-45 years Mothers of Under 1 children Mothers of Under 5 children
v) Supplementary/weaning food	Parents	Mothers of Under 5 children
vi) Promotion of micro nutrients	Families	Parents
vii) Dietary advise during pregnancy/lactation	Household members	Pregnant women and household heads
viii) Growth monitoring and promotion	Families	Parents of Under 5
ix) Promotion of kitchen gardening	Household heads	Land Women

**Lack of Services**

i) Formation of policies for integrating existing services	Target agencies planners/policy makers	<b><u>Agencies:</u></b> 1. Health and Family Planning 2. DPHE-LGRD Ministry 3. Agriculture 4. Social Welfare Ministry 5. Education 6. NGO-Sectors in GOB
ii) Provision of services	Target populations	Underprivileged
iii) Local level infrastructure development - Mothers clubs - Village Health Committees formation - TBAs - Volunteers	Mothers Community  Community Community	Local Leaders

**3. Underlying Illnesses:**

- Diarrheal diseases - A R I - Worms - PEM - Anemia - IDD	Children Children Families U5 children Women 15-49 yrs Women 15-49 yrs	Under 5 Under 5 Mothers & Children Under 3 children Pregnant Women Pregnant women/ Endemic areas
- 6 Preventable diseases (EPI)	U-5 Children	Under-1 children
- Vit A deficiency	U-6 children & mothers	Under-6 children & mothers

**4. Removal of Socio-Cultural Barriers:**

Food taboos, superstition	Families	Heads of household Pregnant Women
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**5. Poverty:**

- Income/employment generation	Underprivileged	Women of rural areas & urban slums
- Skill development programs	Underprivileged	Women of rural areas & urban slums

**GROUP 3 : Clinic Based Intervention Approach**

Priority Intervention /Components	Target Population	Priority-target "High-Risk"group(s)
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**UNDERLYING ILLNESS****(A) Prevention**

1. Through Immunization	U-2 Children & women of 15-45 years.	i) Malnourished children ii) Urban slum populations.
2. O.R.T	All patients	i) U-5 children.
3. VAC Distribution	U-72 months children Mothers newly delivered.	i) With diarrhea ii) Malnourished children.
4. Iron Supplement	All Mothers	i) Pregnant Mothers.

**(B) Supplementation**

1. Micro-nutrients	U-5 children	i) Malnourished children ii) Diarrhoeal patients.
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**(C) Treatment**

Rx of all types of Illness	i) All patients ii) Accompanying sibs <5 iii) Accompanying mothers	i) U-5 children ii) Malnourished mothers
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**(D) Referral System**

To respective health centers	Patients with respective illness.	Severely affected ones.
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**(E) Follow up System**

a) To referral centers	Referred patients	All
b) In the community	Vulnerable	All

LACK OF KNOWLEDGE

To deliver health and nutrition education	All mothers and attendants	Mothers/attendants of U-5 children
<u>LACK OF SERVICES</u>		
a) To develop intra-sectoral collaboration.	Resource persons from PVO & GOB.	N.A.
b) Antenatal services & safe delivery kit distribution.	All pregnant women.	Advanced pregnancy
<u>SOCIO-CULTURAL</u>		
Nutrition counselling and demonstration	Mothers/attendants of all patients	Mothers/attendants of U-5 children
<u>POVERTY</u>		
a) Supplementary food distribution	i) U-5 children ii) Mothers/attendants	i) Malnourished children ii) Malnourished mothers.
b) Compensation	Attendants of poor patients	i) Malnourished ii) T.B. patients
c) Income generation	Attendants of poor patients	Urban slums

**Process Critique:**

This session produced the desired outcome. A longer explanation of "high-risk groups" within a target group would be helpful at the beginning of the session. The concept of having a particular subset within a larger target group, which is at greater risk than others, needs to be emphasized and examples provided to the group.



## SESSION 7

## SUSTAINABILITY

**Objective:** To review four categories of sustainability and to make recommendations for action.

**Timing:** Day 4, afternoon, 1 hour

**Process:** Introduction, 20 minutes  
Recommendations (large group), 30 minutes  
Wrap-up, 10 minutes

**Summary:**

As reported in "Sustainability: Reality Check for PVOs", most PVO project sustainability strategies fall into four main categories:

Financial Viability  
Lasting Benefits of Skills and Knowledge Transfer  
Health Behavior Change  
Maintaining Service Coverage

Similarly, projects participating in this workshop have also formulated sustainability strategies that fall into one or more of the above categories. (See Project Profiles, Appendix 3).

During the opening discussion of this session the group focussed on developing a definition of sustainability. Groups whose sustainability strategy fell into the Financial Viability category wished to define sustainability in strict financial terms, namely, that the community or host government would maintain service coverage without dependence on external financial resources. Examples of program activities implemented to achieve financial viability included income generation projects and establishing cost recovery mechanisms.

Training programs are implemented by many programs as a primary sustainability activity. Most projects encourage community participation at all stages of program implementation in order to strengthen the possibility of a sustained program. These activities fall into the Lasting Benefits of Skills and Knowledge Transfer category.

Studies have shown that for long-term Health Behavior Change, a system for reinforcement/follow-up of this behavior must be in place. To sustain health behavior change, PVOs can increase the level of partnership with indigenous organizations so these organizations can continue to reinforce the health messages to the population after the original project ends. Some participants were skeptical of this need for reinforcement because they believed once a good health behavior is adopted by a beneficiary, it is permanent. Behavior change depends on how well the concept is integrated into the belief/value system of the individual. For example, when an educational message is

given to a mother during a time of increased perceived need (during severe illness of a child) the behavior is more likely to become permanent than if there was no perceived need at the time. (Journal of Health Promotion).

Maintaining Service Coverage through strengthening training, management, and health information systems of government agencies is a fourth sustainability strategy used by some PVOs. Strengthening the national PHC infrastructure through assisting in policy formation, strengthening health service delivery infrastructure, and research can have great impact.

#### Conclusions:

The group concluded that to achieve sustained health programs, activities from each category must be implemented. While some groups may focus on community participation and training, others need to develop effective income generation strategies and strong partnerships with community groups. Finally, some organizations will focus their sustainability efforts at the national level with their collaborative activities with the Ministry of Health.

In order to implement an effective sustainability strategy, PVOs are encouraged to first define sustainability for that individual organization and project, identify a realistic strategy, write a program objective for sustainability, and develop a plan of action for measuring progress towards this objective.

#### Recommendations:

In a large group discussion, the workshop participants agreed that the following recommendations should be considered when planning and implementing sustainable health program activities.

#### GENERAL

-A clear definition of sustainability should be developed for each project in terms of the context of the local situation.

#### FINANCIAL VIABILITY

-Project cost recovery mechanisms are essential to the continuation of program activities. Cost recovery mechanisms result in less dependence on external financial resources.

-Income generating activities in the target community are essential to continued support of the project by its beneficiaries.

-Financial resources should be targeted by identifying crucial interventions and calculating project cost per beneficiary.

#### LASTING BENEFITS OF SKILLS AND KNOWLEDGE TRANSFER

-The community should be empowered with partnership with a

project. Beneficiaries should be involved in needs identification, project planning, ongoing committees, and should receive regular feedback.

-Employing local staff should be emphasized.

-PVO should continually reduce its management responsibility by phasing-over project management to country nationals and the local community.

-Mechanism for the supply of continued external resources (national or international) should be developed.

#### HEALTH BEHAVIOR CHANGE

-NGO should cooperate with the local government structure so behavior change can be reinforced after the project ends.

-Employing local staff should be emphasized.

-Need further study of retention levels of child protective behaviors.

#### MAINTAINING SERVICE COVERAGE

-Form an NGO Committee which has dialogue with government policy makers. This committee should discuss the possibility of reallocation of health resources with the government decision makers.

-NGOs should work with the MOH to strengthen national training, management, and health information systems.



## PROCESS CRITIQUE

### Sustainability

Since sustainability is a broad and controversial subject, there are many ways to address this issue in a workshop of this type.

Defining sustainability is one way to begin. In the opening discussion of this session, some participants revealed a need to define this concept. After some discussion, we saw that the group was unable to concur on one definition. This is an important point, which was brought out in our discussion. Each health project deals with a different set of circumstances and must define sustainability, write objectives, and formulate indicators for sustainability based on an inventory of resources and organizational ideology.

Without a universal definition, the workshop group went on to examine four categories of sustainability activities. Each participating project is involved in one or more of these activities that can lead to enhanced sustainability, but no project has been entirely successful in obtaining sustainability. By considering their successes and constraints, the participants offered recommendations across all four categories as to how programs could have more impact.

The objective of this session was to develop recommendations for sustainability. While time for discussion and sharing would have resulted in a greater number of recommendations, the resulting recommendations are appropriate and realistic. If these recommendations are acted upon by the participating agencies, then much will have been achieved through our discussion.



## MANAGEMENT BY OBJECTIVES

- Objective:** To formulate or refine program objectives, measurable methods, and monitoring timetables for interventions having an impact on the nutritional status of women and children.
- Timing:** Day 4, afternoon, 2:30-5:00pm
- Process:** Introduction to Management by Objectives, 40 minutes
- Brainstorming
  - Developing a Program Strategy
- Writing an Objective, 20 minutes  
(large group)
- Break, 15 minutes
- Theoretical Project Planning, 30 minutes  
(small groups)
- Large Group Feedback, 30 minutes
- Introduction to Objective Worksheets, 15 minutes

**Summary:**

**Brainstorming Exercise.** To begin this exercise, each participant considered the health and nutrition problems faced by their project's target populations. It was agreed that everyone would like to do something about these problems. On the assumption that we each had been funded between 1 million and 5 million Taka, we asked, "How do we design the most effective program with our resources?" First we identified what we need to begin the program. Some needs identified included - manpower, more Taka, equipment, facilities, materials, a target group, list of community needs, and baseline survey data.

Next we brainstormed immediate actions we would need to take, these included - setting project goals and objectives, hiring of personnel, training, plan for supervision, plan for monitoring, schedule for follow-up of training, plan for evaluation, logistics planning for food supplementation and growth monitoring/promotion, access materials for education of the community, and schedule to conduct cost/benefit analysis.

These suggestions for needs and action are by no means complete!

**Developing a Program Strategy.** There are simple guidelines the program manager can follow in developing a program strategy.

## STEPS

### \* Identify the Problem to Be Addressed

### \* State the Program Objective to Impact on the Problem

#### Does your objective answer these questions?

1. What change in the problem will occur? (knowledge change, behavior change, health status change)

FOR EXAMPLE: Increase knowledge..., Increase use..., Reduce incident...

2. How much change? (quantify this change)

FOR EXAMPLE: 60% children..., 100 mothers..., 20 health committees..

3. Who is the target of this change?

FOR EXAMPLE: Mothers..., children..., fathers..., community leaders..., government committees..

4. By when will change occur? (quantify your timeline)

FOR EXAMPLE: within 6 months..., by the end of project..., by December 1990..

Now, look at your objective again and identify program activities/interventions that will address this objective. Remember, keep the objective simple and uncomplicated. If there are several problems to be addressed in the community, write multiple objectives.

### \* Identify Methods/Interventions/Project Activities

#### Ask yourself these questions.

1. What activities can my project do to address this objective?

FOR EXAMPLE: training, ORT sachet supply, community meetings

2. How often must activity occur to achieve the quantity of change?

FOR EXAMPLE: train 50 health workers..., supply 2000 sachets..., conduct 3 community meetings..

3. How often should activity occur in order to meet program objective?

FOR EXAMPLE: 2 trainings per years, 2000 sachets every 2 months, 3 community meetings every six months.

## Theoretical Project Planning

Following the introduction was an exercise in objective writing. Each of five small groups was presented with an identical project scenario. Group members were designated as Program Managers who had adequate financial, human, and information resources to design a project in a rural Bangladesh community. Each group wrote two appropriate, quantifiable, time-limited, and realistic objectives. Methods/interventions to reach these objectives were outlined.

Some examples of problem statements, objectives, and methods for the health program of "Health for Children" are as follows:

Problem Statement: Children of age 6-71 months and mother are malnourished.

Objective: To improve the nutritional status of 50% of 3000 malnourished children to normal by June 1993.

Methods:

- supply supplementary/weaning food
- promote hygiene and sanitation
- promote breastfeeding

Objective: To improve the nutritional status of 50% of 1000 pregnant mothers by June 1993.

- home visits
- improve social benefits

Problem Statement: Night Blindness

Objective: To provide vitamin A capsules to at least 90% of the registered children of 6 months-6 years in the project area in each cycle (twice a year).

Methods:

- training of volunteers and health workers on distribution and health education on vitamin A
- organize crash programs on VAC
- collect reports from staff and volunteers and submit to the appropriate authority

Objective: To promote home gardens among 90% of families of malnourished children and maintain at least 75% families with home garden, by 1993.

Methods:

- conduct baseline survey to identify the families of malnourished children with the facilities of home gardening
- train health staff and volunteers on nutrition education and home gardening
- distribution of seed and seedlings among the community people

-arrange film show in the community

Problem Statement: Baseline survey showed only 25% of mothers are well nourished

Objective: Improve the nutritional status of mothers by 40% by the year 1992.

Methods:

- monthly home visits for nutrition education
- weekly home visits for high risk cases
- form 60 mother's clubs

Problem Statement: 70% (3500) families are below subsistence level

Objective: To improve the income level of 3500 poor families in the 5 years.

Methods:

- organize 100 savings units (35 families in 1 unit)
- savings group meetings once a month

Plan for evaluation:

- percent target families enrolled in savings unit
- percent monthly meetings conducted

Objective Worksheets:

To close the Objective Writing session, each participant was provided with a blank worksheet and instructions to rewrite or revise their existing program objective in order to make them most useful for program management. Participants were asked to complete this exercise as homework.

The following morning, workshop participants requested additional time to complete the Objective Worksheets; some wanted time to access project data from their office. After clarifying questions and considering the best approach to make this a practical exercise, everyone agreed that one additional week would be available to complete the program-specific objective worksheets. One week after the workshop, over half of the 16 participating organizations had revised their objectives, and the worksheets were forwarded to the session organizer for feedback.

## PROCESS CRITIQUE

### Management By Objectives

Introduction - The introduction required too much time, the content should have been reduced.

Hypothetical Project/Objective Writing - Worked well, participants understood the basic concepts being presented.

Objective Worksheets - Participants clearly spent time reviewing their programs' objectives and revising the objective worksheets. Overall, those that completed this exercise did a good job. Only the participants can say, or demonstrate, whether this exercise will be useful to day to day program management.



Session 9      **DECISION/ACTION TREE FOR GROWTH MONITORING & PROMOTION**

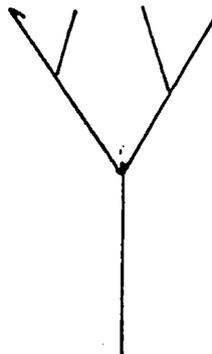
Objective: To formulate a decision tree to be used by grass-roots level workers for growth monitoring and promotion.

Time:              Day 5, morning 9:00-11:00

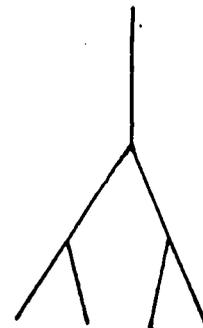
Process:        \* Introduction (15')  
                 \* Two representatives draw a DAT in front (45')  
                 \* Full Group discussion (45')  
                 \* Summary (15')

**A. INTRODUCTION**

- (1) A decision/action tree represents graphically a sequence of decisions/actions that one takes in an orderly fashion so that decision 2 or action 2 cannot come before decision 1 or action 1.
- (2) What is the analogy with a tree ? It is from the branch ramifications which represent the decision points. A tree is made of sequential ramifications into two or more branches at certain points in time. These points represent decision points. The pictorial representation of a tree is taken to illustrate the process of making decisions and undertaking actions in any set of events. The analogy with a tree is not however complete because the direction in a decision/action tree is reversed:



TREE



DECISION/ACTION  
TREE

- (3) Can we apply the concept of a decision-action tree to a growth monitoring and promotion session ?
  - In a GM & P session, we have several actors:
    - . Mothers and children

- . Field health workers and other health personnel
- . Occasionally a doctor.
- Field health workers or other health personnel are performing certain activities such as registering children, examining them, weighing, recording weight, etc.
- At certain times, health workers are asking questions to mothers and getting answers. They also have to answer questions related to child growth (whether child growth is adequate or not, child health etc.) Questions and answers result in decisions and planning of actions.

The concept of a decision/action tree can then be applied to a GM & P session.

#### B. DECISION/ACTION TREE (DAT) MAKING PROCESS

Two participants were selected to do the exercise of drawing a decision/action tree applicable to their GM & P session.

##### 1) Door to door GM & P (AKCHP)

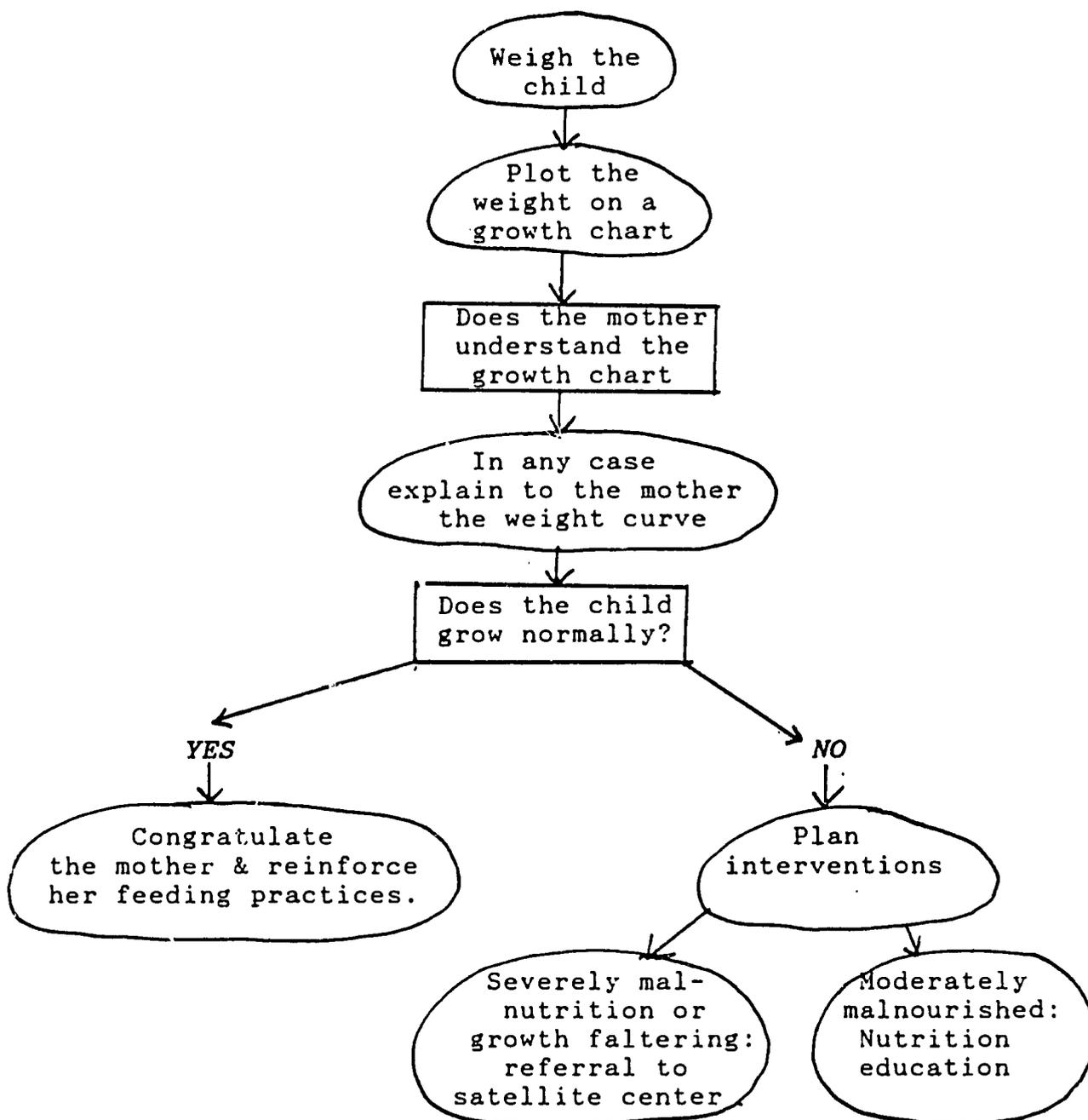
List of steps:

1. Enter the house
2. Greet the mother
3. Introduce him/herself
4. Look for children U 5
5. Weigh the child
6. Ask for the growth chart
7. Plot the weight
8. Ask the mother if she understands the weight curve
9. Interpret the growth curve for her
10. Plan interventions:
  - if moderately malnourished: nutrition education
  - if severely malnourished: refer to satellite center
  - if growth faltering: referral.
- 11) Thanks (Khoda Hafiz).

#### Ordering and identifying action/decision steps

The next step consisted of differentiating actions and decisions by using a circle for an action and a box for a decision.

This exercise results in the following DAT:

DOOR TO DOOR GM & P SESSION

## 2. Clinic Based GM & P Session (ICDDR,B)

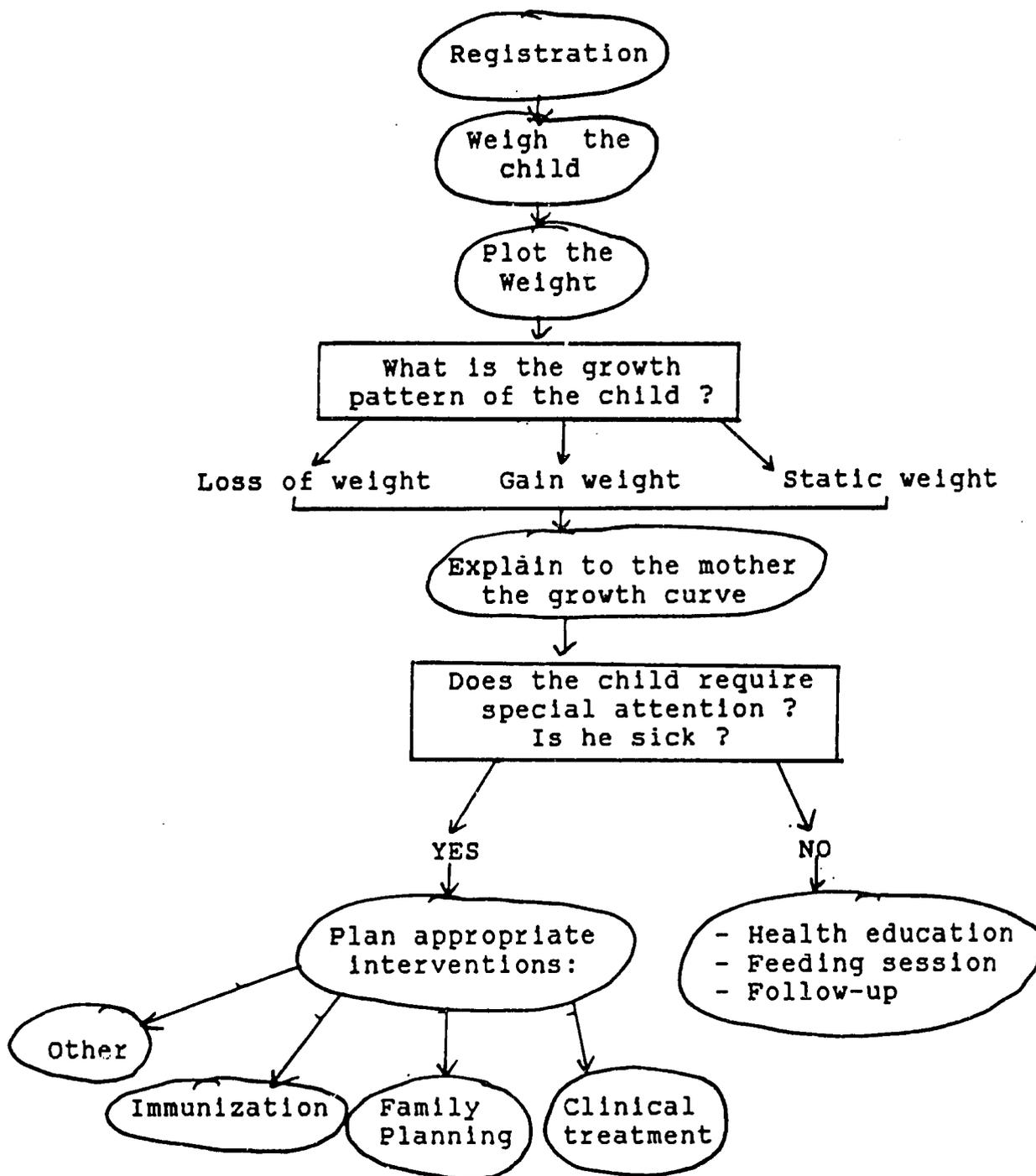
### List of steps

1. Register the child
2. Weigh the child
3. Plot the weight
4. What is the growth pattern of the child ?
5. Explain to the mother the present nutritional status of the mother
6. Counsel the mother on nutrition
7. Is the child sick ?
8. Does he require special attention ?
9. Screen for different interventions
10. Appropriate interventions
11. Health education session
12. Feeding session
13. Follow-up date
14. Medicine distribution
15. Good Bye.

### Ordering and identifying action/decisions steps

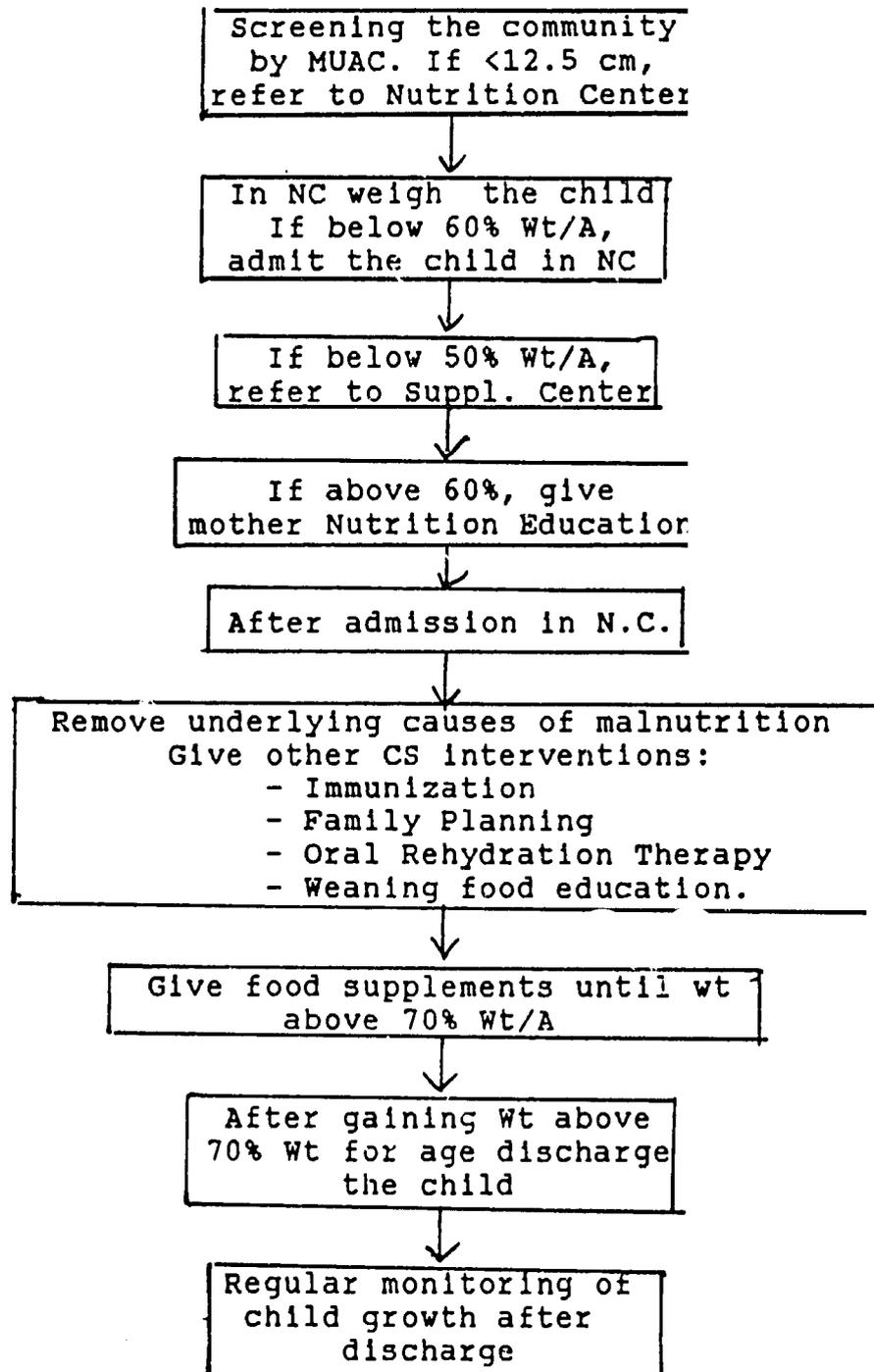
Some of the steps were redundant and the order was rearranged. The next step consisted of drawing the following DAT.

Clinic Based GM & P



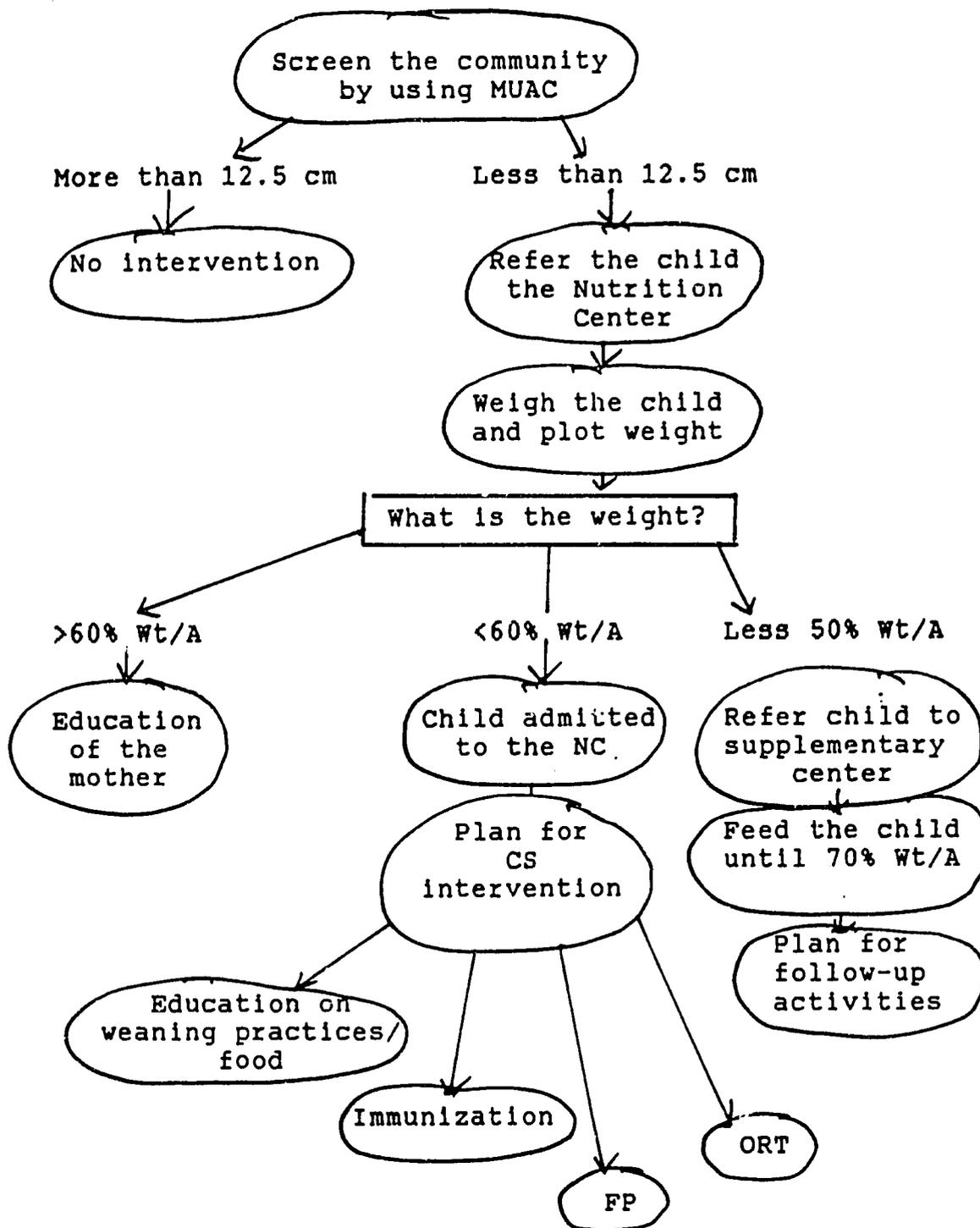
### 3. MUAC Screening Session (WVB)

A World Vision participant presented the following flow chart related to their screening strategy using MUAC.



This example of GM & P activity presented by World Vision of Bangladesh was very relevant for a practical exercise on decision/action tree development.

MUAC based GM & F



### C. Presentation of SCF Universal decision/action tree

GM & P has been criticized recently for being a noneffective intervention for growth promotion. One of the chief complaints about GMP sessions is that no action is taken once the child is weighed which leads mothers to ask the question: <You weigh the child, so what ?> Very often, health workers pay more attention to the process of weighing, recording and plotting to the extent that the weighing activity becomes a substitute to the intervention that should take place.

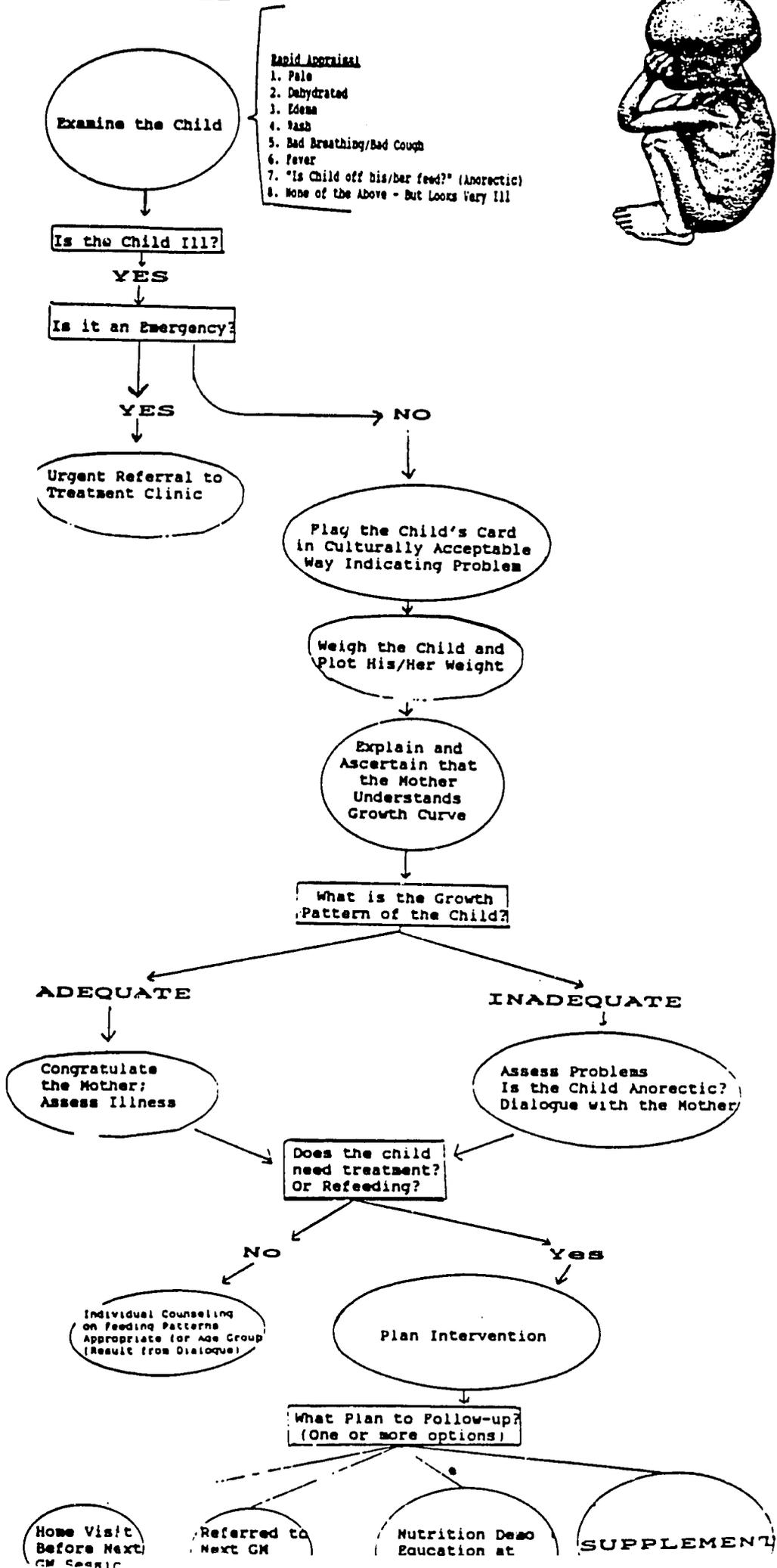
A common complaint is that growth monitoring is not performed properly. Health personnel may not be well trained to use a scale, read a weight or record it on a growth chart. Moreover, they may not be able to interpret it correctly and to explain to the mother the change in child growth.

Another major complaint is that health personnel do not listen to mothers, do not take into consideration their complaints and very often are unskilled to provide appropriate counselling.

GM sessions have also been very often criticized because they do not respond to the urgent need of a sick child. The mother of the ill child wants relevant help with the immediate problem now. Referring her miles away to a distant center or making her sit through a long and needless wait will only alienate her and guarantee that she will not return. Save the Children has tried to create a decision/action tree for GM & P in the light of the criticism expressed by mothers and by the community. While organization, mapping, and logistical management of GM & P sessions may vary from one project to another, and from one country to another, SCF staffers have found that there is an underlying decision tree that is universal for growth monitoring. In addition to its clear layout of the necessary decisions and actions involved in a GM & P session, this decision/action tree may be used as a guide for planning adequate training of health workers and other users.



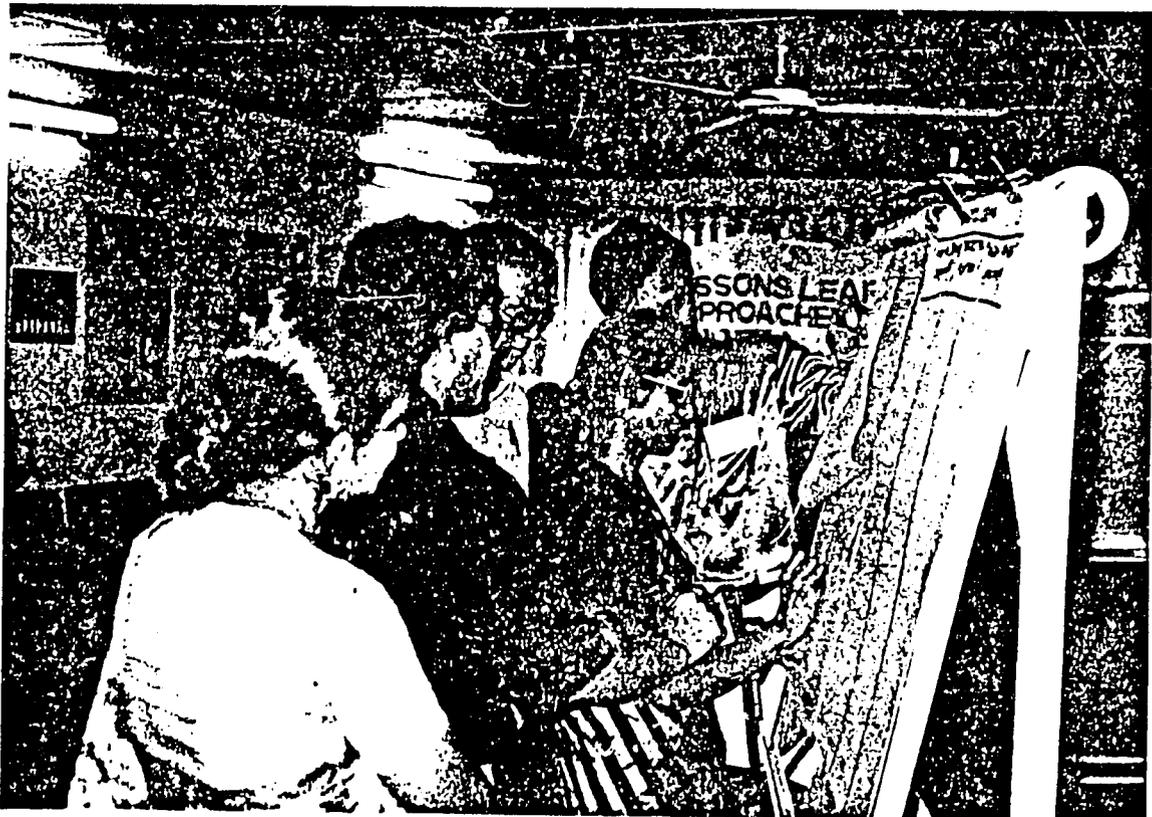
**ILL CHILD**



**Process Critique:**

The current planning of this session proved to be satisfactory and to result in a skill development exercise. However, a careful preparation of those who will present their GM & P method should take place before the exercise and not during the session. Due to time constraint, the DAT making process was made in the large group. It is recommended to break the participants into 2 to 3 groups on the basis of different GM approaches (clinic based, community or door to door based approaches, method-specific GM, etc.) and to allow enough time for presentation and discussion of individual DAT before the large group. More discussion of the universal DAT should be allowed. A minimum of 3 hours is required for this session:

- Introduction: ..... 20'
- Assignment: ..... 10'
- Small group: ..... 45'
- Large group discussion:..... 45'
- Presentation of Universal DAT: 30'
- Large group discussion: ..... 30'



## SESSION 10 INFORMATION/EDUCATION/COMMUNICATION (IEC)

Objective: To identify priority nutritional messages targeted to mothers and fathers on child and maternal nutrition.

Timing: Day 5 afternoon, 1 hour

Process: Introduction (role play), 15 minutes  
 -how should a message be given  
 -how many messages should be given

List Nutritional Messages (small groups), 25 minutes

- To mother about child
- To mother about maternal nutrition
- To father about wife and children

Prioritization Exercise, 15 minutes

Summary, 5 minutes

"I HEAR, AND I FORGET..  
 I SEE, AND I REMEMBER..  
 I DO, AND I UNDERSTAND."

-Confucius

### Role Play - How should a message be given?

The purpose of this role play was to demonstrate the level of retention of a health message by the recipient depending on the method of communication by the health worker. Scenario: A person who is unable to write in Bangla script wishes to learn how to write the word "husband" and requests assistance from a teacher. At first, the teacher explains, orally, how the letters in the word "husband" should be formed. After the teacher departs, the student tries, unsuccessfully, to remember what the teacher said, and cannot write the word "husband" in Bangla script. The teacher returns with the word written on a poster and shows the student how the letters should look when put together. After the teacher departs, the student tries to remember the description and how the word looked and writes the word "husband" in Bangla script with a few errors. The teacher returns with pen and paper and teaches the student to write this word by doing. The student writes the word and demonstrates for the teacher several times. After the teacher departs, the student is able to remember and can write the word "husband" over and over. (One month after this workshop exercise the "student" still remembers how to write this word!)

To mothers about Children:

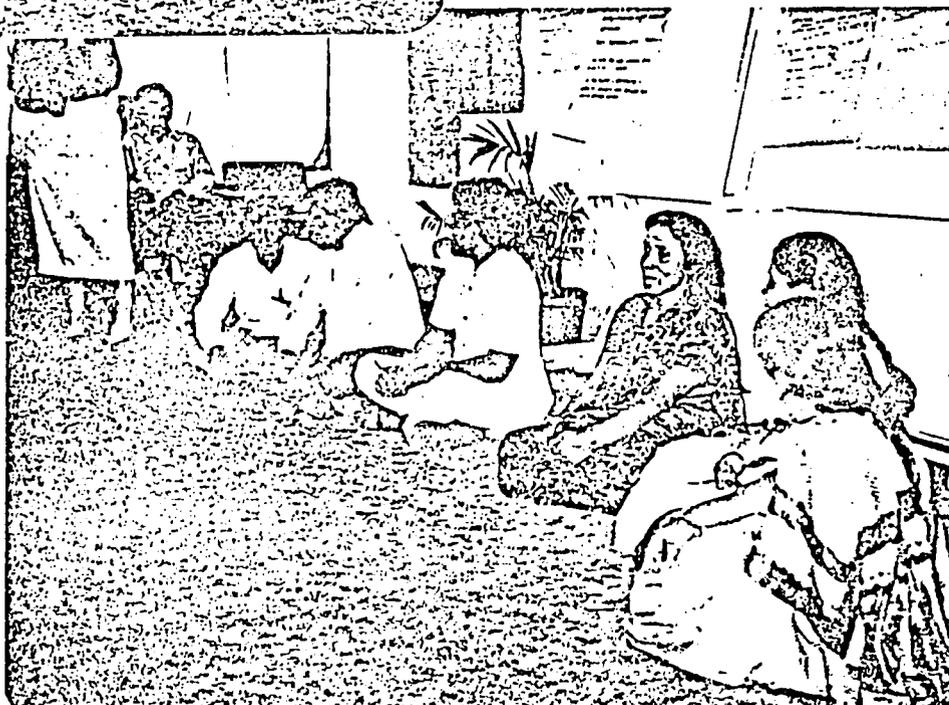
1. Put baby to breast immediately after birth and continue for at least two years.
2. Start weaning food at four to six months.

To mothers about Maternal Nutrition:

1. Eat for two during pregnancy and lactation.
2. Space three years between births.
3. Eat all three types of foods; energy, body building, and protective foods.
4. Take TT vaccine.

To fathers about wife and children:

1. When your wife is pregnant she must eat twice as much.
2. Breast milk is best; encourage breastfeeding at home.
3. Start giving your child supplementary food from the age of four months.
4. Eat three types of food daily.



Communication studies have shown that those in a learning capacity will recall: (Industrial Audio-Visual Association)

- 10% -of what they read
- 20% -of what they hear
- 30% -of what they see
- 50% -of what they see and hear
- 90% -of what they say as they are doing

Role Play - How many messages should be given?

The second role play demonstrated the need to limit the number of health messages given to the recipient in order that the health messages be remembered, and remembered correctly. Scenario: Six workshop participants volunteered to act as a telephone line. Five simple health messages were whispered to the first volunteer one time, these messages were whispered to her neighbor, and so on down the line. The simple health messages were as follows:

"Bu'ld a latrine. Continue feeding your child with diarrhea. Start a kitchen garden. Breastfeed your infant. Come to the immunization clinic next Tuesday."

Evidently, the telephone line was in need of repair. Only one of the original messages was clearly received and some rumors were started, such as, "Someone will come and discuss water and sanitation with you next week."!

As we prioritize health interventions, so must we prioritize the health messages we are passing along to mothers, fathers, and the community. Health behavior is more likely to improve if 2 health messages are understood well than if 8 health messages are misunderstood. While it is nice to know many things, and good to know most things, it is vital to know a few pieces of information with which health can be improved.

#### Health Messages:

In this exercise, three small groups were asked to list their projects' nutrition messages directed at,

- o mothers about children,
- o mothers about maternal nutrition, and
- o fathers about wife and children.

#### Prioritization:

With three categories of nutrition messages displayed on flipcharts, each participant was asked to mark three messages, across all categories, that she/he felt should be given top priority. The workshop group's priority nutrition messages for each category are:

To mothers about children -

## PROCESS CRITIQUE

### IEC: Priority Health Messages

#### General:

Prioritization of interventions, targeting limited resources to high-risk segments of the population, and focussing educational messages on information that is vital are extremely important concepts for effective program management. Through prioritization, the problem of shortages in financial, human, time, and material resources can be tackled. In addition, a level of consistency of health interventions and messages within many independent projects in a country can strengthen the PHC program infrastructure, leading to sustainability. Therefore, the exercise in IEC: Prioritization of Health Messages is important to include in this type of workshop activity.

Perhaps the most important, and unexpected, point made by this exercise is the importance of also targeting fathers when disseminating health messages about maternal and child health.

#### Role Play:

The role play exercises successfully demonstrated the intended messages. The role plays were kept brief, an important strategy since while this kind of activity is entertaining and serves as a good introduction to a workshop session, intense learning does not tend to occur among the observers of a role play.

#### Timing:

This exercise would have been more effective if more time were available. Due to shortness in time, the participant groups seemed rushed when listing health messages. There was no time for each group to present their ideas and no time for clarification of messages.

The result of the prioritization (each participant choosing 3 messages) was interesting; in general, there was agreement on which health messages should be given top priority. Unfortunately, there was no time available to discuss this result, and to consider future implications.

This is an effective exercise whether carried out at the beginning, middle, or end of the workshop week. If this type of session is carried out towards the beginning of the week, the results/conclusions could be used, or built upon, in later sessions.

## SESSION 11

## LESSONS LEARNED

Objective: Synthesize and compile PVO experiences to date in nutritional interventions (approaches and action) and identify implications for broader national policy and future PVO activities in Bangladesh.

Time: Day 5, afternoon, 4:00-5:00 pm

Process: Full group discussion and synthesis

This concluding session was an opportunity to share the various lessons learned with the group. Participants were requested to bring lists of lessons learned to the workshop, however participants choose to provide lists to Dr. Amin during the workshop instead. Dr. Amin compiled the lists, and copies of the full list were distributed during this session. It must be noted that those submitted lessons which were evident or repetitive were combined or omitted and some lessons which were written in Bangla have been translated into English.

The facilitator requested participants from respective organizations to stand and read their lesson out loud when it appeared on the list, as the plenary group reviewed each lesson on the list. Participants could add lessons, however no participant could deduct or revise a lesson without the concurrence of the organization which submitted it. The list of lessons learned as developed by the group follows, incorporating revisions and additions as discussed.



The original list was revised during the workshop session entitled "LESSONS LEARNED". Those lessons which were added are signified by an asterik (\*) and those that were revised with concurrence of the organization are signified by highlighting it's sequential number.

1. Objectives and targets should be well-defined and then target should be fine turned appropriate to the intervention with periodic review and necessary correction. - SCF
2. ARI, as cause of malnutrition is very important, and must be addressed. -SCF
3. Base line survey is essential prior to start a program. - N.M.
4. Target based approach is preferable to community based approach. - CSS.
5. Community leaders should be well-informed about the objectives and targets before and during implementation of the project. - SCF.
6. Not only mothers, but also fathers should be targeted for health education, so that fathers support the mothers to practice aquired knowledge and skill since it is a male dominated society. - ICDDR,B, CSS, N.M., SCF, BRAC
7. Only female health workers are not sufficient enough to educate the male population and a team of health workers from both sex is essential for changing behaviour at the family level. - SCF
- \*8. Regular follow-up, evaluation and fine-tuning of all training and on-the-job competency based on training is essential for nutrition programs. -WV
9. A health information system is vital for identification of future program direction & strategic planning. - SCF
- \*10. An information system containing both health and nutrition information is vital (HNIS). -UNICEF
11. The information not used by the project has no justification to be collected. - SCF
12. Supply of contraceptives from Govt. sectors is frequently irregular, inadequate, which by lowering birth-spacing cause malnutrition. - Ghash-Ful

13. Cooperation from the government side at different levels still seems to be poor. A strong political commitment like EPI is needed for successful nutrition and other health promotion activities through government system with the active assistance from the NGOs. Because, we experienced that nationally committed programs are relatively better implemented by the government workers.  
- BRAC
14. Availability of both preventive and curative facilities is the prerequisite for good nutrition intervention.  
- N.M.
- \*15. In rural areas, there is a tendency to treat patients by symptoms rather than the cause. -ODA
16. It is necessary to identify children with growth faltering and follow up them. - N.M.
17. Growth Monitoring through weighing is a 'doable' thing in Bangladesh and most of socio-cultural constraints in this regard could be overcome over months. - SCF, BRAC
18. Social mobilization on growth monitoring and door to door weighing helps in achieving good coverage. - AKCHP
19. Growth monitoring needs be integrated with provision of treatment and rehabilitation for promotion of growth.  
- SCF, BRAC
20. Integration of Growth Monitoring with satellite clinics and EPI centres has a potential to ensure more participation of mothers as well as a mean to activate the govt. health and family planning workers for service delivery. - BRAC
21. When community feels one is working for it, it involves and participate. - N.M.
22. Orientation of religious leaders elites, village doctors is necessary to get their support. - BRAC
23. Target rosters at the hands of village health workers are essential for good coverage. - SCF
24. High-rate of population shift from and to the urban project areas is a major constraint to achieve good coverage. - Ghash-Ful, WVB
25. In urban slums most mothers are working, which makes follow-up visits to the clinic difficult and irregular.  
- Radda Barnen

26. Provision of only health services can not solve nutritional problems, integrated approach through intersectional collaboration is needed. - Almost every organization.
27. Only income generation activities won't solve poverty the root cause of malnutrition; population growth, social injustice, illiteracy, lack/improper utilization of existing services - all should be addressed to overcome malnutrition. - WV, ICDDR,B
28. Income-generation for woman is very important to combat malnutrition. Mayeder Hate Hate Muldhan Nagadh Taka Hinebe. - CSS
29. In urban slums water sanitation and deworming at regular interval should be included to the child survival program to overcome diarrheal morbidity, one the major cause of malnutritious. - WV
30. Projects, addressing the felt need of the community have greater chance of success and sustainability. - SCF
31. A CS project well integrated into a community involved development program enhance the adoption and sustainability of child protective behaviours. - SCF
- \*32. Active community participation is the principal pre-requisite for mobilizing health volunteers, which are endorsed by respective neighborhood health committees. -WV
33. Implementation of long-term program activities through volunteers is not realistic in Bangladesh rural context, where poverty and under employment is a constant factor. - SCF
- \*34. In the urban slum, working through volunteer women is effective. -ICDDR,B, WV
35. Community health infrastructure development (formation and training of community committees, training of TBAs, formation and training of men's and women's groups, physical facilities) and linkage building with existing govt. facilities is essential for sustainable development. - SCF, BRAC
36. Many Govt. health workers do not feel duty-bound to work. - HKI
- \*37. Health services are the most neglected services in Bangladesh. -HKI

- \*38. Coordination of government mechanisms is very important and essential to implement a program smoothly. -VHSS
- 39. Messages developed by most govt. and non-govt. agencies are not based on scientific method. - HKI
- \*40. If government organizations combine efforts with non-government organizations, it works wonders. -HKI
- 41. There are many health education messages on the same topic, which are different from each other and cause confusion among the population. - HKI
- \*42. Nutrition curriculum is essential for the creation of awareness and knowledge in all education levels. -NNC
- \*43. Illiterate mothers do have very strong opinions and require reasoning when promoting behavioral change. -HKI
- \*44. Flipcharts using photographs from the area are effective nutrition education tools. -AKCHP
- 45. Growth monitoring sessions are effective forum for dissemination of nutrition-education. - BRAC
- 46. Using photographs from the area for printed flipcharts used within the community is an effective nutrition education tool. -BRAC
- 47. The following 7 components are necessary for adoption of a change of behavior or a new behavior :
  - a. Clear, simple, concise message, appropriate for the target group.
  - b. Repeated two way practical demonstration of the expected skill.
  - c. Well-known educator of good personality, capable to earn trust of the target group.
  - d. Mechanism of experience sharing within the target group.
  - e. Reinforcement of the message and skill in time of felt need.
  - f. Availability of some support services within the reach (geographically & financially) of the target population.
  - g. Long term multi-media propaganda on the expected

behaviour.

- SCF

48. Nutrition education should be practical for effective knowledge and skill transfer. - SKS
49. Small group approaches of education is very effective in creating interest among the participants and changing behavior. - BRAC, CSS
50. Repeated discussion in mothers group, ultimately improve their knowledge and practice on specific issues.  
- AKCHP
51. Reinforcement and regular follow-up after nutritional education and rehabilitation is necessary for behavioral change. - ICDDR,B, BRAC
52. For nutritional improvement, general female education needs to be encouraged. - ICDDR,B
53. School children are good disseminators of health messages and skills inside their own families. - BRAC
- \*54. Regular follow-up, evaluation and fine-tuning of all training and on-the-job competency based on training is essential. -WV
55. Although in recent years, rice based ORS has been viewed as "super ORS", it is less accepted by the people than glucose-based ORS. - BRAC
- \*56. Rural women are capable of preparing safe ORS and are able to manage diarrhea if they are trained properly using face-to-face communication methods.  
-BRAC
- \*57. Subsequent follow-up of treated diarrheal patients as well as organizing demonstration meetings with cured patients helps establish the belief in the effectiveness of home-made ORT easily. -BRAC
- \*58. Rice ORS is more effective, better to improve nutritional status and is better accepted by children.  
-ICDDR,B

## Process Critique

1) Greater emphasis needs to be placed on preparation of a list of lessons learned prior to the workshop. Although the preliminary invitation letters requested participants to bring a list of their lessons learned, none were submitted.

2) During the workshop, the list of lessons learned must be clarified. There is some confusion over what "LESSONS" are. Explanation needed:

"Lessons are what has already been LEARNED by organizations during implementation of nutrition programs. It is not what was done (list of activities), but rather what was learned from what was done".

3) Distinguish between recommendations and lessons. A recommendation states what should be done in the future. Documented lessons provide a basis for future recommendations, but are basically a reflection of the past activities.



FINAL SESSION:

REVIEW of WORKSHOP OUTCOMES, OBJECTIVES, and GOALS

WORKSHOP ACHIEVEMENTS: After the lessons learned session, the plenary determined as a group the status of the workshop outcomes, objectives and goals. Dr. Celal Samad assisted the review process by reading out loud the Workshop Outcomes, Objectives, and Goals which were posted on the walls on large newsprint the duration of the workshop. The participants discussed each outcome, objective and goal.

Outcomes:

A) Appropriate and measurable objectives and monitoring indicators for interventions having an impact on the nutritional status of women and children.

(Still in process and will be followed up by Cynthia Carter. Women's nutrition was not discussed in detail).

b) A list of priority interventions and priority target groups in the context of each participant's organizational objectives and limitations.

(This outcome was achieved, however not in context of organization, but in the context of major approaches. Monitoring methods matrix will assist organizations in identifying the appropriate target group).

c) A decision tree to be used by grassroots level workers for growth monitoring and promotion.

(The decision trees produced during the workshop will be adapted to individual's organizations).

d) A list of lessons learned through implementation of different interventions having an impact on nutrition by different PVOs. YES.

e) a list of sustainability recommendations. YES.

f) a list of priority nutritional messages for mothers. YES.

**OBJECTIVES:**

a) To explore nutritional problems of women and children in Bangladesh and their causes, as experienced by workshop participants.

(YES. Accomplished on Day 1)

b) To share PVO experiences in monitoring nutritional and growth status for intervention on an ongoing basis.

(YES. Accomplished on Day 1 and Task Force on Day 5)

c) To share and observe PVO experiences with different approaches and actions/interventions having an impact on the nutritional status of women and children.

(YES. Accomplished on Day 2)

d) On the bases of shared experiences to facilitate the participants in identifying priority nutritional interventions and intervention targets (including "high-risk") in the context of individual projects' objectives and limitations.

(YES. Accomplished on Day 4)

e) To examine PVO accomplishments and constraints in achieving program sustainability through different approaches and to make recommendations.

(Partially on Day 5. Individual accomplishments and constraints were not discussed, rather a broader view)

f) To formulate or refine effective program objectives, measurable methods, and monitoring time table for interventions having an impact on the nutritional status of women and children.

(Not yet completed on Day 4. Follow-up by Cynthia Carter in Baltimore, who will provide comments to all organizations which submitted their objectives for her review).

g) To formulate a decision tree to be used by grass-roots level workers for growth monitoring and promotion.

(Yes, accomplished on Day 5)

h) To inventory IEC nutritional materials which have been found most useful to support family level education, and identify priority nutritional messages for mothers.

(Yes, accomplished by Dr. Amin post-workshop, messages not completely finalized on Day 5).

**GOALS:** All of the workshop goals were reached:

- 1) Compilation of PVO experiences: "lessons learned".
- 2) Skills development:
  - a) measuring methods
  - b) decision tree formulation
  - c) objective writing
- 3) Networking: process begun

#### **CLOSURE:**

A final fish bowl was conducted with two fish: Ms. Anjona Rani Roy, who represents ADRA, a less experienced PVO in nutrition programming, and Dr. Celal Samad, representing ODA, an experienced funding agency which funds several long-term nutrition programs.

Starting with Ms. Anjona, the most important lessons she learned during the workshop was how to identify nutrition need in the community, evaluation and IEC messages. She will apply this to her organization's work through discussions with her Program Director, recommending that nutritional programs are added to the project, as they are still at the planning stage for nutritional interventions. The steps she will take to follow through with this action is to identify the target area and nutritional needs.

Dr. Celal, from ODA, expressed that the most important lesson he learned during the workshop was that MJAC is an effective a screening method, which reaffirmed the new initiative ODA has taken on in developing a new MUAC chart and tape. He will go back to his organization and stress its' importance and usefulness. He will also recommend introducing other methods at their nutrition rehabilitation centers, particularly weight/height for monitoring immediate change in nutritional status.

After the fish bowl was completed, the fishes and facilitator (Donna), moved back their chairs, to merge into the larger circle. In a round robin fashion, participants stated what they will take back to their organization or whatever feelings they have regarding the workshop, affording each participant the opportunity to express herself/himself to the large group for the last time. This exercise also served as a final evaluation of the workshop after 5 full, intensive days.

The responses were remarkable and varied:

- \* great opportunity to meet with other NGO's
- \* most participatory workshop ever attended
- \* enjoyed all the small group discussions
- \* will try to implement Women's Savings Group in urban slum

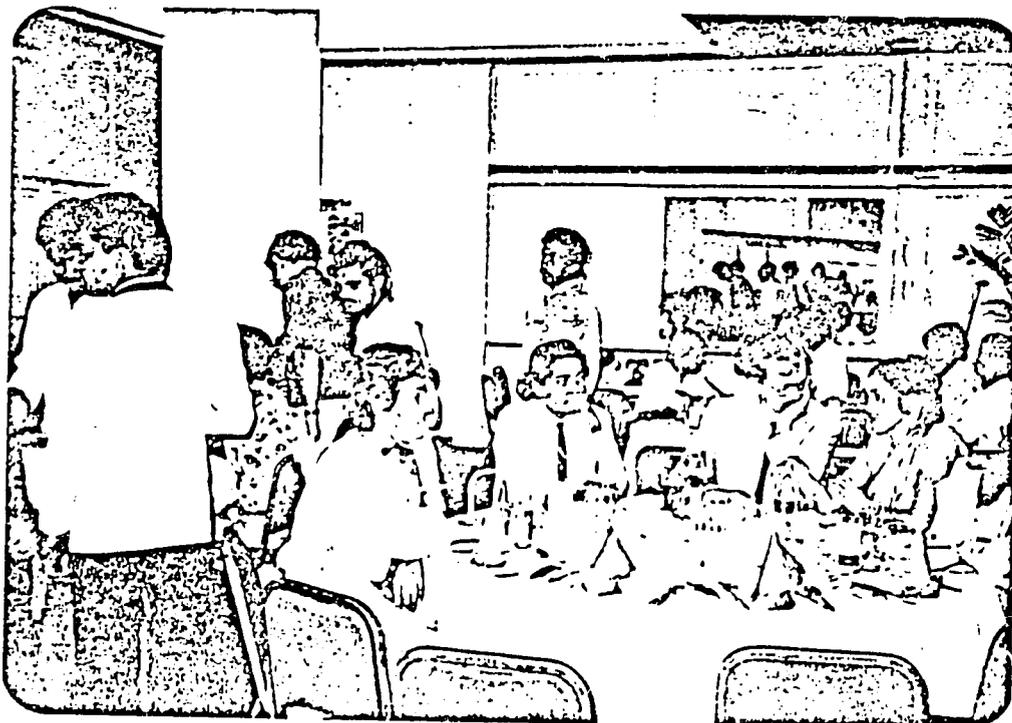
- \* greater knowledge and new experiences
- \* well-organized, organizers worked hard
- \* will make a Decision Tree for field workers
- \* learned a tremendous amount about practical action
- \* the organizers kept the workshop within our reach

Recommendations which were made during this forum included:

- 1) More government participation would be desirable.
- 2) More indepth discussion on maternal nutrition needed.
- 3) Visit other programs for comparison (BRAC, WV, etc...)
- 4) Invite other NGO's: SCF (UK) & SA, etc (were invited!)
- 5) Include session on program planning.

A CLOSING DINNER was held at the Dhaka Sheraton Hotel, which was attended by the directors/managers of participating agencies and the workshop participants.

Ms. Angela Van Rynbach, Director SCF/Bangladesh presented certificates to each of the participants.



## REFLECTION/DAILY EVALUATION

### Purpose:

At the close of each day, each participant completed a Daily Evaluation questionnaire (Appendix 8). The primary purpose of the evaluation was to guide the Organizing Team's decisions regarding workshop design and content for the following day. Though a structured agenda was followed during the workshop, developed using information received from participating agencies, a degree of flexibility in the schedule and training design was maintained in order to adapt the workshop to the changing needs of the participants. For example, the daily evaluations consistently revealed the need for additional time for small group work/discussion. With this in mind, Organizing Team members were able to redesign future sessions allowing less time for formal presentation and more for small group work. A secondary purpose of the evaluation was to allow the participants a short time to silently reflect on the day's activities and how the information presented relates to their program's nutrition activities.

### Process:

Participants completed the evaluation form in 5-12 minutes. The questions were as follows:

1. How valuable was today's session for you? 1 2 3 4 5  
Scale: 1-5 (not very - extremely)
2. What are the most important things you learned today?
3. How do you intend to apply those ideas to your job?
4. What techniques or methods used in today's session contributed most to your learning experience and what techniques or methods hindered your learning?
5. Recommendations:

Immediately following each day's session, the Evaluation Coordinator tabulated and summarized the responses and presented the results to the Organizing Team. Participants' responses were seriously considered and the following day's schedule and process design were adjusted accordingly.

### Summary of Responses: (Detailed List of Responses = Appendix 9)

(1) Overall, each day's numeric ratings were from "good" to "very good". Day 1 numeric ratings were lowest and Day 3 (Ghior field trip) ratings were highest.

(2) Each day, the majority of the participants stated that they learned new information which corresponded with the technical issues discussed. A few participants stated that information presented to them was not new. Often, participant's statements of learning outcomes were unexpected. One participant learned the importance of group discussion for learning. Another

participant's major lesson was learning how others felt about the importance of governmental organization and non-governmental organization cooperation. One participant was pleased to have observed and learned about how to design a participatory workshop.

(3) Most participants plan to take their lesson learned back to their respective organizations to share with their supervisors and counterparts. Many hope to improve/strengthen their programs by adapting and applying new ideas learned at the workshop.

(4) Overall, all the various exercises utilized were considered beneficial to learning. Small group work and large group discussion was most useful to participants. Special mention was also given to fishbowl, role play, and team exercise sessions. Many participants were grateful to be given full opportunity to participate throughout the week. Most participants felt the field visit activity was vital to the workshop experience. Interviewing field staff and conducting discussion groups with beneficiaries greatly enhanced learning. The use of dual languages (Bangla/English) was a hinderance to some participants.

(5) Participants consistently asked that time be watched more carefully and that more time be given for in-depth discussion. Participants asked for more time to formulate solutions to the issues being discussed.

## WORKSHOP FOLLOW-UP ACTION:

I. Continued NETWORKING among the agencies was highly emphasized especially after the beneficial experience of the workshop.

a) Hold a 1-2 day meeting of participants in Dhaka in several months time (August/September/October) to reconvene and discuss action taken to date since the workshop. This may be organized by SCF/Bangladesh if funds are available as per USAID/Washington's recommendation.

b) Discuss setting up a regular "Nutrition Get Together" amongst PVOs implementing nutritional interventions for sharing and various topic presentations (monthly, quarterly, or biannually).

c) Organize a follow-up workshop on MATERNAL Malnutrition is necessary to go one step further behind the major causes of child malnutrition in Bangladesh. One of the agencies perhaps could sponsor a complementary workshop addressing this issue. It requires a special workshop which was beyond the scope of the present workshop.

d) Tap into two important agencies available for agencies for nutritional assistance:

1) VHSS: VHSS is available to assist NGO's to help develop nutritional educational messages or materials. There is also a resource room in VHSS with health education materials for sale.

2) NNC: The National Nutrition Council provides a technical committee to assess nutritional messages. Contact NNC directly to tap this valuable resource.

II. Conduct a 6-month follow-up evaluation of the workshop in November 1990 to inquire if the workshop has affected change in nutritional interventions. (Questionnaires)

**OVERALL WORKSHOP CRITIQUE:**

- 1) A group with widely divergent experiences and skills in nutrition is a challenge to interest during sessions. The coupling of experienced with novice participants during sessions was both beneficial and hindering. The mixture of old and new hands in nutrition left some participants looking for more specific information, while others having to learn rapidly.
- 2) Some participants would have liked to focus in depth on one nutrition intervention. As time limits every workshop, focusing on one issue may be the most effective use of time. For example in this case, a workshop dealing singularly with the topic of maternal nutrition/low birth weight may be an appropriate follow-up workshop.
- 3) Needs assessments should be reviewed by someone from the local culture to deem whether the questions will be understood correctly (field-tested so to speak). The initial needs assessment was not responded to well and a second needs assessment was required to capture the information required.
- 4) Technical resource people perhaps should not be expected to facilitate but rather "facilitators" should facilitate and rely on the technical persons for reference.

## Assignment of Sessions:

SESSIONS	COORDINATOR
=====	=====
Objective A: Review of assessed needs	Donna
Objective B: Monitoring methods of nutrition/growth status	Donna
Objective C: Nutritional interventions	Mohammed
Objective D: Priority interventions and targets	Mohammed
Objective E: Sustainability	Cynthia
Objective F: Objective Formulation	Cynthia
Objective G: Decision Tree Formulation	Mohammed
Objective H: IEC/priority messages on child and maternal nutrition	Cynthia
Goal #1: Lessons Learned	Donna
Field Trip Preparation:	Donna
=====	=====

## NOTE:

Coordinators are responsible for the overall coordination of the session.

Amin will assist coordinators as requested. Coordinators of session may assign resource people.

What is the most important nutritional need in your area? How do you determine the need for multiple interventions? Can you share the results of a baseline survey or physical exam? Have you tried to document existing vitamin A deficiency?

Do you have measurable objectives for the nutrition component of your project? Please list them?

What is the total population served by the impact area? What is the total number of:

0-11 months: \_\_\_\_\_

12-35 months: \_\_\_\_\_

1-59 months: \_\_\_\_\_

women 15-49 years: \_\_\_\_\_

pregnant/lactating women: \_\_\_\_\_

total population of  
impact area: \_\_\_\_\_

What subjects do you need to discuss with other PVO Child Survival project leadership?

What are your personal expectations for the workshop?

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Thank you for completing this workshop needs assessment. Please return to Angela Van Rynbach, Director, Save the Children Federation Office, Dhaka, Bangladesh by March 5, 1990.

**GROWTH PROMOTION WORKSHOP**

Moulvibazar, Bangladesh

May 13-17, 1990

Host: Save the Children Federation/Bangladesh

**WORKSHOP HOUSE ASSIGNMENT:**

Please check the categories that best describes the implementation status of following interventions in your project's nutrition component.

	<u>Not Planned</u>	<u>Experiencing Difficulty</u>	<u>Good Progress</u>
Baseline survey of nutritional status	_____	_____	_____
Survey of foods or food ingredients eaten by	_____	_____	_____
the population at risk	_____	_____	_____
Identification of groups most at risk	_____	_____	_____
Internal Nutritional Status	_____	_____	_____
Micronutrient supplementation	_____	_____	_____
Monitor weight gain in pregnancy	_____	_____	_____
Internal Nutritional Education	_____	_____	_____
Use of colostrum	_____	_____	_____
Exclusive breastfeeding 0-6 months	_____	_____	_____
Initiate weaning 4-6 months	_____	_____	_____
Appropriate weaning foods	_____	_____	_____
Feeding during and after illness	_____	_____	_____
Health Worker/Volunteer Training	_____	_____	_____
School Nutritional Education	_____	_____	_____
Mass Communications	_____	_____	_____
Home Food Production	_____	_____	_____
Growth Monitoring of 0-36 months	_____	_____	_____
Infant Feeding Supplementation	_____	_____	_____
Food supplies	_____	_____	_____
Vitamin A dosing - clinic based	_____	_____	_____
Vitamin A dosing - community based	_____	_____	_____
Nutritional Rehabilitation	_____	_____	_____
t. A high-dose treatment in health facility	_____	_____	_____
Iodination/fortification	_____	_____	_____

From the categories in #1 above, which can you say are success stories?

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WORKSHOP NEEDS ASSESSMENT QUESTIONNAIRE

1. What are the most important nutritional problems in your working area ?

2. Does your project have any interventions having impact on nutrition ?

\_\_\_\_\_ YES \_\_\_\_\_ NO (Please / )  
\_\_\_\_\_

If YES, a) what are the objectives of each intervention?

b) what are the problems of implementation of each intervention ?

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3. Does your project have any nutritional interventions planned to be implemented or under consideration ?

\_\_\_\_\_ YES \_\_\_\_\_ NO (Please / )  
\_\_\_\_\_

IF YES please Name:

4. Does your project have a strategy for sustainability ?

\_\_\_\_\_ YES \_\_\_\_\_ NO (Please / )  
\_\_\_\_\_

IF YES

a) How do you define sustainability ?

b) Please describe your project's strategy for sustainability ?

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5. What issues relating to interventions having an impact on nutrition would you like to discuss with other PVO project staff ?

a) Success issues:

b) Problem issues:

c) Failure issues:

Your Name: \_\_\_\_\_

Your Designation: \_\_\_\_\_

Your Organization: \_\_\_\_\_

Needs Assessment: Nutrition Workshop

Combination of two questionnaires: March 3 & April 3, 1990

I. Nutritional Problems:

Malnutrition: PEM, stunting, wasting  
 lack of nutritional knowledge  
 Poverty; low income  
 lack of food; adequate nutrients.  
 LBW  
 Rehabilitation for malnutrition  
 Diarrhea/malnutrition  
 Maternal malnutrition; also related to frequent pregnancies  
 Vit A deficiency  
 Anemia  
 Inappropriate weaning foods and practices/late introduction  
     of solid foods  
 inadequate sanitation and potable water  
 Food taboos  
 female discrimination  
 Delayed use of colostrum/lack of breastfeeding  
 Intestinal worms

II. Objectives:

not measurable, not time limited  
 Good examples: Aga Khan, World Vision, SCF(USA)

III. Interventions Impacting on Nutrition:

- . At-risk intervention
- Nutritional Rehabilitation Centers
- Urban volunteers
- Vit A distribution and promotion
- Nutrition education
- Training mothers on supplementary & weaning food
- pregnancy monitoring and training
- chart development
- ante-natal care
- family income generating
- income generating projects (job training, etc)
- passive clinic with follow-up nutrition classes
- deworming
- infant feeding practice
- low cost family diet
- break diarrhea/malnutrition interaction
- research projects through NGO's & GO's
- TBA training: pre- and post-natal care
- vegetable gardening
- general women's development
- Women's savings groups

Growth monitoring Management committee: village level  
cadre, govt. health and family planning workers  
Changed attitudes and practices and beliefs  
institutionalization: local community structure: para unit

## VII. Discuss with other PVO's:

### A. Successes:

referral systems (ICDDRDB)  
referral system to other organizations (AK)  
Vegetable seed distribution by volunteers (ICDDRDB)  
ORT House to House (BRAC, CSS)  
House to house weighing for GM (AK)  
Growth monitoring for under 2's & nut. education (IPHN,  
AK, BRAC, CSS, SCF)  
VAC coverage (HKI, ICDDRDB, BRAC, CSS)  
nutritional education; different media (NNC)  
overcoming resistance to weighing (AK)  
Group feeding demonstration (AK)  
home gardening (HKI, ADRA)  
Prepare Nat'l Food and Nutrition Policy (NNC)  
Research projects, workshops, seminars (NNC)  
Nutrition curriculum for medical education (NNC)  
home-based diet for nutrition rehab. (ICDDRDB)  
introduction of semi-solids early age (ICDDRDB)  
health worker training (ICDDRDB)  
appropriate weaning foods (BRAC)  
anti-helminthic therapy & nutrition supplementation (IPHN)  
at-risk identification, weaning foods (SCF)  
crash program of VAC for malnourished children (WV)  
Women's income generation (ADRA)  
Empowering women through savings groups & it's impact on  
nutritional status of children and sex discrimination (SCF)

### B. Problems:

NRC drop-outs  
economic barriers & subsequent income-generating projects  
identification of high-risk  
father's motivation  
birth spacing  
orthodox families  
Muslim religious leaders  
no provision of services for treating/rehab mal.child &  
and pregnant women  
lack of integration; income; employment  
lack of sustainability of growth monitoring programs  
incentives and logistical support  
disparity in KAP & finances of recipients of services  
motivation at every level  
training/motivation of mothers and workers (staff)  
nutrition surveillance

#### IV. Implementation Problems:

lack of community awareness & participation  
lack of community health worker commitment/incentives  
maintaining nutritional status of treated cases  
integration of program: income, female awareness  
educational aspects of families/communication problems with  
target groups  
orthodox resistance  
mothers do not come for regular follow-up  
lack of services to mothers and children  
inadequate space in center  
land problems  
superstitious ideas: weighing children  
absence of mother during home visits  
weighing scale during HV: difficult to carry & hang  
inaequate time for CHW to devote to nutritional education  
apathy of government workers  
lack of supervision: central, district, upazila levels  
indentifying underlying cause of malnutrition  
confounders such as socio-economic status  
targetting affected population  
meeting target time schedule  
sustainability: lack of funds  
high rate of migration (slum dwellers)  
lack of appropriate tools for reporting VAC distribution  
knowledge and understanding about nutrition, but no practice  
beliefs about food during pregnancy

#### V. Programs TO BE implemented:

general nutrition for udner-threes  
Vit A deficiency & treatment, awareness/education  
changing cooking habits  
community-based feeding centers vs clinic based  
training CHW's & mothers in growth monitoring  
field testing/modifying growth chart  
using different media for nutrition  
income generation for mothers with malnourished children  
early breastfeeding promotio.n  
early introduction of solid foods

#### VI. Sustainability: (definition & strategies unclear)

collaboration with government  
human infrastructure: skills transfer for tba's & mothers  
small scale income-generating enterprises  
community involvment/ownership  
cost recovery mechanisms  
adoption of model by other PVO's or institutions of govt.  
Village health committees and mother's clubs  
NHC's supporting CV's

foreign equipment & transportation arrangements  
establishing feeding center with clinical support  
behavioral change not correspond with knowledge/attitude  
practical way of measuring low birth weight

#### C. Failures:

sustained growth after discharged from NCR or poverty  
    stricken families  
activating government health & family planning workers to  
    deliver ante- and post-natal care, as well as  
    growth monitoring from fixed & satellite clinics  
supplies from govt. not sufficient for increased demand

#### D. In General:

nutritional surveillance, rehab & education at:  
    national & community levels  
PVO networking  
PVO/Government coordination  
Nutritional policies  
Nutritional messages  
Integrated approaches  
Supplementation: successes/failures  
urban slum: short/long term approaches  
case-finding and appropriate interventions  
scales & charts: use/availability  
maternal nutrition/lbw  
integrating nutritional surveillance in health programs  
identify research areas for growth promotion

Practical Nutrition Workshop: May 13-17, 1990, Dhaka

Project Profiles:

Organization:	Objectives:	Total population	Good progress:	To Be Implemented(planned):	Sustainability strategies:
1. Age Fair: Community Health Program	<ul style="list-style-type: none"> <li>* 80% of 5 children weighed during home visit</li> <li>* At least 185% mal. U-5's weighed monthly</li> <li>* 60% of mothers should understand the use of chart</li> <li>* Nutrition education</li> <li>* Feeding demonstration to mother of malnourished</li> <li>* at least 65% of women must get health education on colostrum, breastfeeding, and weaning practices</li> <li>* 50% reduction of severely malnourished of U-5's</li> <li>* at least 65% VAC given to U-6's</li> </ul>	<ul style="list-style-type: none"> <li>0-23 months: 3268</li> <li>24-59 months: 4963</li> <li>6-59 months: 6159</li> <li>women 15-49 yrs: 17550</li> <li>pregnant women: 538</li> <li>Total population: 62027</li> </ul>	<ul style="list-style-type: none"> <li>* Door-to-door weighing/growth promotion</li> <li>* referral system to other organization</li> <li>* group feeding demonstration</li> </ul>	<ul style="list-style-type: none"> <li>* A malnourished form has been devised to monitor exact nutritional status of malnourished child</li> </ul>	<ul style="list-style-type: none"> <li>* Community-led programming</li> <li>* active community involvement eg. training CHVs &amp; TBAs so that they catalyze other activities</li> </ul>
2. BRAC	<ul style="list-style-type: none"> <li>* Gained expected weight for age of children 0-2</li> <li>* rates of colostrum feeding increased</li> <li>* increased rate of children in growth monitoring</li> <li>* increased rate of eligible children covered by VAC</li> <li>* level of retention of nutritional education</li> <li>* increased awareness of community about nutrition knowledge</li> <li>* transferable in pre- and post-natal care</li> </ul>	<ul style="list-style-type: none"> <li>0-11 months: 29940</li> <li>1-2 years: 28658</li> <li>3 mos-6 yrs: 163751</li> <li>women 15-45 yrs: 255623</li> <li>Total population: 952610</li> </ul>	<ul style="list-style-type: none"> <li>* fast door-to-door</li> <li>* Growth monitoring U-2's &amp; malnour</li> <li>* VAC coverage</li> <li>* appropriate weaning foods</li> <li>* improvement of nutritional consciousness of community</li> <li>* decrease % high risk &amp; growth faltering</li> </ul>	<ul style="list-style-type: none"> <li>* Community-based feeding center for high risk children</li> <li>* "An Expanded Community Nutrition Initiative: A Planned Limited Experimentation"</li> </ul>	<ul style="list-style-type: none"> <li>* village level nutritional education</li> <li>* Village health committee</li> <li>* Mothers Clubs</li> <li>* GM Management Committee</li> <li>* these committees linked with existing govt. system</li> </ul>
3. ICHS	<ul style="list-style-type: none"> <li>* To treat diarrhea malnutrition malnutrition</li> <li>* To start low cost family diet</li> <li>* To train mother attendants through participatory training</li> <li>* To prevent undernutrition in other cases</li> <li>* To develop a model of a community based malnutrition rehabilitation center</li> <li>* To identify those children at high risk from malnutrition in the village, calculate &amp; considerable, and to enroll these children in the community based malnutrition rehabilitation program thereby improving their nutritional status and decreasing their risk of death</li> <li>* To improve the nutritional status of those children attending the FHC's and to sustain their improved nutritional status through an active growth monitoring follow-up and community education program</li> <li>* To improve the knowledge of mothers of the FHC's regarding concepts of good nutrition and general preventive health messages</li> <li>* To develop and evaluate the effectiveness of a community-based volunteer health system which provides preventive health services to urban slum children under 5 years and their mothers</li> <li>* To decrease the under five mortality and morbidity rates</li> <li>* To augment community awareness to the role of preventive health and child survival interventions</li> <li>* To conduct service-related research and data collection in selective Dhaka slum communities to determine prevalence</li> </ul>	<ul style="list-style-type: none"> <li>0-24 months: 24000</li> <li>0-60 months: 40000</li> <li>15-45 year: 24000</li> <li>Total patients: 68000</li> </ul>	<ul style="list-style-type: none"> <li>* Community referral and follow-up</li> <li>* volunteer delivery system VAC and vegetable seeds</li> </ul>	<ul style="list-style-type: none"> <li>* Preventive health messages focusing on breastfeeding, weaning food practices, cover balanced nutrition &amp; food hygiene</li> <li>* Preventive messages about feeding during illness</li> <li>* Food hygiene demonstration</li> <li>* Recognition of danger signs of severe malnutrition and referral information</li> </ul>	<ul style="list-style-type: none"> <li>* To merge the intervention to the hospital service offered to the target population</li> </ul>
4. ADRA	<ul style="list-style-type: none"> <li>* vegetable gardening</li> <li>* growth monitoring</li> <li>* diarrhea management (GRT)</li> <li>* general women's development</li> </ul>	Data not available	Not mentioned	<ul style="list-style-type: none"> <li>* Village level</li> <li>* Early, frequent feeding</li> <li>* introduction of solid foods</li> <li>* mothers' prenatal and neonatal care</li> </ul>	<ul style="list-style-type: none"> <li>* Project efforts directed towards making activities with the local community, involve the</li> </ul>

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	<ul style="list-style-type: none"> <li>• Educating children, their mothers and grandmothers on the importance of pregnant mothers through "Mother's Health Cards" system, prevention of night blindness of CB children</li> <li>• Free green leafy vegetables of Gochomolir, Cava home gardening, nutrition survey of mothers &amp; children in rural villages, promote home made weaning food, determine nutritional status of newborns, effect of food intake on pregnant women's blood by biological methods</li> </ul>		<ul style="list-style-type: none"> <li>• Dissemination of nutritional knowledge through different media</li> <li>• Publication &amp; documentation of activities on nutrition at the central level</li> <li>• Coordination of nutrition information activities</li> <li>• Implementing research projects</li> <li>• Organized workshop &amp; seminar on nutrition policy</li> <li>• Developed nutrition curriculum for medical education</li> <li>• Revision in the FF TB</li> </ul>	<ul style="list-style-type: none"> <li>• Field testing modified growth chart &amp; manual</li> <li>• Creating advocacy and awareness of nutrition knowledge in village</li> <li>• Dissemination of nutritional knowledge through different media</li> </ul>	<ul style="list-style-type: none"> <li>• National Food and Nutrition Policy</li> <li>• Nutrition promotion through different sectoral agencies</li> <li>• Integration and coordination of all nutrition action programs undertaken by different ministries and NGOs</li> <li>• Effective use of minimal resources to assure maximum benefit to the majority of the target group</li> </ul>
6. Institute of Public Health Nutrition	<ul style="list-style-type: none"> <li>• To create nutritional awareness</li> <li>• To practice proper infant feeding and care of the children</li> <li>• To cure and prevent worm infestation and infectious disease</li> <li>• To improve the nutritional status of the children</li> </ul>	<ul style="list-style-type: none"> <li>0-11 months 254</li> <li>12-35 months 749</li> <li>1-59 months 1414</li> <li>pregnant women 900</li> <li>Total population 7000</li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional knowledge of mothers has been developed to some extent</li> <li>• Children who attend the project have benefited nutritionally</li> </ul>	<ul style="list-style-type: none"> <li>• Community-based nutrition program</li> </ul>	Does not arise
7. World Vision of Bangladesh	<ul style="list-style-type: none"> <li>• Child's weight is raised by 70% of standard weight for age after 4 weeks of nutritional supplement</li> <li>• 95% mothers of these malnourished children are able to prepare balanced diet for their children at the time of discharge</li> <li>• 95% of these mothers are able to prepare and practice OMT at the time of discharge</li> <li>• 95% of under-2 children of this group fully immunized before 1st birthday or within 3 months</li> <li>• 75% of these mothers are motivated to practice birth spacing at the time of discharge</li> <li>• 95% of these mothers in the age group of 15-45 years are immunized against tetanus within 2 months</li> <li>• To provide vitamin A capsule to at least 90% of the registered children under six in the project area</li> </ul>	<ul style="list-style-type: none"> <li>Impact Area A</li> <li>0-11 months 2199</li> <li>12-35 months 4398</li> <li>1-59 months 10248</li> <li>15-49 years 13920</li> <li>pregnant women 1515</li> <li>Total population 64679</li> <li>Impact Area B</li> <li>0-11 months 2587</li> <li>12-35 months 2679</li> <li>1-59 months 13410</li> <li>15-49 years 17698</li> <li>Total population 106000</li> </ul>	<ul style="list-style-type: none"> <li>• Crash program on distribution of vitamin A capsules</li> <li>• A capsules</li> </ul>	<ul style="list-style-type: none"> <li>• Income generation program for the mother of malnourished children</li> </ul>	<ul style="list-style-type: none"> <li>• Utilization of EPI services by the community</li> <li>• Commitment from IHCs and CVs</li> <li>• Free supply and delivery of vaccines by EPI Directorate</li> <li>• Free supply and delivery of VAC by IPHT</li> <li>• Secondment of 5 municipal health workers for 2 training events/year by DMC</li> <li>• Establishment of a fixed health facility in Ward 51 by DMC</li> <li>• Emergence of an urban EPI policy and plan of action for Dhaka</li> <li>• 4 PVO training workshops/year on lessons learned in Child Survival</li> <li>• Establishment of fee-for-service cost recovery mechanism</li> <li>• Small-scale income generating enterprises</li> <li>• IHC supporting CVs after 3 years</li> </ul>
8. CSS	<ul style="list-style-type: none"> <li>• Objective of each intervention is to make family income generating so that parents of children can provide better living, food, and education facilities</li> </ul>	Data not available	<ul style="list-style-type: none"> <li>• Objectives related to immunization, vitamin A, and GRT coverage have been achieved</li> <li>• Health education sessions during community meetings</li> <li>• Attitudes and practices that influence growth of infants and children are changing, the number of children gaining weight is significant</li> </ul>	<ul style="list-style-type: none"> <li>• Change of cooking habits at the end of cow diet 100% families will be covered</li> <li>• Knowledge of vitamin A-rich food 100% families will be covered</li> </ul>	<ul style="list-style-type: none"> <li>• Income generating projects, such as primary societies, agriculture, fishing, netmaking, snail raising, van-rickshaw, etc.</li> <li>• Training on regular basis to help make their jobs profitable</li> </ul>
9. ODA	<ul style="list-style-type: none"> <li>• Rational Rehabilitation Units (RRUs)</li> <li>• Growth chart with MUAC</li> <li>• Adolescent growth chart</li> <li>• Deworming</li> <li>• Vitamin A capsule distribution</li> <li>• Ante-natal care</li> </ul>	Data not available	Not mentioned	Not mentioned	Not mentioned

10. Redde Barmen	<ul style="list-style-type: none"> <li>All children attending clinic are weighed and weights are plotted on their growth charts.</li> <li>Paramedics explain about the nutritional status of children (wt. for age%) to the mothers.</li> <li>Malnourished children and the mothers are referred.</li> </ul>	Data not available	Not mentioned	Not mentioned	Not mentioned
11. HPI	<ul style="list-style-type: none"> <li>Prevent nutritional blindness in 43 refracted children 10-6 years</li> </ul>	<ul style="list-style-type: none"> <li>0-11 months 4 million</li> <li>12-25 months 8 million</li> <li>1-53 months 20 million</li> <li>15-49 years 43 million</li> <li>pregnant women 8 million</li> </ul>	<ul style="list-style-type: none"> <li>Nutrition education</li> <li>Home gardening program</li> </ul>	Not mentioned	<ul style="list-style-type: none"> <li>Programs are implemented in close cooperation of the government and as such helps develop its manpower for future take over</li> </ul>
12. SCF, U.S.A	<ul style="list-style-type: none"> <li>70% of children will be brought under regular weighing program</li> <li>50% of children at risk will be intervened and 50% will improve</li> <li>70% of mothers of under 2 children will be trained in the preparation and use of appropriate supplementary and weaning food</li> <li>75% of children under 6 will be provided with high potency VAC at 6 month intervals</li> <li>100% of pregnant mothers will receive training in nutrition</li> </ul>	<ul style="list-style-type: none"> <li>0-11 months 2200</li> <li>12-35 months 4500</li> <li>1-53 months 9000</li> <li>15-45 years 15000</li> <li>pregnant women 4000</li> <li>Total population 70000</li> </ul>	<ul style="list-style-type: none"> <li>Impact of empowering women through Savings Groups on nutritional status of children and sex discrimination</li> <li>Introduction of chatu as weaning food</li> </ul>	Not mentioned	Not mentioned
13. SCF, U.K	<ul style="list-style-type: none"> <li>BY 1992</li> <li>5 yrs knowledge &amp; adoption of good health practices</li> <li>No severe form of malnutrition among 175 children</li> <li>140 tetraplegia cases</li> <li>85% immunization coverage of the target group</li> <li>65% TT coverage of pregnant &amp; women of child bearing age</li> <li>70% mothers attend antenatal clinic</li> <li>CPR 5.1% among active couples</li> <li>Available and accessible clean water for all</li> </ul>	<ul style="list-style-type: none"> <li>0-24 months 478</li> <li>25-59 months 539</li> <li>1-59 months 1616</li> <li>15-45 years 1616</li> <li>pregnant women 86</li> <li>Total population 5000</li> </ul>	Not mentioned	Not mentioned	Not mentioned
14. Univ. of Dhaka Inst. of Nutrition & Food Science	<ul style="list-style-type: none"> <li>Reduction of percentage prevalence of malnutrition among children under 5 years of age in project areas</li> </ul>	Data not available	Not mentioned	Not mentioned	Not mentioned
15. IHS	Not available	Data not available	Not available	Not available	Not available

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APPENDIX 4

LIST OF PARTICIPANTS IN THE WORKSHOP ON "LESSONS LEARNED IN PRACTICAL NUTRITION: APPROACHES AND ACTION IN BANGLADESH."

(May 13-17, 1990)

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Name	Called	Designation	Organ.	Role	Personal Nutrition	Core Value	Dream
Mohammad Baquer	Baquer	Project Officer	UNICEF	Observer	Rice, egg, fish meat, pulses	Benefit in practice	To serve the disadvantaged people
Dr. Hasib Mahmud	Hasib	Medical Officer	AKCHP	Learn/share experience	Bengali food	Honesty at any cost	To become a community physician
Dr. Atzar Hussain	Atzar	Program Officer Health	SCF	Participant observer	Balanced diet	Sincerity	To be useful to mankind
M. Mandobbar	M. M.	Sen. Project Coordinator	PHI	Participant	Balanced	Spread nutrition education	To emancipate the poorest of the poor
M. Akbarur Rahman	Akbar	Medical Officer	SFS	Participant	Mixed food	Community development	To serve the poor
Tazul Karim	Karim	Research Epidemiologist	BRAC	Listener/share	balanced diet	Benefit in human creation	Significant reduction in MMP & IMF & general improvement in health
Dr. Aminul Islam	Dr. Amin	Public Health Officer	SCF	Member organi- zing team	good	Benefit others	Retire in my native village
Dr. Monuara Begum	Monuara	Medical Officer	BB	Participant	Bengali diet	Honesty	To be a good doctor
Mohamed Manjur	Mohamed	Nutritionist	SCF	Organizer	Spicy food, bread fruit	Sharing in work with people from other countries	To be a poet
Fairhuda Akter	Fairhuda	Nutritionist	PHI	Participant	Balanced low cost diet & fruits	To help poor vulnerable groups	Good future for Bangladesh, grow more food, save the children
Saba Gulla	Saba	Maternal Child Nutritionist	SCF	Learn	Like sweets	Reading books	To retire and flourish in Bangladesh
Dr. Hussain Bhai	Hussain	Program Manager	SSS	Share and learn	Like egg, orange and mango	Research in research	To serve mankind with death
Imdad Ahmed	Imdad	Medical Officer	AKCHP	Participant	Small frequent meals Non-spicy	Love shared is doubled sorrow shared is halved	To draw my role properly, God give me the strength
Iqbal Jahan	Iqbal	Program Officer	SCF	Participant	good	To develop women's status in health & development info	To be a lady executive for the development of society
Sheeraz Haq	Taneer	Freelance consultant	BRAC	Logistics Coord. Facilitator	All organic & natural as possible	Single mindedness & honesty	That my mother and father love me
Dr. Iqbal Anwar	Iqbal	Operations Coordinator	PHI	Participant	Care for less but balanced food	Commitment to work honestly and to service people in the field of PHC	To be a doctor not for the patients but for the people of the community
Amna Carter	Cindy	Technical Support Officer	PHO S.F. JHU	Resource person Educator	Fruit food, don't eat veg eat too much cheese/chocolate	Honesty, hard work, to be happy in work	World peace, human rights for all, food wish for more women leaders
Dr. Rashiduzzaman	Rashid	Project Officer	VHS	Observer/share	conscious but don't always follow	To work for mankind	To survive to work
Dr. Carel Samad	Carel	Program Officer	SDA	Participant	Bread mainly, meat & fish	Family	To improve the condition of the country, especially in the field of health
Dr. Eshaque Ali	Dr. Eshaque	Nutritionist	PHI	Participant	Low-cost balanced diet	To develop the vulnerable groups in Bangladesh in 12 districts	To grow more food to save the country
Dr. Aminul Islam	Amin	Medical Officer	ICDDR,B	Participant	Like vegetables Learn/experience	Self development to serve the poor	To be a good physician
Masud	Masud	Project Manager	AVV	Participant	Balanced foods	Benefit in Aman	Become a great leader of Bangladesh
Anona Paribon	Anona	Development Project Officer	ACRA	Participant	Like vegetables, meat, fish	To serve the poor community	To become a good social worker
Dr. Serma Amin	Dr. Serma	Nutrition Coordinator	ICDDR,B	Learn/assist in nutrition dev.	Expanded diet	To help poor women & children of my country	To make women self-reliant
Donna Sihan	Donna	Health Consultant	SCF	Organizer/ facilitator	Low-fat, no red meat balanced diet	Empower personal & family of man	To develop spiritually for humanity
A. A. R. M. Farouque	Farouque	Medical Officer	PHI	Participant	Rice, fish, vegs, little dairy product	Community spirit	To be a pediatrician
Dr. Rafiqul Haider	Rafiq	Senior Area Manager	BRAC	Participant	Rice & vegetables, non-meat and pulses	Importance of morality for both self & others	Publication of my experience gained in the field of PHC
Dr. Batun Mohan	Batun	Project Officer	SCS	Participant	Like leafy greens	Help poor people	A nutritionist of Bangladesh

WELCOMING ADDRESS

By the Director, Bangladesh Field Office,  
Save the Children (USA)

Workshop on "Lessons Learned in Practical Nutrition:  
Approaches and Action in Bangladesh."

Mr. Taslimen Rahman, joint secretary, Ministry of Health and Family Planning; Mr. Gary Cook, Director, Office of Health and Population , US/AID, Bangladesh; Distinguished guests; Participants and Workshop Organizers, I am pleased to welcome all of you to the inaugural session of the workshop on "Lessons Learned in Practical Nutrition: Approaches and Action in Bangladesh."

We are very honored that Mr. Taslimen Rahman is with us this morning. Your presence and support are, I am sure, an encouragement to us all.

I would like to thank Mr. Gary Cook for US/AID mission support and US/AID - Washington's Bureau for Food for Peace/Office of Private and Voluntary Cooperation for funding support and provision of workshop development assistance through the PVO Child Survival Support Program, The Johns Hopkins University.

The relevance of development activities and interventions having an impact - direct or indirect - on the nutritional status of women and children is clear to all of us. The statistics in Bangladesh show that malnutrition is a very serious problem. According to WHO standards over 70 percent of Bangladeshi children suffer from various degrees of malnutrition. 50 percent of the babies born are under-weight. Malnutrition results from a convergent web of poverty, illiteracy, lack of awareness, inequitable food distribution, diseases, rapid population growth and natural disasters compounded by socio-cultural inequalities.

We are all aware that the government of Bangladesh through the Ministry of Health and Population and various agencies such as the National Nutrition Council, the Institute of Public Health and Nutrition, and the Institute of Food Science and Nutrition, is striving to improve nutritional conditions in this country. Different donors agencies, ICDDR, and national and international NGOs have also contributed to addressing these issues.

Save the Children, recognizing the work being done in this field by so many agencies and the needs still to be met, saw the importance of organizing this workshop. Some of us have success stories to tell, problems to raise or failures to share. We sincerely hope that in this workshop the participants will learn from each other and propose

practical plans of action for nutritional problem areas with financial assistance from US/AID.

The goals of the workshop are to synthesize and compile experiences in nutritional interventions and identify implications for broader national policy and future actions within Bangladesh as well as internationally; to improve staff skills in identifying nutritional problems areas and developing a plan of action; and finally to encourage networking among collaborating agencies. Through a practical visit to the field, plenary sessions and small working group we hope, by the end of the workshop, to have identified priority nutritional interventions and educational messages, to have made an inventory of training materials available and strategized on how to effectively manage nutrition interventions with limited resources all with the aim of improving the health of mothers and children in Bangladesh. In addition, the Lessons Learned in Bangladesh reach beyond its borders and will provide important recommendations to the international public health world.

I wish all of the participants a stimulating and successful workshop which will give all of you a chance to discuss issues and learn from each other in an informal atmosphere.

FIELD TRIP: DAY 3: MAY 15

Purpose:

- a) To assess the impact and coverage of growth monitoring/promotion at the village and family levels and how monitoring, evaluation and supervision takes place at the village level.
- b) To assess integrated development activities as well as integrated health activities which impact on nutrition.
- c) To assess pregnancy monitoring at the village level.

Time: All Day 8:00-5:00pm in Ghior Impact Area, SCF, Bangladesh.

Topic:	Village:	Team Member:	Field Coordinator:
*****			
A. GMP	Jabra	Mansour/Amin	Daniel
B. Integ.	Baniajuri	Cynthia/Lily	Yasmin
C. CS Act.	Tarail-Kakjore	Afzal	Javad
D. Preg. Mn.	Goaldangi	Donna/Tahira	Farida

Each participant will join a group according to interest. The groups will have to be balanced however.

Guided questions have been prepared for each group. A team leader will be selected by each group.

Groups will be divided among the villages and will see different activities. Activity schedules are below for each group. The field visit debriefing will be held in Ghior from 2:30pm-4pm. Departure time from the impact area to Dhaka is 4pm.

Group A. Growth Monitoring & Promotion:

Village: Jabra  
 Field Coordinator: Daniel  
 Team Coordinator: Mohamed Mansour

SCHEDULE OF ACTIVITIES:

- 9:30 Arrive in village
- 10:00 Attend Nutrition Counselling Session at the neighborhood.
- 11:00 Home Visiting
- 12:30 Lunch
- 1:30 Discussion with village staff and field staff
- 2:30 Full group meeting for debriefing
- 4:00 Depart from Dhaka

a) Nutrition Counselling Session:  
Observe nutrition counselling session.

b) Home Visits:  
Randomly select from C and D socio-economic status only:  
(from the records of the field staff)  
6 families of at-risk children  
6 families of well-nourished children

Group divides into three groups. Each group will conduct four home visits (2 well-nourished families and 2 at-risk families). Village staff and field staff will be accompanying the group to conduct home visits.

Below are topic areas to guide your home visits:

- \* perception of their nutrition problems
- \* participation in program
- \* view of program
- \* food availability: family diet (frequency/quantity)
- \* nutrition knowledge & understanding of growth chart
- \* weaning practices/first foods/age of weaning
- \* supplementary food: is it needed?
- \*\* Chatu use: does your child eat it?
- \* follow-up to weighing: what happens?
- \* perception of nutrition counselling sessions
- \* other...

c) Discussions with health workers:

- \* how do identify at-risk
- \* how do you target for supplementary food
- \* how do you decide who needs what (nut. counselling, income generating, treatment, or supplementation)
- \* when do you decide (assess) when a child is risk-free
- \* training/supervision of health workers
- \* nutrition counselling of mothers
- \* follow-up to weighing
- \* referral system
- \* recording system
- \* use of recording
- \* planning weighing sessions
- \* difficulties with actual weighing
- \* program effectiveness in health worker's eyes

GROUP B: Program Integration  
Village: Baniajuri  
Field Coordinator: Yasmin  
Team Coordinator: Cynthia

SCHEDULE OF ACTIVITIES:

9:30 Arrive in impact area/travel to village  
10:00 Meet Field & Village staff  
11:00 Attend Women's Savings Group & conduct  
Focus Group discussion with women

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12:30 Lunch  
1:30 Conduct 12 home visits  
2:30 Full group meeting for debriefing  
4:00 Depart to Dhaka

- a) Discussion with health workers (field staff):
- \* underlying causes of malnutrition
  - \* program interventions which impact on nutrition, outside of nutrition activities
  - \* effectiveness of integrated development
  - \* sustainability concerns
- b) Focus group discussion with Women's Savings Group:
- \* reasons for joining
  - \* changes in their life
  - \* sustainability
  - \* husbands view of their participation
  - \* has the women's nutrition changed? (maternal)
- c) Home Visits
- Randomly select from C and D socio-economic status only:  
(from the records of the field staff)
- 6 families of women in WSGs
  - 6 families of non-WSG participants

Group divides into three groups. Each group will conduct four home visits (2 WSG families and 2 non-WSG families). Village staff and field staff will be accompanying the group to conduct home visits. Discussion guide follows on next page.

Below are topic areas to guide your home visits:

- \* participation in nutrition activities
- \* participation in activities outside of nutrition
- \* perception of their nutrition problems
- \* view of program
- \* food availability: family diet (frequency/quantity)
- \* nutrition knowledge & understanding of growth chart
- \* weaning practices/first foods/age of weaning
- \* supplementary food: is it needed?
- \*\* Chatu use: does your child eat it?
- \* follow-up to weighing: what happens?
- \* perception of nutrition counselling sessions
- \* other

GROUP C: Child Survival Activities  
Village: Tarail-Kakjore (TK)  
Field Coordinator: Javad  
Team Coordinator: Afzal

#### SCHEDULE OF ACTIVITIES:

9:30 Arrive in impact area/travel to village  
10:30 Meet Field(1) & Village staff(4-5)

12:30 Lunch  
1:30 Conduct 12 home visits  
2:30 Full group meeting for debriefing  
4:00 Depart to Dhaka

- a) Discuss with health workers:
- \* describe the family level health education program
  - \* recording and monitoring; data collection/feedback
  - \* major health problems in community (worms, etc...)
- b) Randomly select households for home visits.  
Divide group and conduct home visits focussing on:
- \* major health problems
  - \* home health records and mother's understanding
  - \* participation in program and view
  - \* ORT knowledge and use; relationship with malnutrition
  - \* Immunization knowledge and use
  - \* Family planning knowledge and use
  - \* Nutrition knowledge in general
  - \* Knowledge of Vit A Capsules, why did you take it?
  - \* GMP awareness in general

GROUP D: Pregnancy Monitoring  
Village: Goaldangi  
Field Coordinator: Farida  
Team Coordinator: Donna/Tahira

SCHEDULE OF ACTIVITIES:

9:30 Arrive in impact area/travel to village  
Meet with MCH-PC  
10:00 Talk with women coming to Pregnancy Class  
Observe pregnancy monitoring class  
11:30 Meet with TBA's  
12:30 Lunch  
1:30 Conduct 12 home visits  
2:30 Full group meeting for debriefing  
4:00 Depart to Dhaka

- a) Discuss with MCH Program Coordinator:
- \* how do you detect pregnancies?
  - \* major problems with pregnancy
  - \* pregnancy monitoring: forms, PMIS, new chart
  - \* tba training
  - \* is there a pregnancy protocol?
- b) Before class discuss with pregnant women:
- \* reason for coming
  - \* understanding of class/expectation
  - \* eating habits, need for supplementation
  - \* plan for delivery
- c) Attend pregnancy class. Observe.

d) Meet with TBAs:

- \* nutrition knowledge during pregnancy
- \* nutrition knowledge during lactation
- \* what is given to the newborn
- \* what is done with colostrum
- \* what tools/techniques do you use?  
(ie. sterilized blades, etc..)
- \* birth spacing knowledge

e) Select households for home visits:

- 6 women who have recently delivered
- 6 women who will deliver

Divide group and conduct home visits focussing on:

- \* maternal health knowledge
- \* nutrition during pregnancy
- \* parity/ previous pregnancies
- \* birth spacing knowledge/practice

DAILY EVALUATION SHEET

Date: \_\_\_\_\_

1) How VALUABLE was today's session for you? 1 2 3 4 5  
Scale: 1-5 (not very-extremely)  
Comment:

2) What are the most important things you LEARNED today?

3) How do you intend to APPLY those ideas to your job?

4) What techniques or methods used in today's session contributed most to your learning experience AND what techniques or methods hindered your learning?

5) RECOMMENDATIONS:

Appendix 9

DAILY EVALUATION RESPONSES

(1) How valuable was today's session for you? 1 2 3 4 5  
Scale: 1-5 (not very - extremely)

DAY 1: 23 evaluations received

DAY 2: 22 evaluations received

Score % Responses

Score % Responses

5 18%  
4 0%  
3 64%  
2 18%  
1 0%

5 11%  
4 33%  
3 50%  
2 6%  
1 0%

DAY 3: 18 evaluations received

DAY 4: 17 evaluations received

Score % Responses

Score: % Responses

5 23.5%  
4 53%  
3 23.5%  
2 0%  
1 0%

5 6%  
4 23.5%  
3 64.5%  
2 6%  
1 0%

(2) What are the most important things you learned today?

DAY 1:

- different methods to measure nutritional status for screening and monitoring purposes
- importance of group discussion for broadening knowledge
- new information regarding MUAC

DAY 2:

- clinic-based integrated development approach
- identification of priority interventions
- in order to address sustainability, health should be integrated with other development activities
- realized that there are nutrition problems that my GMP program does not address
- poverty is the major cause of malnutrition
- learned how to prioritize
- community should identify needed interventions
- nutritional status of Bangladesh (UNICEF presentation)
- nothing

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DAY 3: (Ghior field trip)

- strengthens and constraints of SCF/Bangladesh program
- participation by and feed back to the community is important
- intricacies of SCF/Bangladesh recording system
- sustainability needs to be emphasized through community organization

DAY 4:

- how to plan a project through problem identification, objective setting, and determining methods to measure objectives
- carrying out an accurate baseline survey is important before starting a project
- objective writing
- priority interventions
- my feeling about the importance of collaboration between NGOs and GOs is shared by others

(3) How do you intend to apply those ideas to your job?

DAY 1:

- consider new ideas when carrying out project planning
- disseminate information to project staff
- will try to initiate mutual cooperation in times of need
- talk with supervisor about improving project

DAY 2:

- will discuss improving my project with my organization's colleagues
- will implement priority interventions
- will talk to my impact area's community leaders
- will carefully evaluate our program
- will begin health/nutrition education
- will emphasize nutrition component

DAY 3:

- share information with my organization's staff
- start women's savings group
- introduce chatu in my project

DAY 4:

- discuss new ideas with project director
- apply principles of management y objectives during project development
- write a proposal and apply for funds
- rewrite my project's objectives
- try to identify the priority problems of my target group

(4) What techniques or methods use in today's session contributed most to your learning experience and what techniques or methods hindered our learning?

DAY 1:

Contributed = -introductions exercise  
-brainstorming  
-small group work  
-large group discussion  
-fishbowl  
-visuals/posters  
Hindered = -fishbowl

DAY 2:

Contributed = -small group work  
-large group feedback  
-open discussion  
-fishbowl  
-role play  
-formal presentation (UNICEF)  
Hindered = -use of two languages

DAY 3:(field trip)

Contributed = -talking with direct beneficiaries  
-talking with field staff  
-focus group discussion (women's savings group)  
Hindered = -rain/mud!! - otherwise a very useful exercise

DAY 4:

Contributed = -open discussion  
-WAWA  
-brainstorming  
-hypothetical project exercise  
-small group discussion  
Hindered = -none

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