Bangladesh: Mother and Child Health Project

Project Report 2010

1. General data

Country, project location	Bangladesh, Bandarban, Chittagong Hill Tracts (CHT)
Description of project	To improve the health of women and children in Thanchi Sadar Union, Thanchi Upazilla, Bandarban, Chittagong Hill Tracts
Expenditure 2010 (in CHF)	
Length of the project phase	July 2008 – December 2010
Main partners of the project	Humanitarian Foundation (HF)

2. Summary

In July 2008, Terre des hommes Foundation (Tdh) launched a new project on Mother and Child Health (MCH) in the Bandarban District of the Chittagong Hill Tracts (CHT) in the South-East of Bangladesh. The project (2008-2010) was developed in collaboration with its implementing partner, Humanitarian Foundation (HF), a local Non-Governmental Organization (NGO) which was founded in 1999. This was the first time that Tdh was working in the Chittagong Hill Tracts. This is a final report on the project's work done from July 2008 to December 2010. The objective of the project was *"to improve the health of women and children in Tdh's working area"*.

Tdh brought a wealth of experience from its history in Bangladesh to support Humanitarian Foundation as they developed their expertise in health. In return, Humanitarian Foundation contributed considerable local knowledge and good contacts with the Upazilla, which supported the smooth implementation of the project.

It should be noted that before Tdh had launched its operations, local people[1] had virtually no access to health services. In this respect, it is fair to say that the project has come a long way. More than 7'200 mothers and children benefitted from treatment and medication from Tdh's health clinics. As regards WATSAN coverage, the provision of hygienic latrines and safe drinking water was achieved in 2010 in three targeted model villages, instead of five, after budget consideration and feasibility in terms of time.

The importance of this project is self-explaining in a context where the public health system is severely lacking; in particular: a comprehensive approach to Mother and Child Health (MCH). This holds especially true for the CHT: the implementation of the Tribal Health Plan is slow, there are few actors working in the area, and most of them lack focus on prevention. Therefore, Tdh's holistic project approach combining preventive with curative services and small-scale advocacy, was deemed appropriate.

[1] The Chittagong Hill Tracts are less densely populated that the rest of Bangladesh, more isolated, and home to a more diverse population. It hosts refugees from Myanmar, the borders being home to same tribal groups and cultures.

3. Follow-up of the situation and context

The CHT districts are post conflict areas that have been disadvantaged and isolated in the past decades. These districts were ravaged by over 25 years of civil unrest, which officially ended in 1997 with the signing of the Peace Accord. One of the elements of the Peace Accord was to recognize the rights of indigenous communities to land and other sovereign issues, which have yet to be fully realized and remain a source of tension. The signing of the Peace Accord led to a division in the indigenous movement in the CHT and to date, the Peace Accord remains largely unimplemented. The results of the national elections held in December 2008 ushered in a new government on January 6, 2009. The political situation has somewhat calmed down since these parliamentary elections, despite underlying tensions.

The new government declared its intention to "revitalize" its previously introduced concept of community clinics. Between 1996 and 2001, when the current government was in place, a total of 18,000 community clinics were established at union level throughout the country with the exception of the project's target areas. The initiative that called for one clinic per 6,000 people has not reached the CHT districts. Local (Upazilla) officials elected in 2008 failed to bring any help to the people. The status of the Upazilla Health Complex has remained the same, i.e. Upazilla services are fully withdrawn and the local population is completely deprived of their right to health.

Thanchi's overall maternal health situation was severely hampered in several respects. Indeed, the access to health services is very weak. The 35-bed Upazilla Health Complex is well equipped, but unused. Maternal health is completely dependent on traditional sources: Traditional Birth Attendants (TBAs) and quack doctors. The Maternal Mortality Rate (MMR) is very high at 18.35 per 1,000. Women experiencing complications during pregnancy and childbirth die due to the lack of transportation to reach the appropriate health facility or the lack of available health care staff/services at the health facility. Birth registration for children has been initiated in the CHT but is far from universal and remains an issue to be addressed.

With regard to the food security situation in the CHT, the local people's economy is mainly dependent on Jhum cultivation[2], and their self-sufficiency explains why the food crisis had less impact compared to other parts in the country. Moreover, during the project period, some new actors started activities in Thanchi Upazilla; Non Governmental Organisations (NGOs) and the United Nations preventively addressed the food crisis in this area through livelihood support programmes and food assistance.

Concerning the public health situation, however, large parts of the local population remain deprived in the Thanchi Upazilla. The same holds true for Thanchi Union, our target area. The fact that UNDP's health initiative on Community Health Workers (CHWs) and satellite clinics, which was planned to begin during the last quarter of 2008 in Thanchi, has been delayed and started in 2009, only adds to this problem.

[2] Jhum cultivation is a local name for Slash and burn agriculture practiced by the tribal groups in the north-eastern states of India and also in districts of Bangladesh like CHT and Sylhet. This system involves clearing of a piece of land by setting fire or clear felling and using the area for growing crops of agricultural importance such as upland rice, vegetables or fruits. After a few cycles, the land loses fertility and a new area is chosen.

4. Realisation of the project according to plan

This chapter outlines the project's objective and strategy, and main results achieved from 2008-2010. It also outlines the challenges faced, the lessons learnt and actions taken.

4.1 Objective and strategy

The objective (outcome level) of our work was *"to improve the health of women and children in Thanchi Union in the Chittagong Hill Tracts"*. To reach this objective, we have set four expected results,

1. Timely and effective treatment of presenting health problems in Tdh's health clinic,
2. Improved child nutrition and health,
3. Improved reproductive health of women, and
4. WATSAN coverage in three villages within Tdh's working area.

The expertise of our team in Kurigram could be effectively used in conducting Participatory Rural Appraisals (PRA) and a base line survey as part of our preparation work.

Tdh in Bangladesh has implemented this project based on its long and wide range of experience in the country. The intervention logic of the project represented to a large degree a replication of the intervention logic of Kurigram's MCH/N project, as it proved to be relevant and effective; the main differences being a mountainous location, tribal ethnicities and cultures (preference for traditional healing), and a more strained political environment which was new to Tdh. In this regard, Tdh local partner, Humanitarian Foundation, was instrumental in the smooth implementation of the project. They are indeed well-known by the local authorities and communities and they know well the area. Tdh experience and expertise could benefit Humanitarian Foundation as they develop their expertise in health, Tdh investing considerably in the capacity building of our partner organization.

The project strategy was informed by Bangladesh's Poverty Reduction Strategy Paper (PRSP 2005-2008) and the Tribal Health Plan (2005 – 2010). It also reflected Tdh's health and WASH policies. Accordingly, project activities have taken place both at facility and community levels and are based on three cross-cutting and complementing approaches:

- Community health and nutrition education coupled with hygiene promotion (prevention);
- Advocacy by securing the positive support of formal and informal power structures within the community;
- Curative services.

However, our 2009 review of the project strategy's led to the removal of the adolescent health component in favor of an increased focus on maternal health, due to the failure of the public health system, especially at Upazilla and Union levels, and the urgent need to improve maternal health in the CHT. As regards the WATSAN component, several indicators at objective and expected results levels were adjusted by reducing the number of model villages from five to three.

4.2 Principal results achieved

Before Tdh launched its work in Thanchi Union, local people had virtually no access to basic health services whatsoever. Most were living under dire health conditions. Therefore, the project has come a long way in view of its main objective with emphasis, albeit time consuming, on community involvement.

Targeting 2'005 families of 54 villages of Thanchi Union, the project delivered the following results:

Curative health services were provided to 7'274 individual mothers and children from Tdh's clinics. Among these patients, a total of 1,274 (17.5%) were children. Nutritional screening and growth monitoring were unprecedented activities among the population. The growth of children aged 2 to 5 years were monitored biannually and children under 2 years were followed quarterly (as nutrition was not a serious problem in this target area). The fact that the curative services provided to these patients have supported healthier living can be considered one of the project achievements. With regard to referral services, although the number of patients referred to appropriate institutions was gradually increasing, performance could still be improved. Indeed, with an ambulance, the referrals system could be enhanced in order for the patients to reach the appropriate health facility in a timely fashion, The hurdles faced by the population are substantial, ranging from extreme geographical isolation to financial constraints and lacking awareness on the part of communities. Only long term and in-depth health awareness raising, combined with additional monetary investment in staff and target groups (by co-financing the costs related to any referral from such remote areas), could possibly counter-balance the aforementioned hurdles.

As regards **child health**, main results delivered from 2008 to 2010 include reduced levels of neonatal, infant and child mortality and low birth weight. During our project duration, 34 children (8 in 2009 and 26 in 2010) with Acute Respiratory Infections (ARI) were detected by our workers and 29 of them (85%) were treated in Tdh's clinics. In terms of reduction in neonatal deaths, Tdh registered an important reduction from 18.35/1'000 at the time of the baseline to 4.3/1'000 in 2010. Immunization amongst children was completely absent in our remote working areas. Our project has extended immunization to remote communities in collaboration with the government (Expanded Programme of Immunization Department - EPI). Along with the EPI, all the eligible children (410 eligible cases) of our working areas were immunized during the project duration. Exclusive breast feeding was a challenge in this area mainly due to the traditional values of the communities. The rate of exclusive breastfeeding is a big concern, indicated by the fact that only 1.70% children under 6 months of age were exclusively breast-fed in 2009. The trend has strongly increased to 18.70% in 2010. Out of 394 new born babies, 378 (96%) were fed colostrums: a great success with a baseline of nil. Complementary feeding increased too, reaching 49% in 2010.

The project brought a positive impact on **maternal health**. Maternal death has been reduced remarkably from 18.35 to 1.36 per 1'000 (out of 2'202 enrolled eligible mothers). 174 of 591 high risk/complicated pregnant women were identified and monitored. Of these, 82 were referred to Tdh clinics for better care and amongst them 26 visited Bandarban district hospital during pregnancy and 10 for emergency and safe delivery. As part of increased awareness on maternal health issues, and upon request from the community, 32 local TBAs were trained and equipped with basic tools. Skills development of the TBAs consequently reduced the maternal health hazards. 400 deliveries occurred, out of which 50% took place at home assisted by a skilled TBA, which is a very positive trend.

During our Baseline Survey, the PRA exercise revealed that the issue of safe drinking water was one of the main challenges in the working area. **WASH** coverage within Tdh's working area had to be re-adjusted. Initially planned for five model villages, hygienic latrines and safe drinking water were finally delivered in three model villages due to budgetary, environmental, technical and time constraints: the challenging topological terrain required higher transportation costs, additional time and technical resources than available at the time of planning. Indeed, CHT are

not just challenging during monsoon, as most other parts in Bangladesh are. The slightest rainfall renders villages inaccessible. Accordingly, construction work have been postponed and realized in 2010 in three model villages.

In regard to access to potable water, Tdh installed a Ring Well in one village and built two Gravity Flow Systems (GFS) in the other villages. 100% of the population achieved access to safe water per subsequent testing. During the project duration, 102 latrines were constructed (low cost) which reached to 100% households of the three model villages. Intensive awareness sessions were imparted to ensure proper and safe use of latrines, including hand washing with soap after defecation. Children were especially targeted. In December 2010, we conducted a KAP (Knowledge, Attitude and Practice) assessment in all three of our model villages. The findings reveal that 100% of the households uses hygienic latrines, and wash hands with soap after defecation.

4.3 Challenges and obstacles, with corrective measures taken

One of the main challenges of this project was the **geographical location** and its remoteness. All our satellite clinics were located in the remotest areas, where no other actors were present. Even if during the project duration, we observed that some new actors (UNDP and other NGOs) initiated health activities in CHT, none reached such remote areas.

As Tdh aimed to promote as much as possible maternal and neo-natal health, **the logical framework was adjusted** in 2009 by removing components on adolescent health and increasing focus on maternal health. In addition, we added emphasis on building the capacity of Community Health Workers (CHWs), Health Development Committees (HDCs) and Traditional Birth Attendant (TBAs). As regards CHWs and HDCs, training on Primary Health Care and Sexual Reproductive Health was provided, thereby increasing their effectiveness in terms of house visits to and counseling of pre and post-natal mothers, and conduction of awareness raising sessions with post natal mothers within 24 hours of delivery. Regarding TBAs, a curriculumhas been developed and TBAs trained accordingly from January 2010 on.

The traditional beliefs sometimes hindered our interventions, notably in terms of maternal health, exclusive breast feeding, or referral of complicated pregnancies. Trained local TBAs as well as HDCs were valuable support in advocating for safe and healthy practices as they are respected figures within the communities. Significant improvements could therefore be observed during the project period.

The frequent staff turnover was also another challenge which was due to the remoteness of the area of intervention and slightly hampered the project. But our partner HF had taken quick action as and when needed.

5. Prospects

As explained in the annual report of 2009, Tdh has re-considered its country strategy. In order to avoid geographical dispersion of our intervention areas, it was decided to stop our activities in Chittagong Hill Tracts. An evaluation of the Chittagong Hill Tracts project will be carried out in 2011. During phasing out, we endeavored to find an organization willing and able to take over the management responsibility and funding of the project. Unfortunately, no donor could be secured at the time of writing this report. HF has submitted a project proposal to Anesvad

Foundation[3], based in Spain, and currently awaits an answer to carry on the project on the long run.

Most community activities continue thanks to the commitment of HF and its field teams. The Health Development Committees (HDCs) are very proactive. At the end of 2010, they had started to systematically referring high risk pregnancies, deliveries etc., Considering the needs of the community, HF has decided to maintain their existing medical team in the static clinic (six days per week). This includes a laboratory technician, a medical assistant and a health education worker. Two other HF medical assistants will provide health care services in four of five satellite clinics. Moreover, the thirty two TBAs who received training from the project are skilled to conduct safer deliveries and empowered to deliver health and hygiene messages through their continuous work with the communities.

Tdh trained nine HDC members (three from each Model Village) on repairing of GFS and Ring Wells. They are confident and willing to do their own repair works if needed. The necessary costs should be borne by the community equally. However, as HF has other projects in these areas, contact will be maintained and follow up with the HDC to ensure effective use and management of the water systems established in these villages will be carried out.

HF has received 15 trainings in support to their institutional development. The trainings covered topics like Project Cycle Management, Monitoring & Evaluation and Child Protection. In collaboration with Tdh, HF has developed its Child Protection Policy and a Code of Conduct for their staff members. Tdh also supported HF in finding a new donor for its children's education programme. Tdh is confident that HF has the technical knowledge and skills as well as the capacity to carry on its valuable support in terms of mother and child health to the target communities.

[3] Anesvad works to promote and protect health as a Fundamental Right but also encourages social change to tackle the structural causes of poverty, inequality and social exclusion.