MATERNAL-NEONATAL HEALTH CARE AND FAMILY PLANNING (MAMOTA) PROJECT

Save the Children

End Line Evaluation Report

Bangladesh

December 2020 | BGD2012

End Line Evaluation of Mamota Project Bangladesh

December 2020 | BGD2012

Prepared for

Save the Children

Research Team

Primary authors
Dr. Shimul Koli Hossain, Innovision Consulting Private Limited
Ahmed S. Ishtiaque, Innovision Consulting Private Limited

Published by

INNOVISION
Research | Technical Assistance | Project Management

Innovision Consulting Private Limited
Level 3 & 4, House 26, Pragati Sharani, Block J,
Baridhara, Dhaka – 1212

Email: info@innovision-bd.com
Website: http://innovision-bd.com

December 2020

ACKNOWLEDGEMENTS

Innovision Consulting expresses gratitude to Save the Children, for awarding this assignment and for trusting on the capacity to undertake this Endline Evaluation with the purpose to measure the performance against a set of indicators and the impact of the project interventions on health service facilities in providing Maternal, Neonatal Health and Family Planning (MNH-FP) services.

We specially thank the Monitoring, Evaluation, Accountability & Learning (MEAL) Team of Save the Children for their technical direction on designing the methodology and for coordination and management support. We acknowledge the contribution for technical backstopping on designing the tools and for continuous backstopping support during training and data collection.

We express our gratitude to the FIVDB Team for extending cooperation to the survey team during data collection. This support made our task easy and efficient.

We thank the Upazila and Union health facilities, respective Department of Family Planning and Local Government representatives of Sylhet district for sharing technical and strategic information on the status of health and family planning services in the project area.

We would like to thank the Divisional Director, Family Planning, Sylhet, Director (MCH Services) of DGFP and all other officers of the Family Planning Directorate and Sylhet district for sharing their valuable insights into the findings of the study.

We finally acknowledge the wholehearted support rendered by the respondents from Mamota working areas, key-informants and other respondents despite restrictions in this Covid-19 pandemic situation. Without their time and cooperation, the survey would not be complete and evidential. Their contribution helped us to undertake an informative and rigorous study, which we believe will help Save the Children and the consortium in its future endeavours through the Mamota project in Sylhet district in Bangladesh.

PROJECT SUMMARY

Title	Maternal-Neonatal Health Care and Family Planning (Mamota)Project
Date of report	December, 2020
Type of report	Project End line Evaluation
Author	Dr. Shimul Koli Hossain, Innovision Consulting Private Limited Ahmed S. Ishtiaque, Innovision Consulting Private Limited
Email	info@innovision-bd.com
Name of the project	End Line Evaluation Report on Maternal-Neonatal Health Care and Family Planning (Mamota)Project
Project Start and End dates	Phase 2: 2015-2017 Phase 3: January 2018 to December 2020
Project duration	Six years (Phase 2: Three years, Phase 3: Three years)
Project locations:	Sylhet District, Bangladesh Phase 2: Companiganj, Gowainghat, Jaintapur Phase 3: Companiganj, Gowinghat, (SCANU), Balaganj, Golapganj
Thematic areas	Health and Nutrition
Sub themes	Maternal, Neonatal, and Reproductive Health, Maternal, Infant and Young Child Nutrition, Child Health
Total budget	-
Donor	KOICA and Save the Children Korea
Estimated beneficiaries	
Goal (Overall objective of the project)	Improved utilization of MNH-FP services to reduce maternal and new-born mortality rate in underserved communities of Sylhet.

	Companigonj	Gowainghat	Jaintiapur	Balaganj	Golabganj	Total
Pregnant women	4,834	8,271	0	3,418	9,404	25,927
Children under 1 month	4,334	7,415	0	3,065	8,432	23,246
Sick Newborn	NA	NA	860	NA	NA	860
Married WRA (15-49 years of age)	26,670	45,633	0	18,859	51,887	143,049
Total	35,838	61,319	860	25,342	69,723	193,082

EXECUTIVE SUMMARY

The end line evaluation of the second and third phases of the Mamota project was conducted to assess the effectiveness, impact, relevance and sustainability of the Maternal, Neonatal Health-Family Planning (MNH-FP) services provided, to evaluate the supporting mechanisms of local government institutions, such as Union Parishads, assess the capacity of the service providers to deliver quality services and to investigate the health-seeking behaviours of the community. The second phase (2015-2017) of Mamota intervention was implemented in Companiganj, Gowainghat and Jaintapur Upazila of Sylhet, whereas the third phase (2018-2020) consisted of handover of activities in Companiganj and Gowainghat upazilas (2018-2019) and intervention in Balaganj and Golapganj upazilas (2018-2020).

Both quantitative and qualitative method were used to conduct the end line evaluation. The quantitative survey was supported with qualitative FGDs, IDIs, checklists and case Studies. The groups that were selected for the survey included (1) women who have given birth within the last 2 years of the study (observing their health-seeking behaviour and the MNH care they received during their last pregnancy, childbirth & postnatal period); (2) women of reproductive age (15-49 years) who were not pregnant at the time of the survey and did not give birth within last 2 years (observing their usage of contraceptives & their knowledge of family planning methods). Moreover, eleven randomly selected UH&FWCs and two UHCs were studied to examine the changes in infrastructural support and improvements on the supply side.

Groups Selected for the Study

women who had given births in the last 2 years of the study

women age (15-49) who were not pregnant at the time of the survey and did not give birth in last 2 years

Respondents between 18 - 28 years of age

69.5%
MNH group

35.7%
FP Group

Monthly household expenditure below 10,000 BDT

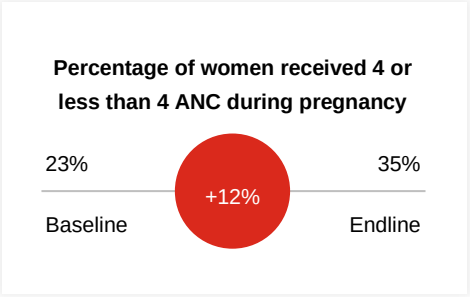
51.2%
MNH group

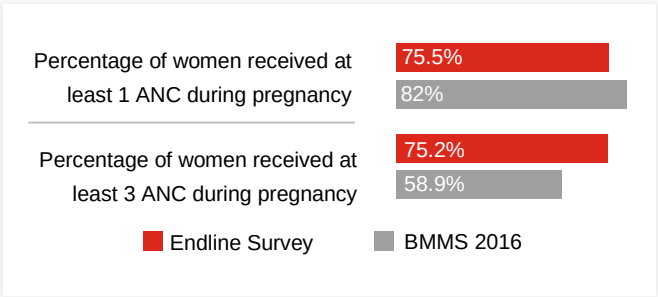
55.1%
FP Group

Study findings suggest that about two-thirds (69.5%) of the respondents of the MNH group and more than one-third (35.7%) of the FP group were between 18 to 28 years of age. The level of education was at the primary level for about two-thirds (65.6%) of the MNH group and more than half (56.2%) of the FP group. The education level of their husbands was found to be (15.0% in the MNH group

and 26.4% in the FP group) even lower. The overall household monthly expenditure was found to be below BDT 10,000 for more than half the respondents in both groups (51.2% in the MNH group and 55.1% in the FP group). On a positive note, it was also found that about two-thirds of the households in both groups (65.3% in MNH group and 63.2% in FP group) had access to a health centres within one kilometre.

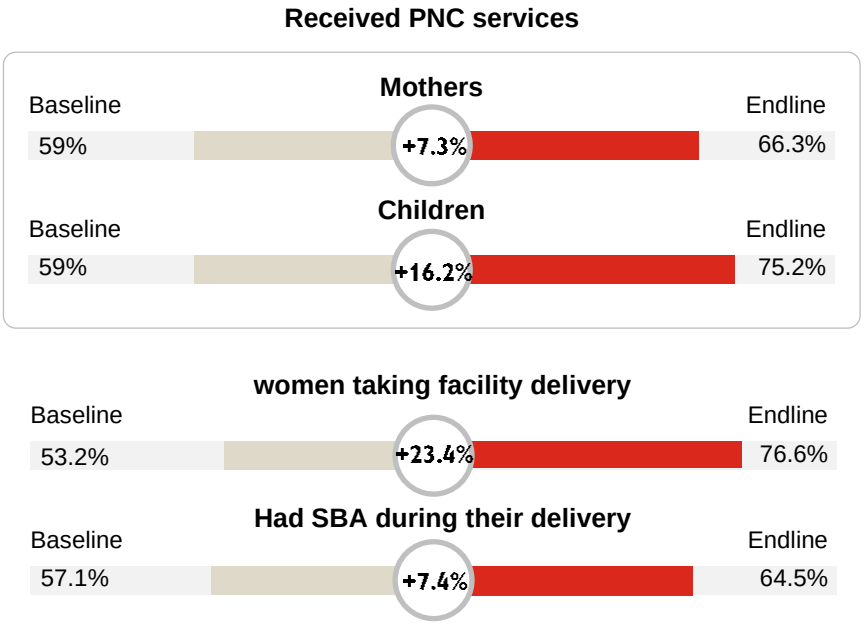
The percentage of women receiving antenatal care at least once during pregnancy by medically trained providers is estimated at 75.5%, which is very close to the national reference value (81.9% according to the BDHS 2017-2018). The percentage of women receiving ANC for four times or more during pregnancy by medically trained providers was found to be 35.0% during the end line survey, which was only 23.0% during the baseline survey.



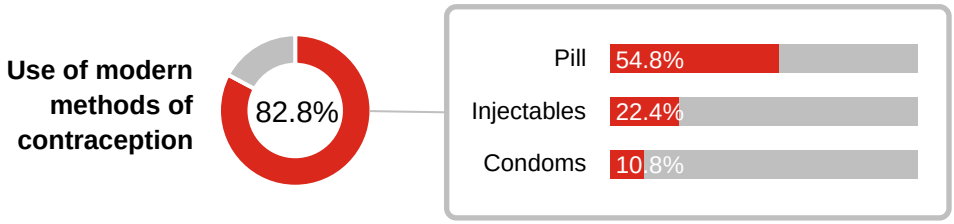


The percentage of women receiving PNC has improved compared to the baseline and national average values. The baseline survey revealed that, of the women who had delivered at the facilities, about 59.0% along with their new-born children had received PNC. This has increased to 77.1% in the case of mothers and 75.8% in the case of children according to the end line findings. It was found that the percentage of women having deliveries at facilities has decreased from the baseline (53.2% versus 50.31%) when compared with the five upazilas of endline. However, when we compare the findings of recently intervened two upazilas (Balaganj and Golapganj) with the results of the baseline study, it was found to be increased remarkably (53.2% Vs. 76.6%). About 56.9% of women reported having skilled birth attendants (SBAs) present during their deliveries which was reported to be 57.1% during the baseline survey. When these two upazilas in the endline survey was considered, the percentage of women who had their children delivered by skilled birth attendants stood at 80.6%.

The baseline evaluation was conducted in Balaganj and Golapganj upazilas before inception of the third phase of Mamota's activities in those two upazilas. The endline evaluation was conducted in 3 more upazilas in addition to Balaganj and Golapganj. Mamota's activities had been withdrawn from these three upazilas (Companiganj, Gowainghat and Jaintapur) three years prior to the endline survey. Therefore, when we compared the findings of the endline survey (from five upazilas) with that of the baseline survey (from Balaganj and Golapganj) the improvements in indicators were not as much as it was expected to be. However, when we compared the endline findings of Balaganj and Golapganj upazilas with the baseline findings, improvements in most of the indicators were obvious and satisfactory.



It was found that knowledge of family planning is universal. Use of any methods of contraception was 82.8% and the modern method was 74.7%t. The most widely used contraceptive is the pill (54.8%) followed by injectables (22.4%). Condoms were used by only 10.8% of the respondents' husbands.



Comparing the end line study data with that of the 2018 baseline survey shows positive improvements in most of the major indicators which includes receiving ANCs for four times or more, percentage of facility delivery, percentage of delivery attended by SBAs, PNC within 24 hours of delivery, knowledge on FP and usage of contraceptives. Overall data from the study suggest that MNH-FP intervention of Mamota Project has induced several positive changes such as the increase in overall awareness and long-term practicing behaviour of the targeted population among the intervention areas.

The key questions for measuring the relevancy, impact, effectiveness and sustainability of the Mamota project interventions were assessed against the findings from the quantitative and qualitative surveys. A systematic and objective assessment of the program design, implementation and results was carried out following OECD/DAC criteria. During the analysis, the project outcome was measured using Likert scale of 1 to 5 and the rationale for assigning each score was obtained by assessing the rationale of the key questions. The results obtained by addressing few questions on relevancy, effectiveness, impact, and sustainability are 5, 4.5, 4.5 and 3.5 respectively.

Many unique lessons were there to learn from this five year-long MNH-FP project. The unique feature of the project is to simultaneously address the supply side and the demand side and to involve the local government with the health system of the community. The study team has identified some of the following lessons which will provide direction in planning of similar type of program in the future

- Addressing supply side (HR, minor renovation of facilities, continuous supply of drugs and other commodities) can increase demand for services;
- Involvement of Union Parishads increase community participation and is very helpful to solve local problems (e.g., boundary wall and electric supply of health facility, patient transportation, etc.)
- Monitoring (supervisory & mentorship visits) and evaluation of a health program is an essential component of quality assurance
- Healthcare providers of the Government (FWVs & SACMOs) were included to share equal burden of work to make the program sustainable

The objective of this evaluation study was to assess the impact, effectiveness, relevancy and sustainability of the project which would help the policymakers to design project in the future in more effective ways. In order to ensure this, some of the recommendations from different stakeholders, include the following:

- To provide 24/7 NVD services, all UH&FWCs must have at least two female paramedics so that one can stay at the UH&FWC all time and another can operate satellite clinics at villages;
- A mechanism should be developed to engage the local midwives and trained FWAs in conducting home deliveries as the percentage of home deliveries by SBAs is very low in the targeted upazilas;
- The people of the village along with Union Parishad should arrange emergency transportation systems to transport severely ill patients from communities to health facilities;
- Union Parishads should take part in improving the healthcare system of the union through regular arrangement of UH&FWC management committee meetings and advocacy to use grants from local Government to improve the UH&FWCs' functions;
- Men (husbands and fathers-in-law) happen to be the decision makers for most families. Therefore, in the future, men should be included in courtyard meetings to make them aware of MNH;
- Use of modern methods of contraception is very low in the targeted upazilas, especially long-acting permanent methods (implants, IUCDs) due to religious barriers and challenges presented in the road to empowerment of women. Policy-makers should take initiatives to involve Imams and religious leaders in dissemination of FP messages. The Ministry of Women and Children Affairs and Ministry of Youth & Sports may pursue accelerated programs in empowering the women of Sylhet district;
- One of the important causes for success of Mamota project was intense monitoring; All Upazilas and Union level facilities should be brought under careful monitoring visits to provide quality healthcare to the communities. Most of the service providers and policy makers put emphasis on monitoring in their interview.
- To endure quality care for underprivileged rural people, the Government needs the support of the Mamota project for the next 2-3 years until all vacant posts are filled up by the Governments paramedics (SACMO & FWV)

The Government of Bangladesh is committed to ending preventable maternal and childhood mortality by 2030. Bangladesh is also a co-signee of Sustainable Development Goals. To attain these commitments, Government efforts alone are not sufficient. The other stakeholders acting in the different sectors in the country should also play their active roles to accelerate the development of the MNH in the country.

PREFIXES

Table of Contents

List of Figures

List of Tables

ACRONYMS

ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Survey
BDT	Bangladeshi Taka
CPR	Contraceptive Prevalence Rate
DGFP	Directorate General of Family Planning
EPCMD	Ending Preventable Child and Maternal Deaths
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussion
FIVDB	Friends in Village Development Bangladesh
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
HH	Household
HPNSDP	Health, Population and Nutrition Sector Development Program
HSC	Higher Secondary Certificate
IDI	In-depth Interview
IUCD	Intra-Uterine Contraceptive Device
KII	Key Informant Interview
KOICA	Korean International Cooperation Agency
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Neonatal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MNH	Maternal, Neonatal Health
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MT	Medically Trained
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization
NMR	Neonatal Mortality Rate
OT	Operation Theater
PNC	Postnatal Care
PPFP	Postpartum Family Planning

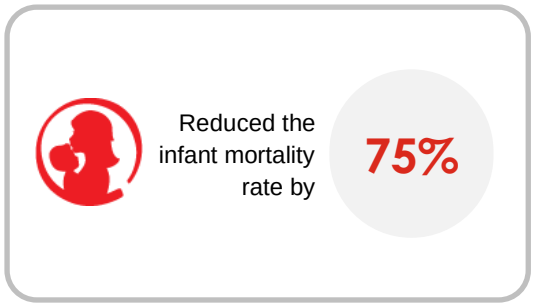
SACMO	Sub-Assistant Community Medical Officer
SBA	Skilled Birth Attendant
SC	Satellite Clinics
SDG	Sustainable Development Goals
SSC	Secondary School Certificate
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UHC	Upazila Health Complex
UHFWC	Union Health & Family Welfare Centers
UNFPA	United Nations Population Fund
UP	Union Parishad
WHO	World Health Organization

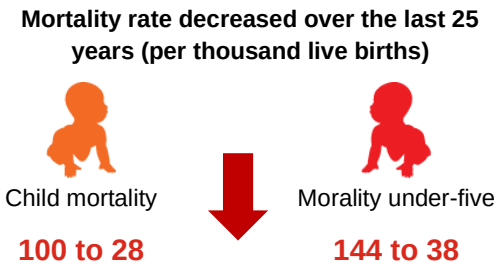
CHAPTER 1: INTRODUCTION

Universally, the physical and mental well-being of a person is acknowledged as a fundamental human right. As such, Article 25 of the Universal Declaration of Human Rights that was drafted in 1948 by the United Nations General Assembly recognizes that every human being has the right to adequate medical care, and that motherhood and childhood are entitled to specialised care. The 'Convention on the Rights of the Child', which was adopted by the United Nations General Assembly in 1989, expands on this proclamation of specialised care required during childhood and stresses on the importance of protecting the rights of children, providing medical support and quality child healthcare, and working towards reducing child mortality and prevention of diseases. In addition, the resolution also places emphasis on the facilitation of supportive conditions that promote children's education and nutrition, family planning, education for parents and cooperation on a global scale to trigger the welfare of children all over the world.

National Commitment

As a signatory of these international resolutions, Bangladesh is obligated to ensure improved health services of its all citizens (Health Policy, 2011). In the spirit of achieving universal health coverage, Bangladesh has committed to end preventable child and maternal deaths by 2030. This pledge, is also in line with the agendas of the Sustainable Development Goals (SDGs) and Ending Preventable Child and Maternal Deaths (EPCMD)[1]. In addition, as a signatory to the global partnership on Family Planning 2020 (FP 2020), Bangladesh is also committed to enhance the standard of FP services and to reduce overall fertility to 1.7 children per woman by 2021 through equitably growing the coverage of successful contraception and reducing unmet needs.[2]





Achievements in health sector of Bangladesh

Bangladesh exceeded expectations by making such a remarkable progress in achieving goals 4 (reduce child mortality) & 5 (improve maternal health) of the Millennium Development Goals. Over the last 25 years (1990 to 2016), Bangladesh has reduced the infant mortality rate by 73 percent, including the reduction of the under-five mortality rate. According to 2014 BDHS figures, child mortality rate has decreased from 100 to 28, and morality under-five has decreased from 144 to 38 per thousand live births.[3]

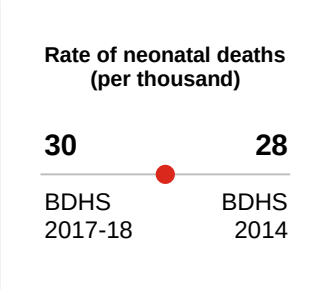
In the last few decades, Bangladesh has also made tremendous progress in reducing the Maternal Mortality Ratio (MMR), the rate in 1975 was 600 deaths per 100,000 live births, which was reduced to 176 by 2015[4]. The drive for pre-natal care, the introduction of health vouchers for poverty-stricken mothers, the deployment of community-based skilled birth attendants, and the introduction of the midwifery program by the Government and United Nations Population Fund (UNFPA), other UN and development partners and NGOs in service delivery has contributed towards these achievements. Moreover, it has also become apparent that the traditional norms of giving birth at home is shifting towards facility delivery for the population; facility delivery has been reported to have risen steadily from 12% in the last decade to 37%.5 Moreover, the contraceptive prevalence rate (CPR) has also increased from 8 percent to 62 percent during the period of 1975 - 2018 in Bangladesh

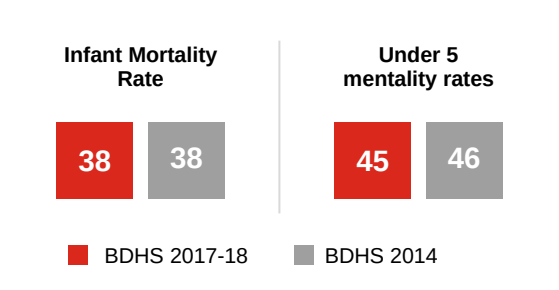
[1] In June 2012, the Governments of Ethiopia, India and the United States of America convened the Child Survival Call to Action in Washington, D.C. to rejuvenate the global child survival movement. Over 178 governments and hundreds of civil societies and faith-based organizations, have signed a pledge vowing to do everything possible to stop women and children from dying of causes that are easily avoidable. Now this commitment called, Ending Preventable Child and Maternal Deaths: A promised Renewed.

[2] FP2020 summit
[3] Bangladesh Demographic and Health Survey, 2014 and 2017-18
[4] Bangladesh Maternal Mortality and Health Care Survey (BMMS)- 2016

Existing challenges in health sector of Bangladesh

Despite the significant decline in infant and child mortality rates in Bangladesh, a large number of neonatal deaths in developing countries, including Bangladesh, still remain a major public health concern. The 2017-18 Bangladesh Demographic and Health Survey (BDHS) shows that the rate of neonatal deaths is at 30/1000 live births which is higher if compared to the BDHS 2014 data (28/1000 live births). Moreover, infant mortality rate accounts for 38/1000 live births and under-5 mortality rate for 45/1000 live births in 2017-18, if compared to the estimates of 2014 BDHS which was 38 and 46 per 1000 live births respectively. Although there is only a slight increase in neonatal and under-5 child mortality rates compared to the 2014 BDHS results, it is still an increase.





Therefore, efforts to minimize new born deaths in Bangladesh need to be renewed. Secondary literature indicates that some of the major contributors to maternal and new born deaths in Bangladesh are the absence of skilled birth attendants during childbirths, and the improper and lower frequency of antenatal care visits. Studies on antenatal care in Bangladesh indicate that the frequency of antenatal care visits of women belonging to poor and uneducated families is lower than that of wealthy families. Only 6.5% pregnant women from lowest wealth quintile receive quality ANC compared to 36.7% women of highest wealth quintile[5]. Some studies have shown that mothers in rural areas, have less access to healthy childbirth as good hospitals are scarce. As a result, during pregnancy complications, women have limited opportunity for accessing adequate care[6]. In developing countries such as Bangladesh, the practice of getting medical check-ups during pregnancy is very poor compared to developed countries, where most (97%) of pregnant mothers have access to ANC (Amrin, 2016)[7]. The percentage of women receiving Antenatal Care (ANC) at least once is stated to have increased in Bangladesh, but the rate is still very low compared to developed countries[8]. The number of women receiving Antenatal Care (ANC) at least once has increased from 63.9% to 81.9% during the period 2014-2018, according to BDHS data 2017-18[9].

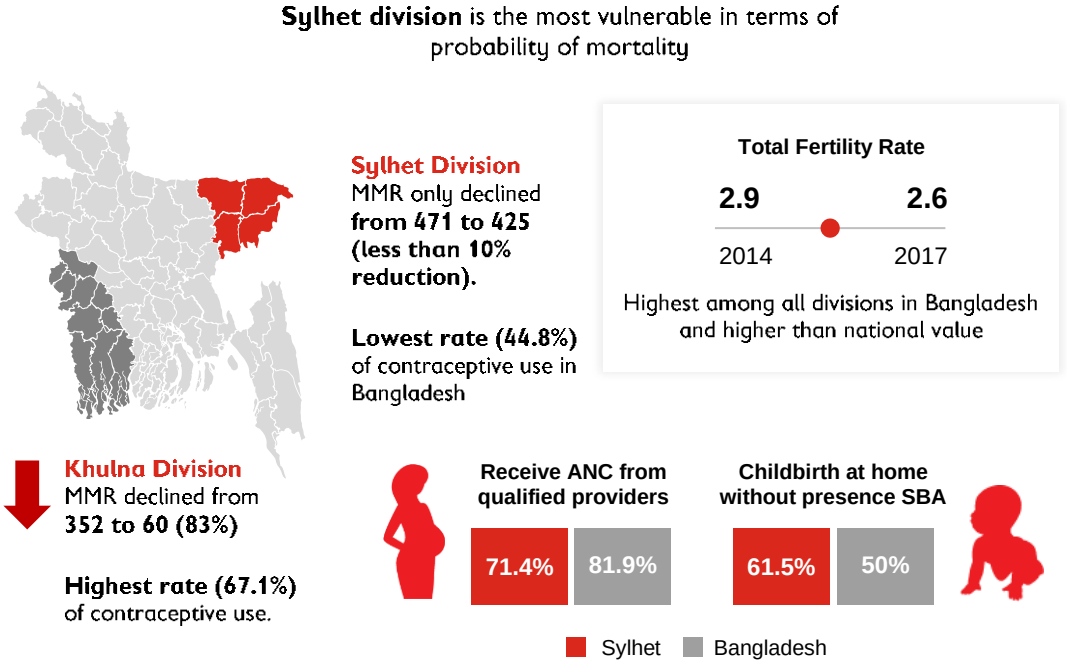
Huda et al. (2017) stated in a very recent study that about one-third of pregnancies are still unintended, often due to a lack of family planning and discontinuation or switching of contraceptives. Most women are aware of at least one form of contraception where the most frequently used form is the oral pill (25.4%), followed by injectable (10.7%), condom (7.2%), and IUD (0.6%) according to BDHS 2017-18 which are mostly distributed by Family Welfare Assistants (FWAs) and Family Welfare Visitors (FWVs)[10]. However, high rates of vacancies in these service provider positions result in gaps in outreach family planning services.

[5] Bangladesh Demographic and Health Survey, 2017-18
[6] Islam and Odland, 2012; Islam et al., 2004; Halim et al., 2011; Pervin et al., 2012
[7] Amrin, 2016
[8] Shahjahan et al., 2012
[9] Bangladesh Demographic and Health Survey 2017-2018, 2019
[10] Bangladesh Demographic and Health Survey 2017-2018, 2019

Regional variation in health services and healthcare situation in Sylhet

While there is a positive shift towards improving Bangladesh's healthcare situation through various interventions, this shift has also led to substantial disparity between different population groups (marginalized versus privileged class) and regions in accessing and using healthcare facilities. Among the eight divisions in Bangladesh, Sylhet has lagged behind in terms of education, maternal & new born healthcare, and family planning facilities compared to other areas, and this trend has not changed significantly over time. Despite its economic advantage over the rest of Bangladesh, Sylhet's health indicators are among the poorest. The government and non-governmental organizations have made numerous attempts to improve the health situation in the Sylhet district, but this has not improved significantly. In addition, the scenario of available healthcare facilities and their use varies among different Upazilas in the Sylhet district. For a longer period of time, Sylhet district has been in a disadvantaged position within Sylhet division. The district of Sylhet is divided into 12 sub-districts or Upazilas, of which Companigonj, Goainghat and Jaintapur are the most backward in terms of educational, healthcare, transportation, infrastructure development, and overall living status.

Moreover, the attempts to reach the marginalized and disadvantaged population living in the remote areas of Sylhet with essential health facilities have been made more difficult by insufficient numbers of healthcare service providers, along with a high rate of vacancies in healthcare personnel positions. Service providers for UH&FWCs and outreach sites in the Sylhet district have gaps in sanctioned vs. vacant positions ranging from 8% to 49% (Human Resource gaps in Sylhet district, 2017).[11]



Also, women and newborn children are often deprived of required healthcare services. A large number of women in the entire district are reported to have little access to antenatal care (ANC), postnatal care (PNC), skilled birth attendants (SBA) and family planning (FP) services. In the Sylhet district, the adoption of family planning with modern methods is not up to the mark. Using the fragility models, Khan and Awan (2017) found that the probability of mortality varied across divisions, the most vulnerable being the Sylhet division. For instance, in Khulna division, MMR declined

[11] Mamota Project Execution Plan, Phase-2, 2017 (Unpublished Report)

from 352 to 60 (an 83% reduction). During the time period, in Sylhet division MMR only declined from 471 to 425 (less than 10% reduction).[12]

In addition, the Total Fertility Rate (TFR) in Sylhet was reduced from 2.9 to 2.6 between the 2014 and 2017 surveys[13] but it is still the highest among all divisions in Bangladesh and higher than national value. In the case of accessing prenatal care from a medically qualified provider, access to these services by rural women of Sylhet division has declined, although an 8% rise has been seen since 2004 at the national level. Currently, in the Sylhet division, 71.4% of women receive antenatal treatment from qualified providers compared to 81.9% nationally[14]. In Bangladesh, childbirth at home without presence of Skilled Birth Attendant (SBA) is still very high (50%), and even higher in the Sylhet division (61.5%), which is higher than the national average[15]. For instance, 90.4% of deliveries took place at home and 88.3% of all deliveries occur without a skilled birth attendance in Gowainghat upazila; the rate of home delivery was 85.6% and almost none of them (85.2% of all deliveries) are attended by skilled providers in Companiganj upazila; and 81% of total delivery is carried out by non-qualified providers and delivered at homes in Jointiapur upazila.[16] Neonatal Mortality Rate (NMR) in Sylhet division was also 28.2% higher in 2014 than national average (28 vs. 39 per 1,000 livebirths)[17].

Moreover, the regional variation in contraceptive usage is very prominent. Between 2014 and 2017, modern method use declined by 2 percentage. Use of contraceptives is highest in Rangpur (59%) and lowest in Chattogram and Sylhet (45%)[18]. Among Bangladesh's other divisions, the Sylhet division has the lowest rate of contraceptive use (44.8%) while the Khulna division has the highest rate (67.1%)[19]. Although Health, Population and Nutrition Sector Development Program (HPNSDP; 2011-2016) aimed to increase modern methods of contraceptive use to 50% in the Sylhet division, modern methods of contraceptive usage in Sylhet need to be increased by 15% in the next 5 years to do so. On a positive note, Sylhet showed a continuous rise in CPR over the past four years, which was the highest among the other divisions[20].

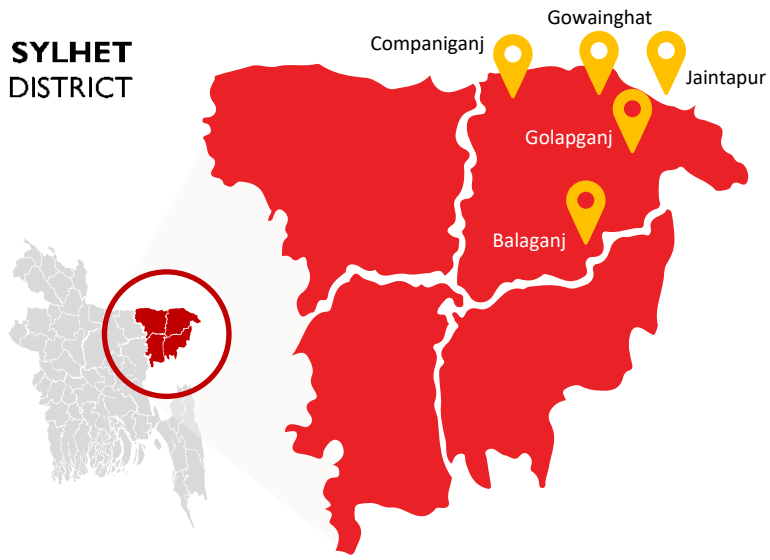
Explanations accounting for Sylhet's poor progress in maternal and child health indicators typically range from its religious conservatism, to its high levels of economic inequity and low levels of female literacy, with more than 35% of women having received no education. In addition, absenteeism in UH&FWCs, insufficient outreach programs, lack of ANC logistics and necessary medicines, high costs of treatment, poor knowledge within the community and minimum involvement of local government in maternal, neonatal health and family planning (MNH-FP) activities etc. are some of the major contributors to the lower rates of key health indicators in Sylhet.

1.2 Background and Objectives of Mamota Project

Taking the situation of healthcare services in the Upazilas of Sylhet district into consideration, and to make an impact on maternal and newborn survival in these remote and underserved areas, Save the Children (SC), with financial support from the Korean International Cooperation Agency (KOICA), engaged a renowned local NGO, Friends in Village Development Bangladesh (FIVDB) to implement the Mamota project activities in order to support the Government in implementing MCH-FP activities at the union level. Save the Children (SC) and FIVDB jointly supports the efforts of Ministry of Health and Family Welfare (MoHFW)), aiming to increase the access of women and new born to quality healthcare and family planning services.

---

[12] CSO Partnership Program, Mamota Project Execution Plan, Phase-2, 2017
[13] Bangladesh Demographic and Health Survey 2014 and 2017-2018
[14] Bangladesh Demographic and Health Survey 2017-2018, 2019
[15] Bangladesh Demographic and Health Survey 2017-2018, 2019
[16] Hossain, November, 2017
[17] CSO Partnership Program, Mamota Project Execution Plan, Phase-2, 2017
[18] Bangladesh Demographic and Health Survey 2017-2018, 2019
[19] Survey, 2014
[20] Mapping health facilities in Sylhet City Corporation, Bangladesh, January 2014



Overall goal of Mamota Project

The overall goal of the Mamota project is to ensure improved utilization of MNH-FP services in underserved communities of Sylhet district which will ultimately reduce maternal and newborn mortality and morbidity among the target population. Interventions under the Mamota project are based on three major objectives:

- Increased availability of quality MNH-FP services;
- Improved quality of MNH-FP services at the facility and community level; and
- Increased awareness and strengthen support of local government. institutions

Project's major intervention:

- Deploy health service providers and support staffs at upazila and union level facilities;
- Upgrade union level health facilities (Union Health and Family Welfare Centre; UH&FWC) to provide 24/7 normal delivery and newborn care service;
- Provide training and job aids for health service providers;
- Conduct supervisory and mentorship visits with district level managers and professional body (Sylhet Medical College/BPS/OGSB) of Ministry of Health & Family Welfare;
- Strengthen transportation system for emergency cases;
- Creation of emergency fund for transfer of complicated cases;
- Functioning of union education, health and family planning standing committee;
- Functioning of UH&FWC management committee;
- Engage school-based adolescents in raising awareness and promotion of MNH services;
- Conduct advocacy meeting (National/district/Upazila/ union/community level).

Project's outcome

- Upgrade and ensure 24/7 normal delivery at union level health facility;
- Increased access to quality healthcare services (specially, ANC/PNC);
- Increased skilled assistance at delivery (delivery by SBA) and facility delivery;
- Strengthened accessible quality treatment for sick newborns at SCANU;
- Strengthen Union Health & Family Welfare Centers (UHFWC) and UEHFP committees.

In the selected upazilas of the Sylhet district which are disadvantaged, the Mamota project was introduced in three phases to ensure quality health services for pregnant women and newborns, along with family planning services. The end line evaluation covers the catchment areas of health facilities that were upgraded in phase 2 and phase 3 during the period of January 2015 to December 2020. The first phase (2012-2014) of the project started with three (03) upazilas of Habiganj district and Jaintapur upazila in Sylhet district. For the second phase (2015-2017) the project was implemented in three (03) upazilas (Companiganj, Gowainghat and Jaintapur) of Sylhet district. In the third phase (2018-2020), the project activities were extended in two new upazilas (Balaganj and Golapganj) and also kept the two old upazilas (Gowainghat and Companiganj)

Before inception of the second phase of the project, a baseline study was conducted in 2018 to generate baseline values for the key MNH-FP indicators as benchmarks for the project monitoring and evaluation, and to provide an understanding of the present situation of MNH-FP services, which eventually help in reducing maternal and newborn mortality rate in project location very effectively.

1.3 Objectives for End-line Evaluation

This end-line evaluation study of Mamota project was undertaken to assess the impact, effectiveness, relevancy and sustainability of the project which would help the policymakers for designing a project of this sort in future in a more effective way so that the benefits of the project could be sustainable, commendable and ideal. The end-line evaluation study investigated the extent to which the project has been successful in achieving the program objectives. In this end-line report, the project's achievements in terms of increased and improved utilization of structured MNH-FP services and awareness about MNH-FP issues were evaluated.

In light of the overall objective of the end-line survey, the specific objectives were:

- Assessment of Maternal, Neonatal Health-Family Planning (MNH-FP) services in project location and quality of these services;
- Evaluation of supporting mechanism of local govt. institutions, e.g., Union Parishad;
- Measuring the capacity of service providers to support quality services, clinical practices, and referral mechanisms;
- Assessment of the health seeking behaviors and patterns of the community people in the project supported health facility catchment areas; and
- Capturing the lesson for future project design in other vulnerable area.

Based on the information gathered through the end-line survey, it is expected that the evaluation of the issues listed above will enable policymakers to understand the deficiencies in the current MNH-FP framework and the obstacles to accessing these services at the community level. Considering that Sylhet is one of Bangladesh's most underserved districts in terms of key health indicators, it would be best to inform the Government of Bangladesh (GoB) and other development partners of what might be the key areas of potential intervention in this region, given the current situation of the availability and accessibility of MNH-FP services following the involvement of the Mamota project.

CHAPTER 2: METHODOLOGY

2.1 Study Design

The end line evaluation study of Mamota project has used a mixed method approach where both quantitative and qualitative data were collected to assess the impact, effectiveness, relevancy and sustainability of the project. The project's accomplishments, regarding increased and enhanced use of structured MNH-FP services, were measured based on both quantitative (household survey) and qualitative surveys (e.g., FGDs, KIIs, IDIs). The quantitative data were collected from two groups of married women of reproductive age (15-49 years).

On the other hand, a range of qualitative survey methods have been utilised, and the survey was conducted among participants from direct beneficiaries (married women and men of reproductive age), adolescent girls, community leaders and decision makers (Chairman and Members of Union Parishad), service providers, policy makers and other stakeholders. The data gathered from the qualitative survey enabled the study team to gain an in-depth understanding of the demand for MNH-FP services in project locations and the quality of these services offered by the facilities which have been upgraded by the Mamota project. The views and opinions of the targeted beneficiaries regarding their healthcare seeking behaviour and quality of those healthcare services were clearly expressed through the qualitative surveys. Moreover, the qualitative data also highlighted the role and capacity of the local government institutions for ensuring equitable and quality healthcare facilities to the beneficiaries.

2.2 Data Collection

2.2.1 Primary investigation

The primary data were collected through quantitative and qualitative data collection methods. A brief discussion on the survey methods is given below:

2.2.1.1 Quantitative Method

The quantitative survey covered the women of reproductive age group and their corresponding households within the catchment area of the Mamota project, which was implemented between January 2015 to December 2020 period, comprising phase 2 and phase 3 of the programme.

Sampling design for the quantitative survey
The sampling framework for quantitative data collection for the end line evaluation of the Mamota project takes into account the goals and objectives of the project and the evaluation study. In order to ensure that the appropriate information is obtained from particular target groups and based on designed interventions, the sampling strategy takes into consideration the intervention strategies, operational structure of the programme and the key research questions of the quantitative survey.

The quantitative analysis based on the household survey assessed the extent to which the project has been successful in improving the utilization of Maternal, Neonatal Health-Family Planning (MNH-FP) services and awareness about MNH-FP issues in the project locations. In addition, the quantitative study helped to determine the impact of the project on the demand for healthcare services (MNH-FP) within the catchment areas of the program among the target population. Another point of interest in the household survey was to assess the accessibility and quality of MNH-FP services in project locations.

The analysis of the data gathered from the household survey, in context of the key objectives mentioned above, highlights the deficiencies in existing system of MNH-FP services, and the barriers in accessing these services at the community level.

Target individuals for household survey:
For sampling purposes of the quantitative survey, the eligible households were categorized into two main groups.

Households with at least

- A woman aged between15-49 year, with a history of live birth in the last 2 years of the survey
- A currently married woman aged between 15-49 years, not pregnant or has not given birth within the last 2 years of the survey

Selection process of the respondents for the first group: In order to determine the required sample size for the first group of respondents (women aged between15-49 years with a history of live birth in the last 2 years), two different measures of healthcare seeking behaviours in Sylhet division were taken into consideration based on Multiple Indicator Cluster Survey (MICS 2019). The indicators are consistent with main outcome indicators of the Mamota project (as defined in the Annex 11 of the ToR).

- Percentage of delivery at a Health facility of women aged between 15-49 years with a history of live birth in the last two years — 40.2% in Sylhet division in 2019.

- Percentage of women aged between 15-49 years with a history of live birth in the last 2 years, who have taken at least 4 ANC visits — 30.0% in Sylhet division in 2019.

Selection process of the respondents for the second group: For determining the sample size for the second group of respondents (currently married woman aged between15-49 years who are not pregnant or has not given birth within the last 2 years), the use of contraceptive among the married couple was taken into consideration.

- Percentage of currently married women aged between 15-49 years who are using (or whose partner is using) any mode of modern contraceptive method — 53.1% in Sylhet division in 2019 (MICS);45% according to the baseline study.

Sample Size:

$$n \geq Design\ Effect\ \frac{\left[Z_{\alpha/2}\sqrt{2P(1-P)} + Z_{\beta}\sqrt{P_2(1-P_2)+P_1(1-P_1)}\right]^2}{(P_2-P_1)^2} \ldots\ldots (1)$$

For MNCHN indicators, while calculating the sample size, the indicator '% of 4 Antenatal Care (ANC) by Medically Trained (MT) provider will increase 9 percentage point' is used. Here, p1=0.467, p2=0.557. Considering this the sample size for Women aged 15-49 years with a live birth in the last 2 years was calculated using formula (1) above. It gives a sample with size ***n = 571***

Considerations: p1=0.467, p2=0.557, Z(alpha) = 1.64, Z (beta) =0.84 (for 80% power), Non-response=5%, Design Effect=1.5, Average Household Size of Sylhet=5, Proportion of 15-49 years women in the total population of Sylhet = 35%

Overall Sample size is **580** for nearly most of the MNCHN indicators relating to the respondent group of mothers having 0-24 years child.

However, this is a subset of the total women of reproductive age group (who are currently married but do not have a child aged 0-24)

$$n \geq Design\ Effect\ \frac{Z^2\frac{\alpha}{2}}{e^2}\ p\ (1-p)\ \ldots\ (2)$$

This formula is used for deciding the sample for the indicators related to overall 15-49 years women (WRA): "% of contraceptive prevalence rate".

Considerations: p =0.5 (assumed), Z(alpha) = 1.96, Tolerable error (e) =5%, Design Effect=1.5, Average Household Size = 4.5, Proportion of 15-49 years' women in the total population of Sylhet = 35%

For this the total sample size is: **586**

As mentioned above, the Mothers having 0-24 months' children are a subset of 15-49 years' women. For considering Currently married woman aged 15-49 years not pregnant or not given any birth in the last 2 years we will be taking 50% additional sample for this group.

Total Sample:

- Women aged 15-49 years with a live birth in the last 2 years: **580**
- Considering 50% additional sample from currently married woman aged 15-49 years not pregnant or not given any birth in the last 2 years: 290. (total sample for CPR indicators will be 876 with desegregation Women of having 0-24 child and without)
- Total Sample: **876**

Sample Selection

The Mamota Project was implemented in three phases. The end line evaluation covered the catchment areas of health facilities that were upgraded in phase 2 and phase 3 during the period of January 2015 to December 2020. In these two phases, the project was implemented in 5 upazilas of Sylhet division.

Table 1: List of Upazilas under different phases of Mamota Project

Phase 2	Phase 3	
2015-17	2018-2019	2018-2020
Companiganj, Gowinghat and Jaintiapur	Companiganj and Gowinghat	Golapganj and Balaganj

Table 2: Renovated Facility List by Upazila and Union

Upazilas					
Facility Type	Companigonj	Gowainghat	Jaintiapur	Balaganj	Golapganj
UHC (Upazila level)	Islmapur Purbo		Jaintiapur	Balaganj	
UH&FWC (Union level)	Islampur Pas. (Parua)	Towakul,	Baurvag,	Boaljur	Bhadeshwar
	Telikhal,	Doubary,	Charikata,	Purbo Gouripur	Budbari Bazar
		Rustompur,	Darbost,	Purbo Poilanpur	Sharifganj
		West Jaflong	Fotehpur		Bagha
					Laxmipasha

The study applied a multi-stage cluster sampling strategy for the quantitative (household) survey, where the households were selected through a stage-by-stage procedure. The quantitative analysis of the end line evaluation covered catchment areas of 21 UH&FWC facilities that were upgraded under the Mamota project in two phases between 2015 and 2020. To begin with, 11 UH&FWCs (at least half) were randomly selected from these 21 renovated UH&FWCs.

The rationale behind selection UH&FWCs in the first stage of sampling was based on the understanding that any individual woman can avail healthcare services from a UH&FWC, and households living in villages around the UH&FWC are more likely to take services from that particular facility. Based on this selection criterion, a sample of 11 UH&FWC facilities were randomly selected out of the 21 renovated UH&FWCs.

Table 3: Selection of Health Facilities

Upazila	Health facilities selected for the study		
Companiganj	Islampur purbo	Telikhal	
Gowainghat	Rustampur	Doubary	Towakul
Jaintapur	Charikhata	Baurvag	
Balaganj	Purbo gouripur	Boaljur	
Golapganj	Bagha	Bhadeswar	

In the second stage, 2 distant villages and 2 nearby villages from each UH&FWC were selected randomly from the catchment areas of the UH&FWCs. The enumerators visited each household of the villages (2-5 enumerators in each village depending upon the population of the villages) and

categorised married women of reproductive age into two groups: one group (women aged between 15-49 years with a history of live birth in the last 2 years) for MNH data collection, and another group for FP related data collection (married women aged between15-49 years who were not pregnant and have not given birth in the last 2 years). A sample pool of a total of 4790 women was listed (2095 women for the first group and 2696 for the second group). From this sampling framework, 10-15 women were randomly selected from each village (in proportion to the population) using the randomization command of Microsoft Excel. Thus, samples of 485 from the first group and 470 from the second group were obtained.

A point to note, is that due to lower population size and number of UH&FWCs in Companiganj upazila, the sample size for Gowainghat and Balaganj during the inception stage was proposed to be 96 and 57 samples respectively. However, since then we have conducted some additional interviews in Gowainghat (120) and Balaganj (72) upazila. After conducting these additional interviews, the total achieved sample size for the study derived at 896 (as opposed to 876 proposed in the inception report).

Table 4: Achieved sample size

Upazila	No. of Health Facilities (UH&FWC)	No of Health Facilities selected randomly	No. of Villages	Population in the Upazila	Sample Size (MGBLY)	Sample Size (MWRA)	Per village sample (MGBLY)	Per village sample (MWRA)
Companigonj	3	2	8	25%	80	80	10	10
Gowainghat	5	3	12	22%	120	120	10	10
Jaintiapur	5	2	8	18%	80	80	10	10
Balaganj	4	2	8	13%	72	72	9	9
Golapganj	5	2	8	22%	96	96	12	12
Total	22	11	44		448	448		

***MWRA- Married Women of Reproductive Age who are not Pregnant or has not Given Birth Last 24 Months.*
***MGBLY-Mother who has Given Birth During the Last two Year*

2.2.1.2 Observation Checklist

The study team has closely observed 11 UH&FWCs and 2 UHCs from the study locations. Several indicators were selected before conducting the observations, and the performance of healthcare service of the selected UH&FWCs and UHCs were assessed against those indicators. Both qualitative and quantitative data were used to assess those indicators.

2.2.1.3 Qualitative Survey

The end line study of the Mamota project used a range of qualitative methods to get an in-depth understanding of the demand for MNH-FP services in the project locations and the quality of these services offered by the facilities upgraded by Mamota project. It also aimed to collect information regarding the role of local govt. institutions, e.g. Union Parishad as supporting mechanism for accessing required healthcare. Another key objective was to measure the capacity of service providers to support quality services, clinical practices, and referral mechanisms. Overall, the qualitative survey findings highlighted the achievements of the projects in terms of strengthening the healthcare facilities, and availability of quality services, and examined the scope of sustainability of the project activities after the conclusion of the project period.

Survey Instruments

Different kinds of survey instruments have been deployed for the end line evaluation. A brief description of the survey instruments is given below:

- ***Key Informant Interview (KII):*** *The Key Informant Interviews (KIIs) included the government health service officials - (DGFP) and higher officials of the project implementing partners – (FIVDB)*
- ***Focus Group Discussions (FGD):*** *Given the approach of the study, a qualitative survey instrument such as Focus Group Discussion (FGD) was considered quite appropriate. Since discussions were administered in an interactive group setting, participants talked freely with other group members. FGDs were conducted based on a guideline, where children and adults who are part of the community were invited to join and express their views, opinions and share their experiences.*
- ***In-Depth Interviews (IDI):*** *The rationale for administering in-depth interviews for this end line study was to allow respondents to answer with spontaneity the lead and probe questions in a non-threatening environment (in their own settings). The study team conducted in-depth interviews with the Supervisors at upazila level (Medical Officers, Upazila Family Planning Officers), the health service providers (FWVs, SACMOs, FWAs, FPI and paramedics) at the union level facilities and the FIVDB officials.*

Table 5 Distribution of qualitative sample

Method	Respondents/ Units	Number activities/Sample size	Number of Interviews or FGDs
Observation	Facility observation	11 selected UH&FWCs (selected for quantitative sample) including 2 UHC	13 Facility observation
KII and IDI	With service providers, local government representatives (Union Parishad Chairman and Members), local and national level key (e.g., DGFP) stakeholders and experts	Upazila level: MO, UFPO Union level: FWV, SACMO, Paramedic, Technical Officer of FIVDB, FPI and FWA National level: Divisional Director, Sylhet, Director (MCH-S) and DD (MCH); project lead from FIVDB) (4 in total)	14 in each Upazila 4 in national level Total 18 KII/IDI
FGD	With Front line health workers, Community group members, Adolescent girls, Married Male, Female of reproductive age group	With front line health workers (5 FGD) Community group members (1 FGD) Married Male (2 FGD) Female of reproductive age group (3 FGD) Adolescent girls (4 FGD) to assess the Mamata intervention on improving knowledge on adolescent health)	15 FGDs
Case study	who had significantly been benefited from the Mamota intervention	1. Woman receiving ANC from UH&FWC 2. Woman receiving contraceptives from UH&FWC 3. Woman delivered at UH&FWC 4. Woman referred from UH&FWC to higher facility	4 case studies

2.3 Data Analysis

Several descriptive and inferential statistical instruments and techniques have been used to analyse the results of the end-line study. The quantitative data was collected using KOBO Toolbox (an online data collection platform) that stores data in the cloud server and allows to download in MS Excel format. For data management and interpretation, the study used SPSS. Several discussion sessions were held among the team to draw on key messages at the beginning of the data analysis. All data was then analysed systematically.

2.3.1 Evaluation of the End Line Indicators

By analyzing the findings collected from the household surveys, IDIs, KIIs, FGDs and secondary data, the end line indicators were used to evaluate the impact, effectiveness, relevancy and sustainability of the Mamota project interventions. Keeping in mind the goals and objectives of the Mamota project, the quantitative indicators were mainly measured through the household survey data. Qualitative approaches have been used to assess the current structure of healthcare facilities and delivery system. The insights from the KIIs with different stakeholders will help give insight on how to better execute the project activities. For estimates on the national baseline of the Maternal Mortality Ratio (MMR) and Neonatal Mortality Rate (NMR), and comparative analysis, secondary data sources such as the Bangladesh Maternal Mortality Survey 2016 and the Bangladesh Demographic and Health Survey 2017-18 were also used. The following table shows the major end line outcome indicators, along with the source of data for that assessment.

Table 6: Assessment and evaluation of the major end-line indicators

Mamota Project Goals and Objectives	Indicators	Source of data
Goal: Improved utilization of MNH-FP services to reduce maternal newborn mortality in underserved communities of Sylhet district	Neonatal mortality rate (NMR)	Secondary Sources; BMMS 2016, BDHS 2017-18
	Maternal mortality ratio (MMR)	Secondary Sources; BMMS 2016
Objective 1: Increase availability of quality MNH-FP services	% of women received any ANC (at least one) by medically trained provider.	Household Survey
	% of women received 4 ANC by medically trained provider.	Household Survey
	% of women received PNC (Mother) within 24 hours of delivery by medically trained provider	Household Survey
	% of women received PNC (Newborn) within 24 hours of delivery by medically trained provider	Household Survey
	% of delivery conducted by Skilled Birth Attendant (SBA)	Household Survey
	% of delivery held in health facility	Household Survey
	% of married women of reproductive age knew about family planning (postpartum family planning methods)	Household Survey
	% of eligible women used any modern method of contraception (Contraceptive use rate)	Household Survey

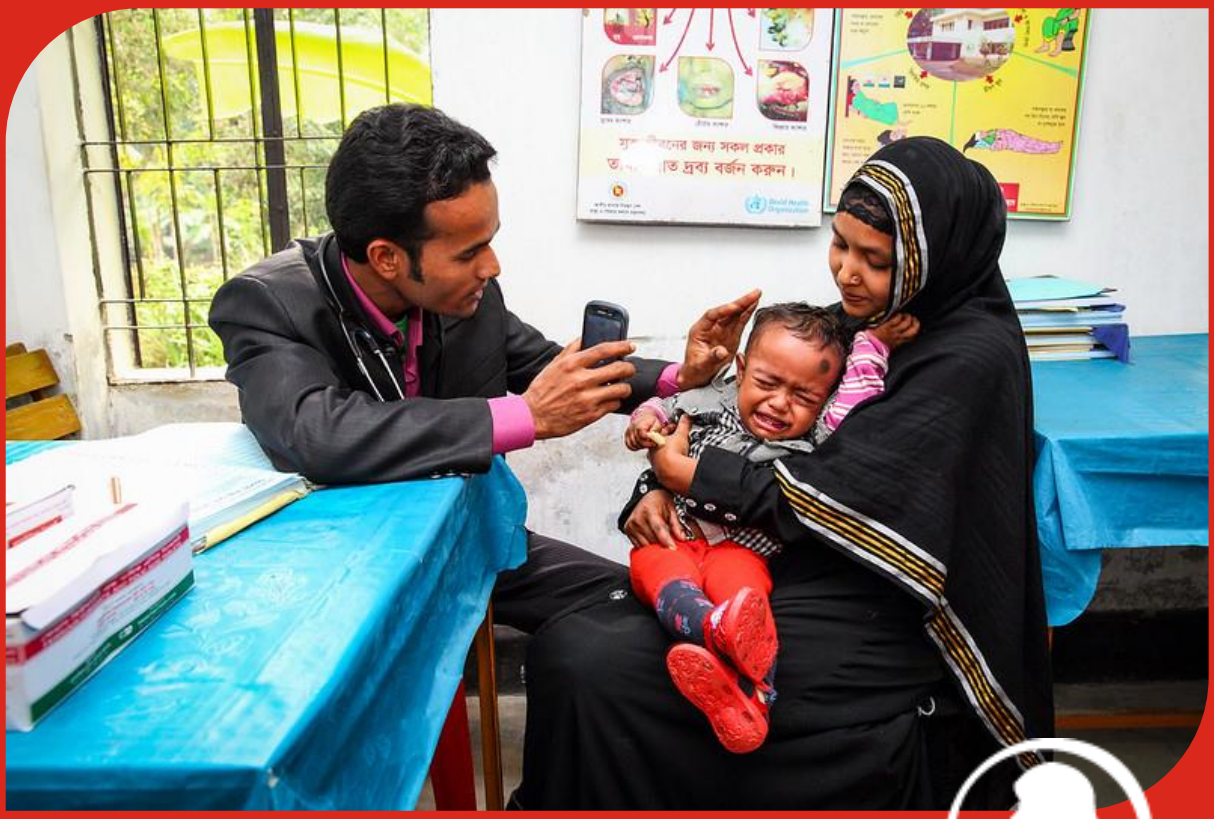
Objective 2: Improved quality of MNH-FP services at the facility and community level	% of deliveries in health facilities used Partograph and administered Oxytocin.	In-depth Interviews, baseline study reports
Objective 3: Increased awareness and strengthen support of local government institutions	% of functional UH&FWC management committee	FGDs, Key Informant's Interview
	% of women recall at least two danger signs during pregnancy period	Household Survey
	% of women recall at least two danger signs of newborn	Household Survey

2.2 Ethical Consideration

Within targeted population, the assessment team interviewed a diverse group of women in terms of age (15-49 years), ethnicity, religion, and socio-economic status. Ethical standards were maintained during each interview to ensure the interviewee is giving informed consent for participating in the data gathering process. Moreover, the team ensured that the identities of the interviewees remain confidential. Data protection measures were ensured to protect the identity of all participants, and any other information that may put them or others at risk. Moreover, before starting the interview, the respondents were clearly informed about the goal and objective of the evaluation study. The study team also took the appropriate approvals from Directorate General of Family Planning (DGFP) before starting the data collection in the project locations.

2.3 Limitation of the study

As a total of 44 villages from the catchment areas of 11 Union Health & Family Welfare Centres were randomly selected by the study team, it was difficult, in some cases, to select the list of eligible households from villages due to a lower population size of particular villages. Moreover, due to the remoteness of some locations, commuting in those selected villages was quite difficult for the study team. Some of the respondents also reported inaccessibility in receiving PNC from health centres due to the effects of the COVID-19 pandemic. Overall, given the unprecedented circumstances, respondents found it difficult to give opinions regarding possible areas of improvement and the accessibility status of MNH-FP services in the project locations where the situation has been further exacerbated due to the effects of the pandemic. Moreover, due to the COVID-19 situation, the overall project activities were hampered to a certain degree in the study locations.



CHAPTER 3: FINDINGS OF THE STUDY

The quantitative and qualitative assessment of the project focuses on the key indicators formed during the baseline study. This part of the research attempts to conduct a comparative study against the baseline findings of the previous studies, and the recent quantitative and qualitative findings in order to highlight the key factors which have gone through possible changes (improvements or decline). The quantitative and qualitative assessment will shed some light into the various levels of institutional arrangements on which the Mamota project has been able to make an impact. These findings will help provide insight on the areas which should be focused on if a situation arises where the project may have to be extended; or at the very least, the data from this study can help stakeholders formulate plans of action at the policy level.

3.1. Background Characteristics of Maternal & Newborn Respondents

A demographic profile of the respondents (mothers who gave a live birth within last two years of this survey) was drawn from the results of the quantitative survey in terms of age, level of education, occupation, age of the husband, level of education of the husband, and occupation of the husband. Table-16 in the Annex 2 presents the overall profile of the respondents. The age distribution of the respondents indicates that 70.0% of the respondents belong to the age group of 18-28 years, while 28.2% of the respondents were between 28-38 years Only about 1.0% were 38 years old or above. Furthermore, the data indicates that although about 55.3% of the respondents were in the age group 18-24 when they were married, almost half of the responds (42.7%) were at the age below 18 at the time of their marriage.

70%
Respondents belong to 18-24 years' age group

55.3%
Respondents belong to 18-24 age group at marriage

42.7%
Respondents belong to **'below 18**' age group at marriage

Mother's Age

The findings indicate that among the respondents receiving antenatal care (ANC) at least once during pregnancy, there is not much variation based in the age. However, when considering respondents receiving antenatal care three or more times during pregnancy, it was found that the percentage of women doing so decreases drastically with the increasing age of the women; indicating an inverse relationship between the two factors. The results indicate that about 72.0% sampled women of age below 20 years received antenatal care 3 or more times, while only 50.0% respondents of aged 35 or above did the same. A similar trend was also observed among respondents with 4 or more ANC visits, where the number of visits decrease as the average age goes up.

72%
sampled women of age **below 20 years** received 3 or more antenatal care

50%
sampled women of age **35 or above** received 3 or more antenatal care

The survey data indicates that there is not much corelation between the age of the respondents, and the percentage of facility deliveries and the assistance of qualified birth attendants as the numbers did not vary much with age. However, the results also suggest that the status of receiving postnatal treatment for mother and newborn children within 24 hours of birth, was found to differ substantially depending on the age of the respondents. It is observed that percentage of receiving PNC is lower for older women and their newborn children. We also have to take into account the opinions of the attendants of the patients in the decision-making process as their previous experiences usually matter when it comes to taking the decision to stay in the hospitals longer, or to leave for home as soon as possible.

Mother's Education

It is found that the educational status of mothers of children under two has a positive impact on the attitude of receiving antenatal care during pregnancy. Women with a higher level of education have been reported to have a higher uptake of ANC. The results show that the educational level of women played an important role in women seeking facility deliveries and assistance of skilled birth

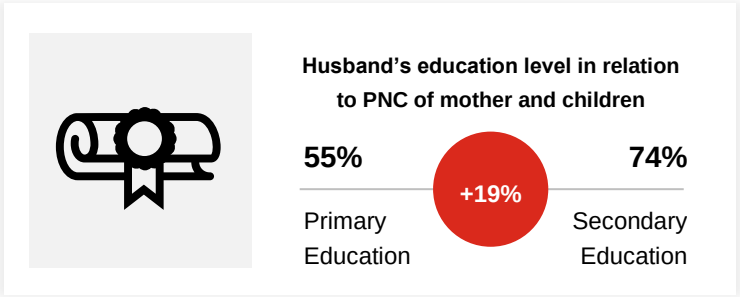
attendants. With the rise in the educational level of mothers, the percentages of facility deliveries and deliveries by skilled birth attendants were found to have increased. Instead of delivering babies at homes, educated mothers generally choose to go to the hospitals and avail the services from a professional caregiver. The results show that the educational level of women is positively associated with in availing postnatal check-up by medically trained service providers within 24 hours of delivery. Most educated mothers choose to get their PNC services immediately after delivery. Around 78.0% of the sampled women who completed secondary or higher-level education reported to have received PNC services. Comparatively, among the women who reported to be illiterate, only about 51.0% of mothers received PNC.

78%
sampled women who completed secondary/higher-level education received PNC services

51%
sampled women from illiterate group received PNC services

Husband's Education

The findings show a degree of commonality between the level of education of the mother and that of the husbands. The higher level of education among both groups of respondents were found to have a positive impact on women receiving ANC treatment during pregnancy, facility delivery, assistance of professional birth attendant, and postnatal care for mothers and children within 24 hours of delivery (Table-17 in Annex 2). The percentages of both facility deliveries and delivery by skilled birth attendants were found to increase with the increase of husband's education level, just as it was the in case of women.



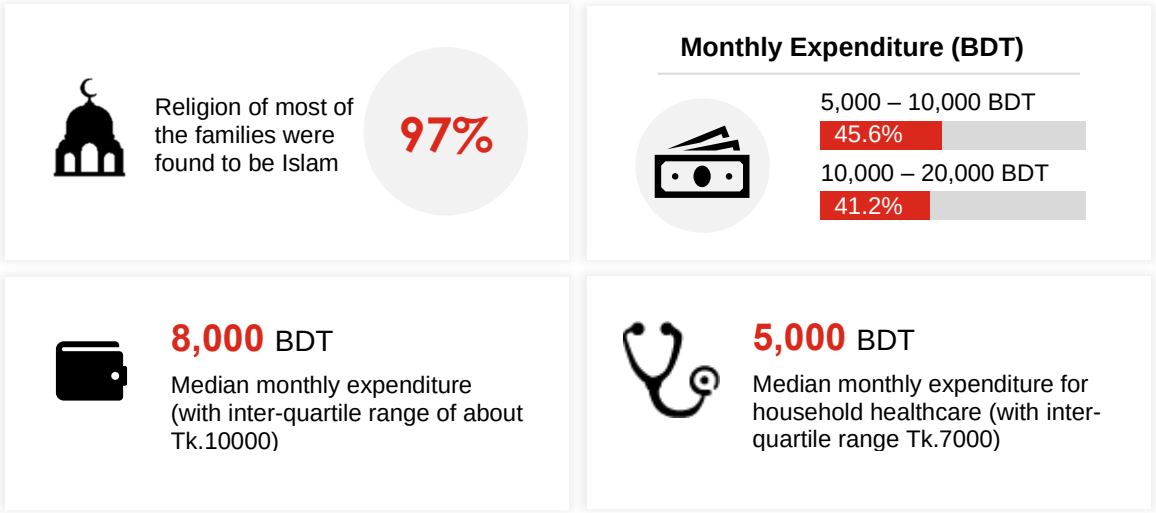
The percentage of receiving postnatal care within 24 hours of delivery for mothers and children was found to increase from 55.0% to 74.0% as the husband's education rose from primary level to higher secondary level respectively. As it is expected that educated husbands are more likely to encourage their wives to avail services from trained service providers, and because in most cases the husbands are the decision makers (above 70%), when it comes to which hospital to go to, when to visit, the necessity of regular check-ups, asking for a trained personnel, deciding if they can afford a private clinic or whether to go to a government health facility, etc., this finding, which indicates about a 20% increase in availing PNC after delivery corresponding with the rise in education level, is understandable.

Number of Children

ANC, facility delivery, presence of SBA during childbirth, and PNC within 24 hours of delivery were found to have a relationship with number of children mothers had. It was found that the women with 2 children or less made more healthcare services/visits during pregnancy and childbirth, than the women who had 2 children or more.

3.2. Household Profile Respondents of the Maternal & Newborn Group

Since the study was conducted in a region of Bangladesh such as Sylhet, as s expected, the religion of most of the families would be Islam (97.0%). Nearly half of the households had a monthly expenditure within in the range of BDT 5000 - 10000 and 41.2% households had a monthly expenditure within the range of BDT 10000 - 20000. The median monthly expenditure is estimated at Tk.8000, with an inter-quartile range of about BDT 10,000. On the other hand, the median monthly expenditure for household healthcare purposes specifically is estimated at BDT 5,000 with an inter-quartile range of Tk.7000 (See table -17, Annex 2).



Among the respondents, about 31.0% reported that Union Health and Family Welfare Centre/Sub-centre/RD is the nearest health centre to them, as it was expected to be. On the other hand, about one quarter of the respondents reported that government community clinics were the nearest health centres to them. About 17.0% of the respondents reported that the nearest health centre to them is the Upazila Health Complex. The percentage of respondents with health centres within one kilometre of the respondent's homes was about 41.0%, while a staggering 80.0% of the respondents are found to have access to a health facility within 2 kilometres of their residence. This reflects the accuracy of the sampling design of the survey, and the fact that distance itself is unlikely to be a major hindrance in reaching the clinics. Rather, it is likely that other factors such as lack of proper vehicles and approach roads could pose as a bigger barrier to access in general. The data suggests that about 8.0% of the respondents live in areas where the nearest health facilities are more than 4 kilometres away.

According to the primary data, the percentage of women receiving antenatal care during pregnancy, facility delivery, assistance of professional birth attendants and postnatal care (for mothers and children) within 24 hours of delivery increases as the socio-economic status of the households improves. This implies that during pregnancy, women belonging to wealthier households receive more care, opt for more facility delivery with the assistance of skilled birth attendants, and avail more postnatal care after delivery. It was also found that they occasionally visit private clinics if they are not satisfied with the service, they get from the government clinics. Sometimes they seek second opinions as well.

Moreover, the results also indicate that respondents from the low-income population prefer not to use healthcare facilities due to lack of money. Although the services they can avail from UH&FWCs under the Mamota project are free of cost, the transportation cost associated with visiting UH&FWCs are an added cost for them. Some of them even reported that they view these visits as

a bit of a hassle for them. In addition, respondents from low-income groups also reported that it becomes very difficult for them to afford the hospital expenses when they are referred to the Osmani Medical College Hospital in case of emergencies. In fact, respondents further reported that they often are instantly referred to Osmani, regardless of an emergency. The women of the community reported that they fear private medical hospitals will recommend them to do a caesarean delivery, which will be too expensive for most of them. These are some of the issues that contribute towards discouraging the respondents in the local community to seek services from the UH&FWC facilities.

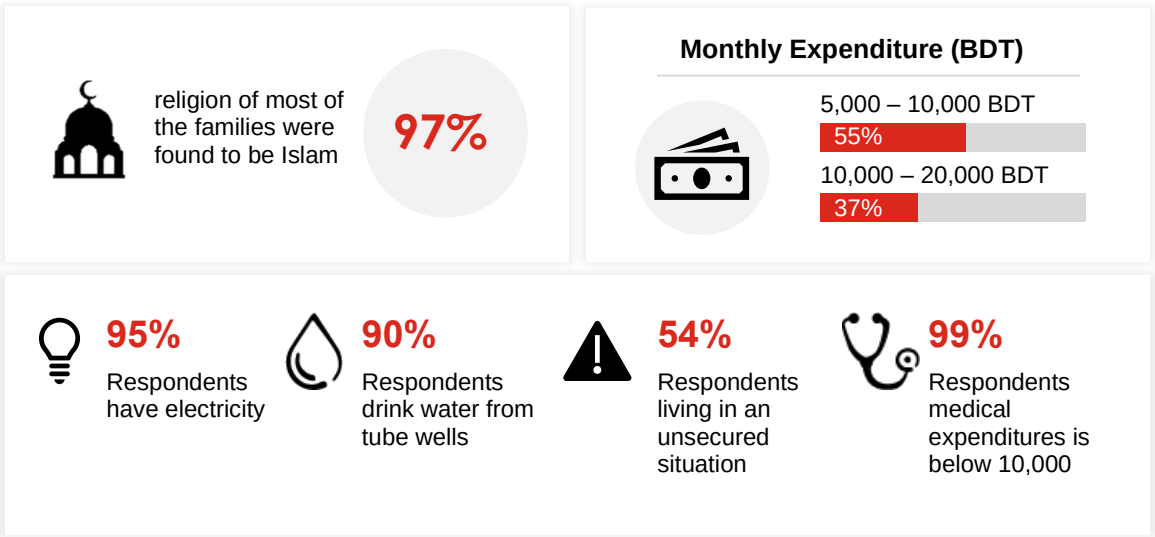
3.3. Background Characteristics of Family Planning Group Respondents

This section provides a brief description of the characteristics of the group of married women of reproductive age (15-49 years) who were not pregnant at the time of the survey and have not given birth within the last two years of the survey. The study collected information of the respondents regarding their current age, educational level, occupation, husband's age, husband's educational level, and husbands' occupation. The demographic profile of the respondents and their husbands is shown in Table 17 in the Annex 2. The age distribution of the respondents indicates that about 44.7% are between the ages of 28-38 years. About 17.2% of the respondents are aged 38 years or above. According to the findings of the study, over half of the respondents were found to have attained primary level education. The findings also indicate that about 14.3% of the respondents have no formal education at all, while18.5% respondents reported that they were illiterate. It was found that 97.9% of the respondents are housewives (See Table-17, Annex 2). Unexpectedly, illiteracy was found to be higher among the husbands (26.4%) than the wives/respondents (18.5%). In terms of the husband's occupation, about 21.5% are found to engage in farming, while29.8% reported to be unskilled labourers, and about 19.4% were found to be skilled labourers (See Table-17, Annex 2).

3.4. Household Profile of Respondents of the Family Planning Group

Similar to the other group of respondents, it was found that about 97.0% of the families are Muslim. Almost all respondents (95.5%) have electricity in their houses and 90.0% access drinking water from tube wells. Regarding condition of food security of the surveyed households, about 54.0% were found to be food insecure. Furthermore, it was found that many of them had taken several loans to meet the demand of food in their households.

The findings indicate that about 55.0% of the households have a monthly expenditure within BDT 10,000. Also, about 37.0% of the households were found to have a monthly expenditure between BDT 10,000 to 20,000. However, among almost all (99%) the respondents, the household healthcare expenditure was found to be below BDT 10,000 (See Table- 21, Annex 2).



Nearly 47.0% of the respondents reported that the Union Health and Family Welfare Centre/Sub-centre/RD is the nearest health centre to them, and it is the place they usually visit when required. On the other hand, 33.0% of them reported that government community clinic is the health centre nearest to their homes. About 38.0% of the respondents reported that the health centres is within 1 kilometre of their residence, and 20.0% reported that it was about 2 kilometres from their homes (See Table-21, Annex 2)

3.5 Progress of ANC/PNC Care, Delivery & Skilled Birth Attendance

Interviews with different health service providers from upazila and union helped assess the current situation by gaining insight about the degree of change in the service patterns, communication with the community people, service quality control and monitoring mechanisms, and emergency preparedness the study team gained further insight about the impact of Mamota project interventions, and its effectiveness in ensuring quality maternal and child healthcare services in the community, and whether there has been a positive shift in their relationship with the community leaders and local government bodies for ensuring improved utilization of MNH-FP services in underserved communities of Sylhet district.

This section discusses the status of the main indicators related to maternal and newborn health. Table 7 shows the results of the study in terms of the major indicators related to antenatal care, postnatal care and facility delivery derived from the household survey data. The percentage of women availing antenatal care at least once during pregnancy by a medically trained service provider is estimated at 75.5%, which is very close to the national figure (81.9% of women receive any sort of antenatal care during pregnancy) according to the recently conducted BDHS 2017-2018. The percentage of women receiving ANC 4 times or more during pregnancy by medically trained service providers was found to be 35.0% (n=366) during the end line survey, which was only 22.6% during the baseline survey. The status of women who availed PNC has also improved when compared to the baseline and national average value. 71.1% of the sampled women were found to receive PNC within 24 hours by medically trained service providers, which is higher than the figure (52.1%) reported by the BDHS 2017-2018 and baseline value (59.2%). On the other hand, 75.8% of the newborn received PNC within 24 hours by medically trained service providers, which is also higher than the BDHS data (52.2%) and baseline value (59.2%). Lack of awareness and lack of services in the health centres are identified as the prime causes for not going to health centres for to avail medical services.

Table 7: Major Indicators Comparison Table

Sl.	Indicators	Balaganj, Golapganj		Companiganj, Gowainghat, Jaintapur, Balaganj, Golapganj	National Value (BDHS 2017-2018)
Outcome level		Baseline (2018)	End line (2020)	End line (2020)	
1	% of women received at least 1 ANC from a medically trained provider	83.9%	94.85%	75.5%	81.9%
2	% of women received 4 or more ANC from a medically trained provider	22.6%	51.2%	35%	47% (from any provider)
3	% of women delivered at facility	53.2%	76.6%	50.31%	49.6%
4	% of delivery conducted by SBA	57.1%	80.6%	56.91%	52.7%
5a	% of women delivered received PNC within 24 hours of delivery from a medically trained provider	59.2%	72.2%	71.1%	52.1% (within 48 hours of delivery)
5b	% of newborn received PNC within 24 hours of delivery from a medically trained provider	59.2%	80.2%	75.28% (child)	52.2 (within 48 hours of delivery)
6	% of women recall at least two danger signs of pregnancy	46.3%	90.8%	60.6%	
7	% of women recall at least two danger signs of newborn	44.8%	73.8%	49.3%	
8	Contraceptive Prevalence Rate (CPR) –any method		67.5%	82.8%	61.9%
9	Contraceptive Prevalence Rate (CPR)- modern method	75.0%	60.9%	74.68%	51.9%
10	Postpartum Family Planning Rate	75.0%	69.1%	31.3%	

During the end-line survey, it was revealed that, the percentage of women seeking facility delivery has also increased from 53.2% to 76.6% in Balaganj and Golapganj upazila. 80.6% women reported to have been assisted by a skilled birth attendant (SBA) during their delivery, which was reported to be 57.1% during the baseline survey in Balaganj and Golapganj upazila.

Moreover, the status of skilled birth attendance and facility delivery has also improved in the end line survey compared to the baseline and national reference value. The respondents who had deliveries at home and received PNC services from trained service provider (SBA) was found low in the end line study when compared to the baseline and the national value. Moreover, information on

the progress on some other indicators such as deliveries conducted in health facilities where partograph was used and oxytocin was administered, and functionality of UHFWC management committee were collected through qualitative findings (Discussed in chapter 4 and 5).

"The study team came across a respondent from the field visit (Case of Mitu) who recently gave birth to her first child at the Bagha UH&FWC in Sylhet district of Golapganj Upazila. Now she is undertaking PNC service from there and is very pleased with the services of UH&FWC."

(Full case details in annex)

Furthermore, the qualitative findings revealed that, all of the surveyed health service providers in the union level had received training on providing ANC and PNC services to the pregnant women and mothers, as well as on neo-natal and child healthcare services under the Mamota project interventions. Majority of the service providers were found to be well aware of their duties and responsibilities, and reported that their services are mostly related to providing healthcare to reproductive women, pregnant women, adolescent girls and neo-natal care, along with primary healthcare to general people. The health service providers also reported that they are satisfied with training services provided to them under the Mamota project, and that these trainings have helped them to become more efficient at their workplaces.

Opinion from the health service providers: The health service providers mentioned that, due to the Mamota project interventions, the people of the community, especially women are now becoming more inclined towards seeking healthcare from the UH&FWCs. Health services coverage in different parts of a specific union have widened due to the project interventions which have improved the quality of health services in the community significantly. Moreover, collaboration with the community leaders (UP members, Members of Community Clinic, teachers, elites) with the health service providers has also improved the dissemination of healthcare information to the community people. Since the inception of Mamota project, various types of awareness activities such as courtyard meetings with women and their husbands, campaigns, and assemblies have been arranged in the project locations to inform the community people about the project activities and to encourage them to visit the UH&FWC for proper healthcare services. Family Welfare Assistants (FWAs) reported that they visit the communities to create awareness among the women there regarding the importance of ANC, Delivery care, PNC and neonatal healthcare. They also provide counselling services and motivates them to use family planning methods. These days, Satellite Clinics (SCs) are also arranged in different villages of a Union from time to time. Moreover, the findings show that the local people (especially local leaders and elites) are helpful to the service providers in smoothly conducting these services in the community.

The data also suggests that majority of the respondent are well aware of the national instructions regarding COVID-19 safety measures. It was observed that the respondents practiced hygiene measures such as hand washing and wearing a mask far more than maintaining social distance. Interestingly, two respondents were found to know nothing regarding COVID-19 at all. This finding is quite surprising as the government's initiative in the awareness campaign for COVID-19 left no area in Bangladesh untouched (Table 21, annex2).

Before the Mamota project interventions were conducted, most of the community women preferred to receive maternal and child healthcare facilities at home, and most were unaware of the healthcare facilities available to them. Moreover, many were found to be dissatisfied with the services of the UH&FWCs before the Mamota project interventions were conducted, as there was a shortage of healthcare professionals and unavailability of healthcare officials at the centres. Some of the health

service providers further validated this by reporting that a lack of qualified and adequate number of health workers in the UH&FWCs often demotivates the community people to visit the facilities.

In addition, poor transportation and communication system in some of the areas were major factors in contributing towards the unwillingness of the people in the community to seek healthcare services from these health centres. The local UP Chairman and UP members are considering the improvement of the transportation system for the people in the community to ensure proper access to healthcare services from the UH&FWCs/health centres.

Opinions from the female group: The respondents reported that since the inception of Mamota project, they avail maternal and child healthcare services from their nearby UH&FWCs. They are now aware of the ANC and PNC facilities because of the various activities of the Mamota project. Majority of the women respondents acknowledged that, with the support of Mamota, ANC and PNC services are now available at FWCs located in their Unions. Medical services such as antenatal care, delivery service with proper hygienic procedure, regularity of vaccine and vitamin capsules for children, contraceptive pills and iron tablets, treatment for common diseases of children like- diarrhoea, fever and cough all are now available at the UH&FWCs of their locality. They have also reported that they were provided counselling and psychological support services by the Mamota staff regarding the services they need to get, or which they are about to receive. After the Mamota project interventions, some of the women reported that they can now avail the required health services from the nearby UH&FWC without having to take permission from their husband/in-laws. They also reported that their family members are cooperative about seeking services from UH&FWC.

> “I can now go to the nearby UH&FWC without taking permission from my husband and in-laws. After giving birth to my last two children at home without the presence of a SBA, I gave birth to my third child in this Ramprosad UH&FWC. I also took ANC and PNC services when I was pregnant. Mamota staff have encouraged me on taking ANC/PNC services. I along with my family members are highly satisfied with the services under the Mamota project and they encouraged me to take further health services from there.”
>
> *–Nazma Begum (26), Charikatha, Jaintapur, Sylhet.*

Opinion from the male members: Most of the male respondents reported that, as a part of the Mamota project intervention, during the courtyard meetings the FWAs counselled them about the importance and advantages of availing quality health services from the UH&FWCs and encouraged them to allow their wives in seeking maternal/child healthcare from there.

However, some male respondents of the FGDs were found to still perceived pregnancy and childbirth as a ‘natural’ phenomenon in a woman life which did not require a healthcare facility or special medical care. In their view it is perfectly

normal to have childbirth take place at home, just as traditionally their mothers and grandmothers had done.

Opinions from the community group members: Findings from the FGDs with the community group members revealed that they have also seen a positive shift in the perception of the male and female community members regarding seeking health care facilities from the UH&FWC. Another issue that was observed by the respondents of the FGDs with community group members was that most of the women who are financially well off prefer going to private clinics as they feel more confident in finding all the services they want, there. They also feel that private clinics treat them better when compared to the behaviour they experience from the government health facilities. However, the people who belong to a lower socio-economic status, in cases of emergencies, do not have a choice but not to seek medical assistance from government clinics where the service providers may be reluctant to provide them with any quality services. Mamota project inventions have brought some relief to some of these difficulties among the lower income population.

Opinions of the adolescents: The findings from the FGDs with the adolescent girls revealed that the interventions of the Mamota project, have helped the adolescent girls to gain more knowledge about their monthly menstruation issues and importance of maintaining hygiene during periods. They have also reported that they were now aware of the physical and hormonal changes that occur during the adolescence period. According to the adolescent respondents, the Sub-Assistant Community Medical Officer (SACMOs) visit the schools and provide information and counselling services to them regarding these matters. During this COVID-19 pandemic, the healthcare providers of UH&FWCs have also disseminated information regarding the contamination and prevention of COVID-19 to the people of the community.

However, an alarming point to note from the findings of this study data is that about 24.0% of mothers did not receive any ANC services. This could be due to a variety of factors which includes but are not limited to, lack of knowledge/awareness of the mothers, education level, their economic condition to afford the service, the availability of health services (health facility, including proximity of the health centre to their home; health service provider; shortage of medicine; etc.). The finding that about 34.0% of the mothers also did not receive any PNC services at all is yet another cause for alarm. It is imperative to identify whether this result of a lack of education of the mothers, motivation of the attendants to go back home as soon as possible, or the unwillingness of the service providers. Also, it was observed that when availing both ANC and PNC services, majority of the respondents complained that they were not counselled at all regarding the advantages of taking ANC and PNC services. This could be seen as another point for improvement for the UH&FWCs facilities in future.

3.6 Comparison of MNH Indicators in different study locations

Figure 1 illustrates the comparison of the MNH indicators (percentage of mothers who received ANC at least 3 times, mothers who received ANC at least 4 times, percentage of mothers who delivered at facility, percentage of births attended by SBA, and percentage of mothers & newborn children who received PNC) among the intervening Upazilas. Based on the results mentioned in the figure, we can see that the status of all maternal and child healthcare indicators varies among the Upazilas. It was found that Golapganj and Balaganj Upazila occuphad the highest percentage of women receiving ANC services (both at least 3 and at least 4 times) during pregnancy and facility deliveries. It is inferred that if the initial service from any particular clinic is well received by the patients, they will likely keep visiting those facilities for future services.

The findings of the survey will certainly help the project team to devising proper action plans in their respective Upazilas. This will not only help achieve project goals, but in the long run it will also support the government clinics towards achieving a positive reputation among the local community. A positive image among the community leaders and the potential patients goes a long way towards sustainability.

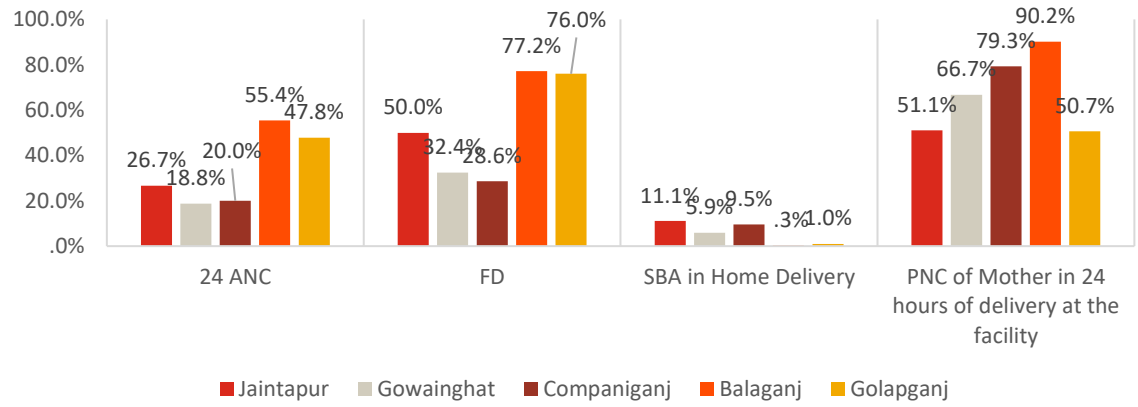


Figure 1: Comparison of MNH Indicators in 4 Intervening Upazilas

3.7 Contraception & Modern Methods Usage

This section discusses the use of contraceptives and contraception methods among the respondents. The respondents (women of reproductive ages (15-49 years) who were not pregnant at the survey point or has not given birth within last two years of the survey) were asked about their knowledge and awareness, and the progress of using modern contraceptive methods was also observed. Furthermore, the family planning services provided by the UH&FWCs were also measured.

The following figure focuses on the major indicators related to the use of contraceptives and contraception methods found in the survey. The household survey data indicates that almost all the respondents were familiar with family planning methods. However, the baseline survey results showed that about 90.0% of the respondents had the knowledge, indicating an increase in the awareness level of the respondents. This could be regarded as a direct impact of the Mamota project interventions. Although most respondents reported gaining the knowledge about the family planning method from their family/relatives/friends, a significant number of respondents also reported gaining the knowledge from UHFWCs (40.0%), from Satellite clinics (21.0%) and from Community Clinics (23.0%). Only a few respondents said they gained the knowledge from mass-media and social media (Table 26, Annex 2).

Baseline findings revealed that about 75.0% of married women in the intervention area were using a form of modern method of contraceptives which has remained same (74.7%) in the end line survey findings. If we disaggregate the data, we can see that this static condition of data is due to a low CPR in Balaganj upazila (50.7%). According to the qualitative finding, the lower rate of contraceptive prevalence in Balaganj was instigated by their desire for taking another baby, migrant husbands, menopause or natural break in menstruation or their preference to not using any method.

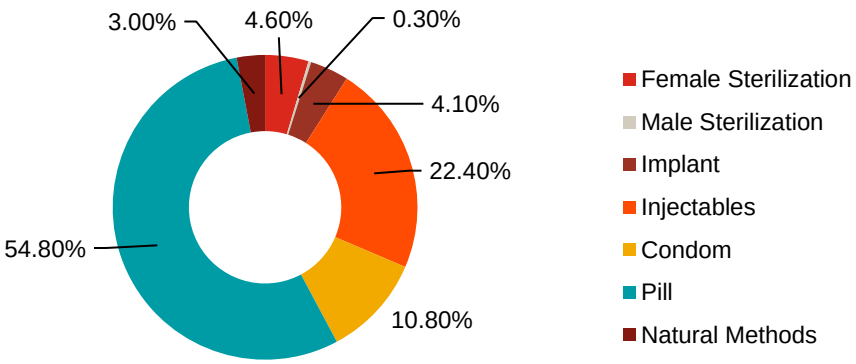


Figure 2: Use of Family Planning Methods

The figure 2 indicates the percentage of women who are currently using different methods of family planning. The analysis of household-level survey data indicates that contraceptive pills are regarded as the most common method of contraception within the intervention areas. It was found that about 54.8% of the respondents were using pills at the time of the survey, which was 49.0% during the baseline survey. The percentage of women using other modern methods within the intervention areas such as implants, injectables and condoms were 4.1%, 22.4% and 10.8% respectively. Among these three methods, the use of injectables was found to be very close to the national level figure, and the use of implants and condoms were found to be slightly higher within the intervention areas the national level figure. It was also observed that about 5.0% of the women adopted the permanent method such as tubectomy within the intervention areas, which was also higher than the figure provided by the BDHS-2017-18 survey. Regarding the source of contraceptives, most of the respondents' access contraceptives from the pharmacy (38.8%), while a significant number of respondents also collect it from the UH&FWC (23.7%).

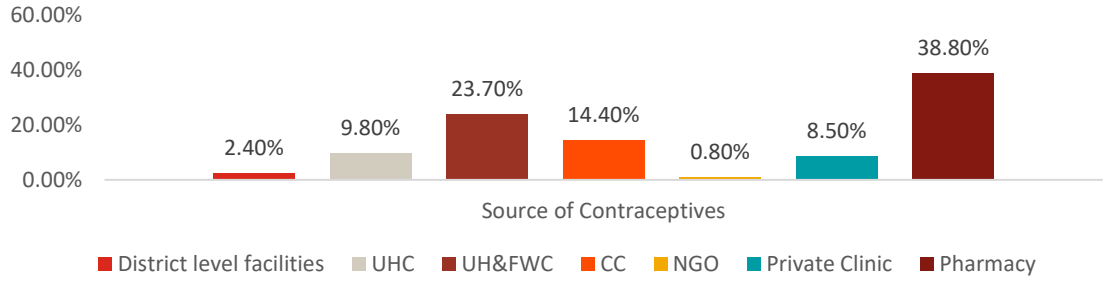


Figure 3: Source of Contraceptives

> "Having conceived two months after my marriage, I was told about the progesterone only pill after my first daughter was born. I would then have second daughter less than 15 months after the first. Now, I am on my second postpartum visit to the center, this time however, to be put on the progesterone only pill. I know the benefits and possible side effects of going on the progesterone only pill."
>
> *- Hasina (23) (Full case details in the annex)*

Postpartum Family Planning (PPFP) usage in Balaganj and Golapganj Upazilas

The study estimates the rate of PPFP usage, along with adoption of the modern contraception methods within the Balaganj and Golapganj Upazilas, as the project interventions have been implemented in these two upazilas both in baseline and end line stages. The options that are currently being practiced more these days among respondents are pills and condoms. In that respect, we find that Balaganj and Golapganj have a higher usage of pills. This could simply be due to the fact that particular clinics have a higher availability of pills and condoms, while others have easier access to injectables. Personal preference of the service providers and their methods of counseling could also play a role in terms of which method is being practiced in certain areas. It would be interesting to look into the financial capacities of respondents in these areas to see if this variation of behaviour is due to the affordability of the contraceptives, accessibility, or something entirely different.

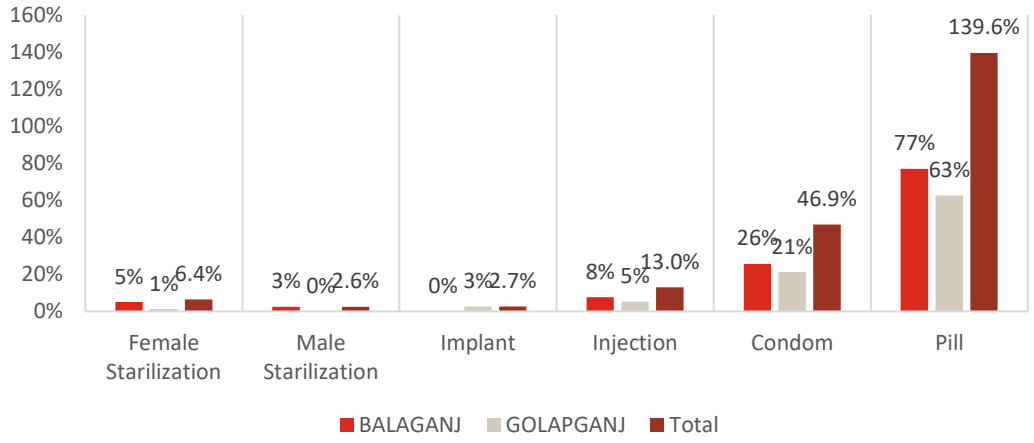


Figure 4: Modern Methods of Contraceptive Usage in Intervening Upazilas (%)

CHAPTER 4: STATUS OF INSTITUTIONAL CAPACITY, SUPPORTING MECHANISM OF LOCAL GOVERNMENT INSTITUTIONS, KEY CONTEXTUAL ISSUES AND BARRIERS FOR VISITING HEALTH CENTRES

Name of the UH&FWC

1. Rustampur (Goainghat)
2. Doubari (Goainghat)
3. Darbost (Jaintapur)
4. Charikata (Jaintapur)
5. Purbo gouripur (Balaganj)
6. Boaljur (Balaganj)
7. Islampur (Companiganj)
8. Telikhal (Companiganj)
9. Budhbari Bazar (Golapganj)
10. Bagha (Golapganj)
11. Bhadeshwar (Golapganj)

*Name of upazila in parentheses

Name of the UHCs

1. Balaganj UHC
2. Jaintapur UHC

The study team observed that the current status of the institutional capacity of the health facilities of the UH&FWCs and UHCs to assess the availability and quality of health services in the selected study locations.

The team also noted existing gaps in the quality of the health service delivery system for the rural people in the surveyed UH&FWCs and UHCs. In this regard, 11 UH&FWCs and 2 UHCs in the study locations were closely observed. Several indicators were selected before conducting the observation to create a checklist, and the performance of healthcare service of the UH&FWCs and UHCs were assessed against those indicators.

The main findings of the indicators are described below:

4.1 Status of infrastructural facility in the surveyed UHC and UH&FWC

The study team also examined the infrastructure of the facilities of the health services in the surveyed UHCs and UH&FWCs by assessing the existing conditions of the UHCs and UH&FWCs buildings in terms of the boundary wall, cleanliness, infrastructure of SACMO and FWVs room, adequate space in staff quarters, toilet, status of delivery and recovery room, electricity etc. After the Mamota project interventions, the buildings of the UH&FWCs have been renovated, a delivery/labour room for pregnant women has been established, necessary equipment for a normal delivery have been provided, waiting areas facilities for the patients (bench, chair, playing space for children in the UH&FWC) have been upgraded. Moreover, minor renovation and repair of the staffs' quarters have also been done as a part of the project intervention. The details of the infrastructure of the facilities (Table 24, Annex 2) which have been renovated and upgraded after the Mamota project intervention is given below:

Boundary wall: While observing the status of security of the UHCs and UH&FWCs, it is found that, in both of the two UHCs of Balaganj and Jaintapur, there is boundary wall all around the specific UHC area. However, in case of the UH&FWCs, out of eleven, seven UH&FWCs have boundary walls.

Electricity and Generator: The study team has observed that in all the surveyed UHCs and UH&FWCs there is electricity facility for the smooth operations of the health centers. In case of presence of the generator facility, in the two (02) surveyed UHC, there is generator facility. However, among the surveyed UH&FWCs only 3 have generator facility.

Hygiene and cleanliness: In case of maintaining hygiene and cleanliness in the UHCs and UH&FWCs, it was observed that, in all the surveyed UH&FWCs and UHCs the staffs maintain proper hygiene and the toilets and surrounding area of the health centers are mostly clean.

Status of Labour/delivery room: It was observed that among all the surveyed UHCs and UH&FWCs there is a delivery room. In both of the UHCs, the equipment for the labour/delivery room were deemed adequate to meet the needs of the patients, and proper cleanliness and hygiene was observed to be maintained. Not only the UHCs, all the renovated UHFWCs were also found to have labour rooms and similar equipment. However, whether the adequacy of the labour/delivery room and equipment will meet the demands of the rural patients remain a matter of concern. Findings revealed that, among the surveyed UH&FWCs, only the Doubari (Goainghat) UH&FWC delivery/labour room and equipment were deemed adequate for the patients.

Adjacent staff quarter: All the surveyed UHC and UH&FWC were found to have staff quarters adjacent to the health centres. The living conditions and services were deemed to be in a good state in all of the UH&FWC staff quarters surveyed.

SACMO and FWVs room: It was observed that there is separate room for SACMO and FWVs in all the surveyed UH&FWCs. Almirah, Chair and shelf are the most common equipment observed in their rooms.

4.2 Status of communication and required healthcare information system for the service recipients

Communication (Road and transport facility): The findings of the study show that the roads are in a good state and the rural dwellers can easily go to the UHCs and UH&FWCs without much problem. After the inception of Mamota project, approach roads to the UH&FWCs have been reconstructed considering the sufferings of the rural people in accessing healthcare from the UH&FWCs in these areas. Moreover, the community group leaders (UP Chairman and Members) are also undertaking effective measures to reconstruct and develop the roads for the community people.

Citizens Charter at the UH&FWC and UHC: The citizens charter displaying information regarding the types of health services available for the community people in the respective UHCs and UH&FWCs was found to be available in all the surveyed health centres except the Bagha UH&FWC.

4.3 Status of supporting mechanism of local government institutions

Frequency of UH&FWC management committee meeting: The status of the supporting mechanism of local government institutions to healthcare services was derived by observing the frequency of UH&FWC management committee meetings and the support provided by the Union Parshad. It was found that through the UH&FWC management committee, the local government officials were be associated with health facilities of the respective union/upazila. The study team noted that all the surveyed UH&FWC management committees conduct regular bi-monthly meetings. Moreover, the meetings minutes are also maintained properly for keeping records and references. The findings from the FGDs revealed that the UP Chairmen and the chairmen of the UH&FWC management committees are very helpful in taking quick decision as they have authority to look after and improve all institutions of a union; such as the construction of approach roads to the UH&FWCs, providing grants from local government, etc.

4.4 Status of record keeping system for proper management of the UH&FWC and UHC

It has been observed that all the surveyed UH&FWCs and UHCs properly maintain the registers/records of the regular activities. The concerned staffs also update the registers/record book on amonthly basis. All the surveyed UH&FWCs and UHCs were observed to maintain general patients' register, adolescents' and child's register, ANC, PNC register, Satellite Clinic register, delivery register, FP register, MR register, movement and visiting register, medicines register and referral slips. Findings also revealed that the list of pregnant mothers is registered into the ANC register of the UH&FWC. Prior to this, they have also enlisted into EDD list which have been

maintained in all UHFWCs that linkage with FWA registers and PW registration. Moreover, a monthly delivery report chart (referring to the number of deliveries conducted per month) was observed to be displayed in all the FWCs.

4.5 Status of supply of medicines and other health services

Availability of medicines and health services: The findings show that emergency contraceptive pills, Misoprostol, Iron, Calcium, Folic acid, and oral pills (Apon/Sukhi) were some of the most common medications among the supply of medicines given by the UH&FWCs and UHCs to the people of the community. Moreover, in all of the surveyed UHCs and UH&FWCs, the SACMO's medicine stores were observed to be well ventilated and clean, however, they were also noted to be quite messy. The data shows that the medicine stock register is updated per month by the staffs of the UHCs and UH&FWCs. Nevertheless, findings from the FGDs with the women of the community and IDIs with the UH&FWCs' health service providers indicate that the availability of various types of medicines is not sufficient to meet the demands of the citizens of the community. It was observed that all the surveyed UH&FWCs attended 8 satellite clinic sessions with the people of the community. Other health services provided by the surveyed UHCs and UH&FWCs are given in the table- 25(See annex 2).

> "From the moment I was brought to UH&FWC for my first childbirth, the paramedic apa was always beside me from admission to till discharge. She was really supportive and gave me a lot of courage during my delivery"
>
> - Mitu (22 years); a participant of female group FGD, Bagha Uh&FWC, Golapganj Upazila

Impressive behaviour and attitudes of the UH&FWC staffs: The respondents reported that they are quite satisfied with the behaviour of the staffs while visiting the UH&FWCs for seeking healthcare services. The rural poor women also commented that when they go to the private clinics and hospitals, they are not treated equally as well as wealthy patients because of their economic status. The attitude of the doctors and staffs is unsatisfactory and it often becomes a source of extra stress for patients of low economic status. Since the intervention of Mamota project, the behaviour of the staff in the UH&FWCs have improved, and nowthey are more friendly and responsive to the patient's needs and issues, and deals with them with patience. Some of the respondents even said that the behaviours and attitude of the paramedics and staff of the UH&FWCs was so positive that it has motivated them to revisit the centres again.

4.6 Status of manpower in the UH&FWC and UHC

The study team observed that after the inception Mamota project, paramedics have been appointed in each of the UH&FWC. However, the number of SACMO, paramedics and FWVs were deemed insufficient to meet the demands for the healthcare services of the people. It was also found that in some of the surveyed UH&FWCs, MLSS and Aya have been provided from Mamota project. Except the Telikhal UH&FWC (Companyganj), Ayas have been appointed in all of the surveyed 10

UH&FWCs and 2 UHCs. In case of MLSS, in 2 of the surveyed UHCs and 7 of the UH&FWCs, MLSS have been posted by the Mamota project. However, findings show that the MLSS position is vacant in Telikhal FWC (Companyganj), Boaljur FWC (Balaganj), Doubari FWC (Goainghat) and Rustampur FWC (Goainghat).

The in-depth interviews with DGFP (MCH) officials revealed that they face some obstacles in ensuring skilled and adequate manpower at the UH&FWCs. Though DGFP is trying to prepare the health officials by continuously providing them training on MNH-FP, Child Health, Post Abortion Care, long (e.g., EOC training, OT Management training, Midwifery training) and short course training (MCH, Adolescent health, Child health), refresher trainings for doctors and paramedics (SACMOs & FWVs), sometimes the authorities face difficulty in ensuring the FWVs/SACMO's employment/retention at the UH&FWCs. This is probably because, the FWVs/SACMO's usually preferred to work at the UHC and MCWC rather than UH&FWCs after receiving training. Some also moved to other cities to seek better work opportunities. As a result, it is difficult for the authorities to ensure 24/7 presence of a health service provider at all the UH&FWCs, which was also found to be one of the major reasons of the respondents' reluctancy to visit the centres. Moreover, they also acknowledged that the available healthcare services at the UH&FWCs are not sufficient to the needs of the people of the community.

4.7. Challenges in existing service delivery system reported by the service providers

Findings from the qualitative survey with the health service providers also revealed some of the challenges in the existing service delivery system such as:

Lack of manpower: Unavailability of sufficient number of service providers such as FWVs, paramedics at the some UH&FWCs causes serious barrier for the community people to receive proper advice and treatment. The health service providers reported that there is a lack of qualified manpower in the UH&FWCs to respond to the needs of the huge number of patients. Findings from the health service providers also revealed that it becomes difficult for them to attend to 5-6 patients at the same time due to lack of manpower. The paramedic typically tends to attend to the critical patient first in that situation. Sometimes due to lack or absence of skilled manpower they had to refer the critical patients to nearest UHC or to the Sylhet M.A.G Osmani Medical College and Hospital.

Lack of modern medical equipment's and medicines: All the service providers reported that there is an absence of adequate materials and equipment related to MCH in the UH&FWC. In such cases, due to lack of instrument and medicine for safe delivery and baby resuscitation (oxytocin, misoprostol), and also because of the absence of skilled FWVs in UH&FWCs, the paramedics/FWVs/SACMOs refer the patient to the UHC and other private clinics to get such services. Moreover, required medicines are not available except some common medicines (Calcium, iron, Vitamin supplements, medicines for fever, cough etc.). Even the quantity of medicine is not adequate to fulfil the necessary demand of the people which lead to gap between UH&FWCs' staffs and patients. Though some of the medicines are given free of cost to the patients from the UH&FWCs, some are prescribed by the paramedics which the patients have to buy by spending additional money from other dispensaries outside the UH&FWCs. In some cases, the poverty-stricken patients prefer not to buy that prescribed medicine due to shortage of cash.

Short term training is not enough: The trainings which were provided to the paramedics and FWVs under the Mamota project interventions were organized for a short duration (1-2 days). These short-term trainings were reported to be not enough for the health services providers to deal with different types of health issues of the people in the community. Moreover, the service providers also reported difficulties in treating complicated cases. These complications need to be explored further.

Presence of social and cultural barriers in the community: Though a significant number of people in the community have shaken off most of the of cultural and social sigma surrounding the issues, some people still reserve negative sentiments regarding availing healthcare services from the health centres. Due to a lack of awareness, they still rely on home remedies for resolving any health issues, something which can cause serious health damage, and sometimes even the death of patients. Some of the women and their family members still prefer to give birth at home rather than at health centres due to the fear of having to go through acaesarean delivery.

Poor communication and transportation system: Poor communication and transportation system is still considered to be an obstacle in availing health services from the UH&FWCs. Poor people in the rural regions often can't manage any transportation during emergencies. During the rainy season, this situation becomes even worse. Moreover, the UH&FWCs do not provide any ambulance services to the critical patients during emergencies or as referrals.

Lack of funding: In most cases, the Union parishad do not have any emergency fund allocation to deal with these types of emergencies. In some cases, the respected union parishad or LGs cannot provide the required emergency support for the poor families because of the insufficient fund collection and transportation.

However, after the inception of Mamota project, the policymakers reported that, there is a positive shift in ensuring improved healthcare services to the people in remote areas. Mamota has successfully reduced the deficiency of skilled manpower at the UH&FWCs. The project has also provided training to the health service providers on maternal and child health care issues so that the people of the community can access these services at their doorstep and from nearby UH&FWCs. The DGFP officials also reported that Mamota project has renovated the infrastructure of the some of the UH&FWCs such as renovations of delivery room, post-natal or recovery room, paramedics' room, waiting area and toilets. Most importantly, the Mamota project has strengthened the engagement of local government bodies (UP Chairman and UP members) in ensuring quality health services for the community. The DGFP officials and FIVDB coordinators also reported that, the UP bodies of the respective upazila have now become very responsive to the healthcare needs of their community people. In some cases, local chairman and members repaired/constructed the roads so that the rural people can easily visit the UH&FWCs of their unions. Moreover, findings from the IDIs also revealed that local chairman also provided solar panel to some UH&FWCs to back up power supply.

CHAPTER 5: COMPARISON BETWEEN BASELINE AND ENDLINE INDICATORS

Some primary key outcome indicators were selected in both the baseline and end-line surveys against which the performance of the project interventions at the study locations and evaluated to compare the outcomes of the baseline and end-line situations.

The household survey data has been utilized to estimate the end-line indicators of antenatal care (ANC), postnatal care (PNC), facility delivery (FD), skilled birth attendance (SBA), knowledge of women regarding family planning (FP), women's knowledge on danger sign during pregnancy/delivery/newborn, modern contraceptive usage, method of contraception and functional UH&FWC to assess the present scenario.

Table 8: Comparison between Baseline (July 2018) and End line (October 2020) Data of Mamota Project

Major Project Indicator		
Indicators	**Baseline**	**End line**
≥4 ANC	23%	35%
Place of ANC	62% from doctors' chamber	37% from UH&FWCs, 14.4% from UHCs
Facility Delivery	53.2%	50.31%
Delivery conducted by SBA	57.1%	56.91%
SBA assisted Home delivery	8.4%	13.6%
PNC in 24 hours of delivery	Mother & newborn-59% in case of facility delivery 12.4% in case of home delivery	77.1% of mothers & 75.8% of children received in facility delivery; 5.6% of mothers & 8.2% of children received in case of home delivery
Using of FP	75% using modern methods	82.8% using modern methods
Types of contraceptive	Oral pill-49% Injectables 11.8% Condom- 22.2% Female Sterilization-10.4%	Oral pill-54.8% Injectables-22.4% Condom- 10.8% Female Sterilization-4.6%
Knowledge on FP	89.6%	100%

Status of availability and accessibility of quality Maternal-New-born Healthcare Services

The required data to assess the improved quality of maternal and new-born health services after the Mamota project interventions were derived from the household survey and from secondary data with the women respondents who have given birth in the last 2 years during the project implementation period.

The main indicators considered were the percentage of mothers received antenatal care, percentage of deliveries at health facility, use of oxytocin and partograph during normal vaginal delivery at the facilities, percentage of deliveries attended by skilled birth attendant, and percentage of newborn/mother received postnatal care. In addition, knowledge on danger sign and quality of healthcare is also considered as a MNH indicators. Figure 10 shows that the healthcare providers at the UH&FWC have been using partograph and oxytocin in all cases of normal vaginal deliveries.

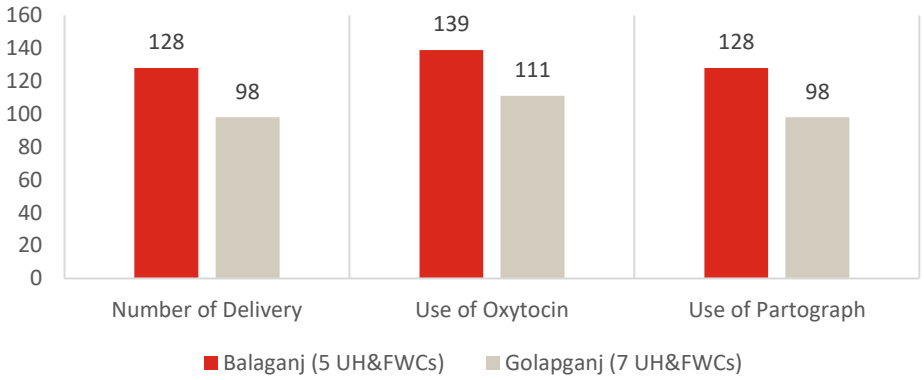
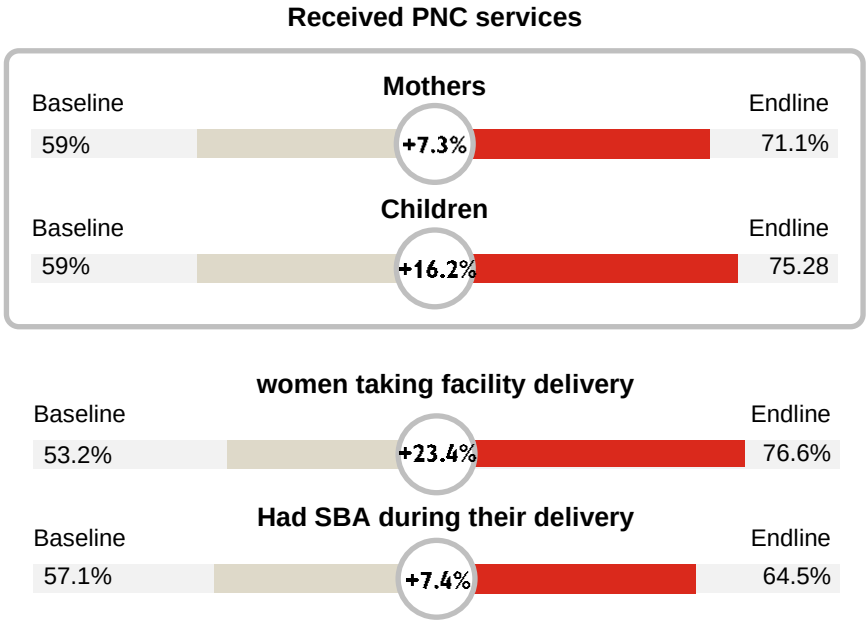


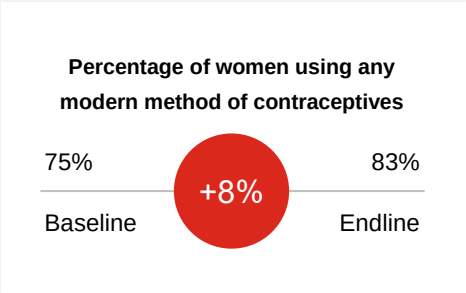
Figure 5: Use of Oxytocin & Partograph during NVD at 12 UH&FWCs in Balaganj and Golapganj (Time period- 24 September, 2020 – 25 October, 2020)

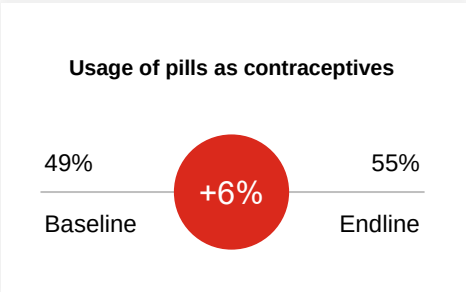
Progress on major MNH and FP indicators

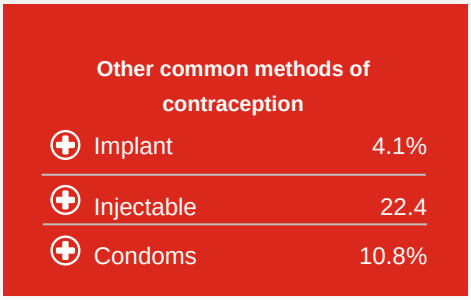
Compared to the baseline, the percentage of women receiving ANC 4 or more times during pregnancy by medically trained service providers is 35.0% (n=366) during the end line survey, which was only 23.0% during the baseline survey. In case of availing PNC services, about 59.0% mothers and new-borns received PNC services within the intervention areas during the baseline study, which has increased to 71.1% in case of mothers and 75.2% of children after the Mamota project interventions. The findings of the end-line survey also revealed that the percentage of women opting for facility deliveries has also increased from 53.2% to 76.6% in Balaganj and Golapganj upazila. 80.6% women reported to have had a skilled birth attendant (SBA) during their delivery, which was reported 57.1% during the baseline survey.



The knowledge on family planning was increased from the baseline (around 90%) to the end line (100%) stage, indicating an increase in the awareness level of the respondents. This could be regarded as a direct impact of the Mamota project interventions. Although most respondents reported gaining the knowledge about the family planning method from their family/relatives/friends, a significant number of respondents also reported gaining the knowledge from UHFWCs (40.0%), from Satellite clinics (21.0%) and from Community Clinics (23.0%).



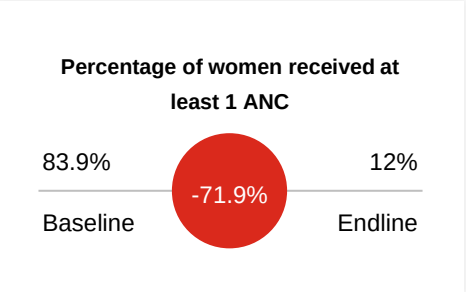


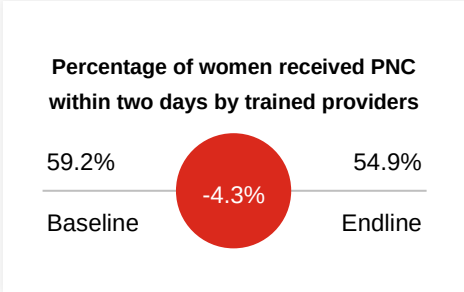


Baseline findings revealed that about 75.0% of married women in the intervention area were using a form of modern method of contraceptives which has remained same (74.7%) in the end line survey findings. If we disaggregate the data, we can see that this static condition of data is due to a low CPR in Balaganj upazila. The analysis of household-level survey data indicates that contraceptive pills are regarded as the most common method of contraception within the intervention areas. It was found that about 54.8% of the respondents were using pills at the time of the survey, which was 49.0% during the baseline survey. The percentage of women using other modern methods within the intervention areas such as implants, injectables and condoms were 4.1%, 22.4% and 10.8% respectively. Among these three methods, the use of injectables was found to be very close to the national level figure, and the use of implants and condoms were found to be slightly higher within the intervention areas the national level figure

Baseline and End-Line Comparison in Balaganj and Golapganj

While comparing the data in the two upazilas (Balaganj and Golapganj) where the project interventions has been implemented both in baseline and end-line stage, a positive change has been observed in the major key indicators (receiving ANC at least once, ANC at least 4 or more times, facility delivery, delivery by SBA, PNC within 24 hours of delivery for both mother and child, knowledge on FP, danger signs of pregnancy and newborn children). The CPR in two upazila has been decreased because of the respondents' expectation for a baby, or their migrant husbands, or menopause etc.





CHAPTER 6: IMPACT, EFFECTIVENESS, RELEVANCY AND SUSTAINABILITY OF MAMOTA PROJECT INTERVENTIONS

In order to assess the relevance and fulfilment of the project objectives, effectiveness, impact and sustainability of the Mamota project interventions, a systematic and objective assessment of the program design, implementation and results was carried out following OECD/DAC criteria[21]. The key questions for measuring the relevancy, impact, effectiveness and sustainability of the Mamota project interventions were assessed against the findings from the quantitative and qualitative survey. During the analysis, the project outcome was marked using Likert scale of 1 to 5 and rationale for assigning each mark is also given in the following table.

[21] *http://www.oecd.org/dataoecd/29/21/2754804.pdf.*

Relevance of the project

Relevancy of the project and its intervention in light of the needs and priorities of clients and target groups have been assessed against the following key research questions.

Table 9: key research questions

Key Questions	Score	Rationale
Is the project doing the right thing?		Findings from the end-line survey reveals that the project has undertaken several measures to meet the health care need of the community people through ensuring awareness of the community regarding health care facilities, increasing health care services such as ANC/PNC/SBA services at the union level UH&FWCs, counselling and psychological support services, providing equipment and manpower in the UH&FWCs, renovation of the UH&FWCs, linkage with the local government bodies to ensure equitable health care services for the community people etc.
How important is the relevance or significance of the intervention regarding local and national requirements and priorities?		After the inception of Mamota project, the policymakers reported that, there have been a positive shift in ensuring improved healthcare services for the community people of the remote areas. Mamota has successfully reduced the deficiency of skilled manpower at the UH&FWCs. The project has provided training to the health service providers on maternal and child health care issues so that the people in the community can access these services at their doorstep and from nearby UH&FWCs. The Mamota project has renovated the infrastructure of the some of the UH&FWCs at the union level such as renovation of delivery room, post-natal or recovery room, paramedics' room, waiting area and toilets which is contributing to quality healthcare services at the remote level. Most importantly, the Mamota project has strengthened the engagement of local government bodies (UP Chairman and UP members) in ensuring quality health services for the community.
Are the activities and outputs of the programme consistent with the intended impacts and effects?	5 	After the inception of Mamota project, different types of awareness raising sessions such as courtyard meeting with women and their husbands, campaigns, assemblies have been arranged to make the community people aware of the project activities and to encourage them to visit the UH&FWCs. Coverage of health services (ANC/PNC/Facility delivery/SBA) in different parts of a specific union have increased

	compared to the national figure than before due to the project interventions which has improved the quality of health services in the community significantly. Collaboration with the community leaders (UP members, Members of Community Clinic, teachers, elites) with the health service providers also has also improved the dissemination of healthcare information to the community people. Moreover, the local UP Chairman and UP members are considering to improve the transportation system for the community people for ensuring proper access to healthcare facilities from the UH&FWCs/health centres.

Effectiveness of the project

The effectiveness of the project has been assessed through evaluating the success of the project in terms of its outputs and outcomes (taking into account their relative importance)?

Table 10: The effectiveness of the project based on the outputs and outcomes

Key Questions	Score	Rationale
Did the project achieve its intended outcomes?		The project has achieved its intended outcome through upgrading and ensuring 24/7 normal delivery at union level health facility; has increased access to quality healthcare services (specially, ANC/PNC) at the UH&FWCs, increased skilled assistance at delivery (delivery by SBA) and facility delivery (64.5% women reported to have skilled birth attendant (SBA) during their delivery); strengthened accessible quality treatment for sick newborn children at SCANU; strengthen Union Health & Family Welfare Centres (UH&FWC) and UEHFP committees.
Are there any differences in outcomes achieved by different groups		Community men and women with higher educational status were found to have positive impact on receiving ANC and PNC services from a trained service provider. The percentage of postnatal care within 48 hours of delivery for mothers and children was found to increase from 55.0% to 74.0% as the husband's education rose from primary level to higher secondary level. That is about a 20.0% increase in the positive direction. Male-headed households were observed to have higher percentage of receiving antenatal care (ANC) 3-4 or more times during pregnancy. Findings from both baseline and end-line survey also revealed that, the percentage of women receiving ANC/PNC and health facility services

		from health centres has increased gradually with the increase of the socio-economic condition of the households.
Are the objectives of the project being achieved?		The project has improved the accessibility and availability of quality MNH-FP services at the facility and community level according to the objectives. It has increased awareness and strengthen support of local government institutions in ensuring equitable health services at the community level.
How big is the effectiveness or impact of the project compared to the objectives planned?		Comparing the end line with the baseline data, most of the indicator (≥4ANC, facility delivery, delivery attended by SBA, Home delivery attended by SBA, PNC within 24 hours of delivery, Knowledge on FP and contraceptive use) shows remarkable improvement. We can conclude that MNH-FP intervention of Mamota has brought remarkable changes in awareness and behaviour of the targeted population in the intervention areas.

Impact of the project

Table 11: Impact of the Project

Key Questions	Score	Rationale
Does the project contribute to reaching higher level objectives (preferably, goal and objectives)?		The project has increased the availability and accessibility of MNH-FP services, improved the quality of services and increased awareness and support of community people and local government (Union Parishad). During the five years of the project interventions, union level health facilities of the government were strengthened by appointing paramedics and supporting staffs to the vacant posts, renovation of infrastructures of the UH&FWCs, augmentation/acceleration of awareness building activities and bridging between local government and health facilities.
What is the impact or effect of the project in proportion to the overall situation of the target group or those effected?		After the project interventions, findings reveal that more than one-third of the respondents (35.0%) received ANC 4 or more times from medically trained providers; 37.0% received ANC from UH&FWCs and 14.4% from UHCs. More than half of the respondents (50.9%) delivered at facilities. Those who delivered at homes, 13.6% of them received assistance by SBAs, which is significantly high than the national average and even the baseline. In case of facility delivery, more than two third of mothers (66.3%) and three-

	fourth of children received post-natal check-up (PNC) within 24 hours of childbirth. 82.8% of the respondents reported to use of modern methods of contraception. The adolescent's girls have gained knowledge about their monthly periodical issues and importance of maintaining hygiene during menstruation. Overall, after the project interventions, the healthcare situation of the study location has remarkably improved.

Sustainability of the project

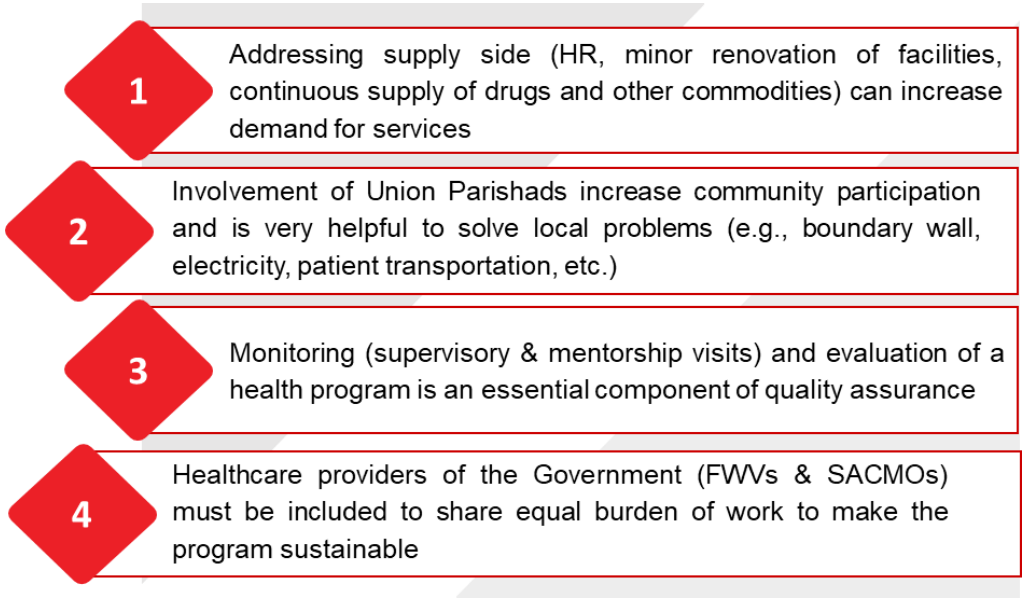
Table 12: Sustainability of the project

Key Questions	Score	Rationale
Are the positive effects or impacts sustainable?		The positive effects of the project are still not sustainable. This is because our government is still not prepared to carry on the project interventions. There is a lack of qualified manpower in the UH&FWCs to respond to the demands of the huge number of patients. Findings from the health service providers also revealed that, it becomes difficult for them to attend to 5-6 patients at the same time due to lack of manpower. Sometimes due to lack or absence of skilled manpower they had to refer the critical patients to nearest UHC or to the Sylhet M.A.G Osmani Medical College and Hospital. Moreover, there is an absence of adequate materials and equipment required for MCH-FP. In addition, the local government body (Union parishad) do not have any emergency fund allocation to deal with these types of emergencies.
How is the sustainability or permanence of the intervention and its effects to be assessed?		For measuring the sustainability and permanence of the project interventions, the preparation of the government should be assessed. It is important to monitor that whether the healthcare providers are performing their duties appropriately at the union/upazila level. Accountability of the health service providers should be ensured by their supervisors. The central monitoring system of the UH&FWCs should be stronger and should closely monitor the performance of the health service providers. Community volunteers should be involved for the promotion of UH&FWCs to create motivation among the local community for seeking healthcare from the health centres.

CHAPTER 7: LESSONS LEARNED, CONCLUSIONS AND POLICY RECOMMENDATIONS

7.1. Lessons Learned

From the five-years intervention of the Mamota project, the key lessons that the study team have identified are as follows:



7.2 Conclusion and Policy Recommendation

This study was conducted to investigate the effectiveness, impact, relevance and sustainability of MCH-FP based health project implemented by Save the Children and FIVDB in five upazilas of Sylhet district. The project aimed to increase the availability of and access to MNH-FP services, improve quality of services and increase awareness and the support of community people and local government (Union Parishad). The duration of the project was five years (2015-2020) and during this period, union level health facilities of the Government were strengthened by appointing paramedics and supporting staff to the vacant posts, renovation of infrastructures of the UH&FWCs, augmentation/acceleration of awareness building activities and bridging between local government and health facilities.

From the above discussion in the previous chapters, when we compare the end line survey data with baseline survey (2018), most of the indicator (≥4ANC, facility delivery, delivery attended by SBA, home delivery attended by SBA, PNC in 24 hours of delivery, knowledge on FP, contraceptive use, danger signs in pregnancy and newborn children) shows remarkable improvement. We can conclude that MNH-FP intervention of Mamota has brought remarkable changes in awareness and behaviour of the targeted population of intervention areas.

Based on the finding of the study and the relevant analysis derived from it, the following recommendations are suggested to be implemented:

- All UH&FWCs must have at least two female paramedics so that one can stay at the UH&FWC all time and another can do satellite clinic at the villages
- There are still some deliveries being conducted at home without the presence of SBA at the intervening upazilas. To reduce or mitigate the challenges, the SBA assisted delivery should be

increased through capacity development of existing FWV/FWA/HA for conducting deliveries at the home level."

- UH&FWCs should have ambulances to carry referral patients in case of emergencies
- The people of the village along with Union Parishad should arrange an emergency transportation system to transport severely ill patients from the community to health facilities
- Union Parshad should take part in improving healthcare system of the union; they must ensure the arrangement of bi-monthly meetings of UH&FWC management committee and must monitor the services of UH&FWC and satellite clinics. UP also should allocate Government grants to improve the services of UH&FWC
- Men (husbands and fathers-in-law) happen to be the decision makers for most families. Therefore, in future, men should be included in courtyard meetings to make them aware on MNH
- Use of modern methods of contraception is very low in the targeted upazilas, especially long-acting permanent methods (implant, IUCD) due to religious sentiments and lack of empowerment among women. The policy-makers should take initiatives to involve Imams and religious leaders in dissemination of FP messages. Ministry of Women and Children Affairs and Ministry of Youth may offer accelerated programs in empowering the women of Sylhet district.
- To ensure quality care for underprivileged rural people, the Government needs the support of the Mamota for next 2-3 years, until all vacant posts are filled up by the Governments paramedics (SACMO & FWV)

One of the important causes of success of the Mamota project was intense monitoring. All Upazilas and Union level facilities should be brought under intense monitoring visits if we want to provide quality healthcare to the rural people. Most of the service providers and policy makers put emphasis on monitoring in their interviews.

The government of Bangladesh is committed to ending preventable maternal and childhood mortality by 2030. To attain government's commitments, only public efforts alone are not sufficient. All major stakeholders acting in the different sectors of the country should also play an active role in accelerating the development of the country. The country has achieved significant progress in the health sector with the support of development partners, UN bodies, non-government and private organizations. Currently, the country is in the middle of the 4th health sector program (HPNSP). This is an important period to prepare a meticulous plan for the next health sector program. The support provided by the Mamota project could be an example of a successful GO-NGO endeavour therefore,this evaluation study will help the policy-makers gain valuable insight and pedantically develop a future program.

SCI EVALUATION RESPONSE PLAN

Recommendation	Planned action	Timeline	Responsible
UH&FWC should have minimum two FWVs to provide 24/7 delivery services;	*Until the Government can mitigate HR issues, female SACMOs could be trained on midwifery and could be posted to the UH&FWC s providing24/7 NVD services;*		
All *Government SBAs should be monitored to evaluate the quantity and quality of normal delivery conducted by them. They should be more involved in assisting childbirths that take place at home;*			
A strong community based referral *system* ***for MCH emergency*** *should be developed with leadership of Union Parishads;*			
UH&FWC Management Committees need to strengthened to improve healthcare system of the union			
More awareness *building meetings should be conducted to increase usage of modern methods of contraceptives; Men and households' heads should invited to attend these awareness building sessions;*			

ANNEX1: SURVEY TOOLS

Sample Survey Questionnaire

Survey Questionnaire – Part A

Mamota Project

(Maternal-Neonatal Health Care and Family Planning)

Household Questionnaire for the Endline Evaluation

Eligibility Criteria for Selection of Households (Part: A)

Household having a mother who has given birth in the last 2 year (mothers having 0-24 years' child) is eligible for collecting data on MNH service and facility delivery.

INFORMED CONSENT
Hello. I am ……., have come from Save the Children/FIVDB located in Sylhet. They are working with govt. to improve health status in your area. I would like to know some information about health services e.g. ANC, PNC and Family Planning that are providing by govt. in your area. This information will help Save the Children to implement health project in this area very competently. The survey will take approximately 20 minutes. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. The information will be used only for research purpose. Participation in the survey is completely voluntary and depends on your will. You have the freedom for not participating in the survey or you can stop the interview at any point of time. But, I hope that you will participate the survey, because your opinion in very much valuable for this survey. I would be very happy if you participate the survey, which are immensely important for proper implementation of the project by the Government of Bangladesh and the Save the Children/FIVDB. May I begin the interview now? ☐Yes ☐No Name of Respondent: Sign of Respondent: Date:

1. Information about interviewer

1.1	Name and Sign of Interviewer			
1.2	Name and Sign of Supervisor			
1.3	Date of Interview			
1.4	Starting Time		Ending Time	

2.1 Information about Study Area

		Name	Code
2.1	Upazila		
2.2	Union		
2.3	Village		
2.4	Ward		
2.5	Household No.		

Part A

Respondent's Background including Household Information and Status of ANC, PNC, SBA, Facility Delivery and Knowledge about Danger Sign of Pregnancy

Section A: Respondent's Background (Mothers who has given a birth in last 2 yearsyear) (October 2018-October 2020)			
Now I want to ask you some questions about you and your husband:			
No.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	SKIP
101	What is your current age? (Probe by checking date of birth through NID)	Year (full year) ..... ☐☐	
102	What is your marital status?	Married ..... 1 Separated ..... 2 Abandoned ..... 3 Divorced ..... 4 Widow 5	
103	What was your age at marriage?	Year (full year)..... ☐☐	
104	Did you study in school or madrasa?	Yes, School ..... 1 Yes, Madrasa ..... 2 Yes, Both ..... 3 No ..... 4 No formal education but can read & write	→**106**
105	What is the highest class you have completed (years of schooling)? (Write 00 for no class passed)	Illeterate……1 No Formal Education ..... 2 Primary ..... 3 Secondary..... 4 Graduate..... 5 Others..... 6	
106	What is your main occupation?	Agriculture in own land..... 1 Agriculture in rented land (Borga) ……..2 Day laborer/unskilled laborer (household, farming, etc.) ..... 3 Skilled laborer (long term employee/ carpenter/mason/fisherman/boatman/ Handicraft)... ..... 4 Housewife……..……5 Own small business/Entrepreneurship ….6 Service Holders ..... 7 Others_____ ..... 96 (specify) (specify)	
107	What is your religion?	Islam..... 1 Hinduism..... 2 Buddhism..... 3 Christian..... 4 Others_____ ..... 96 (specify)	

108	What is the age of your husband?	Year (full year) ..... ☐☐ Don't know 99	
109	What is the highest class your husband had completed (years of schooling)?	Illiterate……..1 No Formal Education……2 Primary ..... 3 Secondary..... 4 Graduate..... 5 Others..... 6 Don't know 99	
110	What is the main occupation of your husband? **[Multiple Answer]**	Agriculture in own land..... 1 Agriculture in rented land (Borga) ……..2 Day laborer/unskilled laborer (household, farming, etc.) ..... 2 Skilled laborer (long term employee/ carpenter/mason/fisherman/boatman/ Handicraft)... ..... 3 Household Work …… 4 Own business/Entrepreneurship ……..5 Service holders ..... 6 Others_____ ..... 96 (specify) (specify)	
111	Mobile number (personal or familial)	.....	

(99-do not know, 96 & X-others use for all options)

Section B: Household Information			
No.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	SKIP
201	Who is the household head?	Husband .....1 Father-in-law.....2 Respondent Heself.....3 Mothe-in-law……..4 Others……..96	
202	What is the current age of the household head? (Probe by checking date of birth through NID)	Year (full year) ..... ☐☐	
203	Had the household head attended School or Madrasha?	Yes, school .....1 Yes, madrasa .....2 Yes, both .....3 No .....4 Don't know 99	→ 205
204	What is the highest class of household head had completed (years of schooling)?	Illiterate……..1 Non Formal Education…… 2 Primary .....3 Secondary .....4 Graduate .....5 Others.....96 Don't know 99	

205	What is the main occupation of the household head? Multiple <u>Add skip instructions in these 3 questions.</u>	Agriculture in own land .....1 Agriculture rented land (borga)……2 Day laborer/unskilled laborer (household, farming, etc.).....3 Skilled laborer (long term employee/ carpenter/mason/fisherman/boatman/ Handicraft)… .....4 Household Work …… 5 Own business/Entrepreneurship ……6 Service holders.....7 Others_____.....96 (specify) (specify)	
206	How many members are there in your household?	Female..... ☐☐ Male..... ☐☐	
207	What type of toilet do your household members use?	Sanitary/Pucca/Pit Toilet (waterproof)……....1 Pucca/Pit toilet (not waterproof).....2 Kutch toilet.....3 Open field .....4 Others_____.....96 (specify)	
208	Does the household have electricity facility?	No Electricity .....1 Polly Bidut .....2 Solar…….3 Others……96	
209	What is the main source of drinking water of the household?	Supply water/tap water from deep tubewell .....1 Tube well .....2 Dug well/Spring .....3 River/canal/lake/pond .....4 Others_____.....96 (specify)	
210	What is the total amount of land of the household including homestead?	Decimal ☐☐☐☐	
211	What is the amount of annual expenditure of the household? (Monthly)	_____taka/month _____taka/year	
212	What is the amount of annual **health expenditure** of the household? (Monthly)	_____taka/month _____taka/year	
213	Whether the household suffered from food shortage in any point of time during the last two year?	Yes .....1 No 2	
214	What is your nearest health centre/hospital? **[Multiple Answer]**	Medical College Hospital .....1 District Sadar Hospital .....2 Mother and Child Welfare Centre.....3 Upazila Health Complex .....4 Union Health & Family Welfare Centre/Sub Centre/RD.....5 Comunity Clinic.....6 Satellite Climic/EPI Centre.....7	

		NGO Health Centre ……..8 NGO Clinics/Hospitals .....9 Private Hospital/Clinic .....10 Doctor's Chamber .....11 Others _____ .....96 (Specify)	
215	What is the distance of the nearest health centre/hospital from your home?	Less than 1 km ……..1 1 km ……2 2 km ……3 3 km ……4 More than 4 km …….5	
216	How long have you been living in this village?	_____year	

Section C: Information about ANC, Delivery, PNC, FP & Other Issues			
No.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
301	How many living children do you have?	Boy _____. Girl_____	
302	How many times were you pregnant?	_____number	
303	Age of last child? Instruction: write day if 0-28 days	Month..... Day.....	
304	Where did you give birth to your last child?	Home _____ Facility_____	
305	For home birth: Why did you not visit facility?		
306	For home Birth: Who conducted the delivery?	SBA .....1 TBA .....2 Dai .....3 Relatives .....4 Mother/aunt/grandmother .....5 Others 99	
307	Was your last birth alive?	Yes ..... 1 → No 2	**309**
308	If no, how old when s/he died? Instruction: write day if 0-28 days	Month..... Day.....	
309	Sex of Youngest Child	Boy ..... 1 Girl.....2	

Information about ANC			
401	During your last pregnancy, did you	Yes ..... 1 No……..2 →	402 a

	receive any health service as ANC?		
402	If yes, how many times did you receive the ANC?	1 time.....1 2 times……2 3 times……3 4 times……4 More than 4 times……	
403	Where/to whom did you receive ANC? (multiple answer may come in this section) **[Multiple Answer]**	Medical College Hospital..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Others (Specify) 96	
404	Who provided you ANC?	CSBA/CHCP……1 PCSBA//Paramedics……...2 Nurse/FWV ……3 Doctor……..…4Others..... .....96 Don't Know……99	
405	Were any of these tests done during ANC visit of your last pregnanc y? **[Multiple Answer]**	Weight Monitoring.....1 BP Checking ……2 Blood Grouping .....3 Rutine Urine Test.....4 Ultrasonogram .....5 Per abdominal Examination…….6 Others……96	
406	During your last pregnanc y did any of the health worker (FWA, HA, NGO Worker) come to	Yes _____number No	

	visit you at home?		
407	Has anybody told you to take ANC or importance of ANC?	Yes ..... 1 No……..2 ⟶	409
408	Who has told you to take ANC?	…….	
409	Have you attended any advocacy meeting (session on health education)	Yes ..... 1 No……..2 ⟶	410 a
410	Who has conducted the advocacy meeting (session on health education)	……..	
410 a	Have you seen any breastfeeding corner at UHFWC? Applicable, if received ANC at UHFWC/ RD (code 5)	Yes ..... 1 No……..2 ⟶	411
410 b	Have you used breastfeeding corner at UHFWC? Applicable, if received ANC at	Yes ..... 1 No……..2	

	UHFWC/ RD (code 5)		
411	Have you received TT injection during your last pregnanc y?	Yes ..... 1 No……..2 ⟶	501
412	If yes, from where you received TT?	Medical College Hospital..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 At home ……..12 Others (Specify)_____..... 96	

Information about Facility Delivery & PNC			
501	What is the delivery place of your youngest child?	Medical College Hospital..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 At home ……12 Others (Specify)_____..... 96	
502	In case of facility delivery; how long did you stay there after delivery?	_____Number of Hours	
502a	In case of facility delivery; has anybody counselled you or tell you about postpartum family planning (PPFP)?	Yes ..... 1 No……..2 ⟶	
502b	Have you received or accepted PPFP?	Yes ..... 1 ⟶ No……..2	503
503	How good was the behavior of the service provider? Applicable, if delivered at UHFWC/RD (code 5)	Very Good Good Average Below Average Poor	

504	How was the overall quality of service? Applicable, if delivered at UHFWC/RD (code 5)	Very Good Good Average Below Average Poor	
504a	Has anybody told you to conduct facility delivery or importance of facility delivery?	Yes ..... 1 No……..2	
504b	Who has told you to conduct facility delivery or importance of facility delivery?	…….	
504c	Have you attended any advocacy meeting (session on health education)	Yes ..... 1 No……..2 →	505
504d	Who has conducted the advocacy meeting (session on health education)	……..	
505	During delivery at home, who assisted your delivery at home?	SBA TBA Dai Relatives Others.....96	
506	Did your child receive any sort of PNC check-up within 24 hours of delivery?	Yes ……..... 1 No……2	
507	Did you receive any sort of PNC check-up within 24 hours of delivery?	Yes ……..... 1 No……2	
508	In case of Home Delivery did your child receive any PNC check-up within 24 hours?	Yes ……..... 1 No……2	
509	In case of Home Delivery did you receive any PNC check-up within 24 hours?	Yes ……..... 1 No……2	
510	How long after delivery you were checked up?	_____ days	
511	Who provided you PNC check-up?	SBA CHCP NGO Paramedics FWV/SACMO Doctor Others	
511a	Has anybody told you to take PNC or importance of PNC?	Yes ..... 1 No……..2 →	511c
511b	Who has told you to take PNC or importance of PNC?	…….	
511c	Have you attended any advocacy meeting (health education session on PNC)	Yes ..... 1 No……..2 →	512

511d	Who has conducted the advocacy meeting (health education session on PNC)	……..	
512	Do you have any idea about emergency fund for maternal and child health?	Yes .....1 No……..2 →	514
512a	What are those?	Transport vehicle…….1 Approach roads ……..2 Equipment/machineries …..3 Infrastructure development ……4 Infrastructure repair ……..5 Maternit Allowance ……..6 Allowance from NGO ……7 Don't know …….96 Others ……99	
513	If yes, have you ever received any help from this fund for your check-up?	Yes .....……1 No…….....2	
513a	Which allowance have you received?	Transport vehicle…….1 Approach roads ……..2 Equipment/machineries …..3 Infrastructure development ……4 Infrastructure repair ……..5 Maternit Allowance ……..6 Allowance from NGO ……7 Don't know …….96 Others ……99	
514	What is the transport that you use to go to health centre? **[Multiple Answer]**	Boat .....1 Van/Rickshaw.....2 CNG/Motor Vehicle.....3 Public Transport…….4 Others.....96	
514a	Do you have any idea about pick-up point?	Yes .....……1 No…….....2	
514b	Who has told you about pick-up point?	……..	
Information about Breastfeeding & Immunization			
515	What did you give your baby within 1 hour of delivery as first food?	Honey/water .....1 Breast milk (clostrum) ……2 Formula Milk……..3 Others……..96	
516	Have you done exclusive breastfeeding? (for the child of aged 6 to 12 months) (Note: only breastmilk)	Yes .....1 No…….....2	
517	Are you maintaining exclusive breastfeeding? (for the child of aged less than 6 months)	Yes .....…1 No…….....2	
518	Whether the child were given required immunization as per the guidelines?	Yes .....…..1 No……2	

519	Where did you get your child immunized?	Medical College Hospital ..... 1 District Hospital ..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex ..... 4 Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic..... 6 Satellite Climic/EPI Outreach .....7 NGO Health Centre ……..8 NGO Clinics/Hospitals ..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Others _____..... 96 (Specify)	

(99-do not know, 96 & X-others use for all options)

Knowledge about Danger Sign of Prgnancy			
520	Do you know about the 5 danger signs of pregnancy?	Yes ..... 1 No……2	
521	If yes, what are the danger signs? **[Multiple Answer]**	Bleeding……...…1 Headaches and/or blurred vision……..2 High Fever……3 Prolong labor……..…..4 Convulsion……...5	
521a	From where you have learnt about the danger sign?	……	
522	Do you have any idea about neonatal danger signs?	Yes……1 No……..2	
523	If yes, what are the danger signs for neonatal? **[Multiple Answer]**	Not feeding since birth or stopped feeding…….1 Convulsion……..……2 Fast breathing……...…3 Fever or hypothermia……...4 Weakness or lethargy……..5 Infection of umbilicus (Omphalitis)…….6 Jaundice ……. 7 Pneumonia……. 8 Others …….. 99	
523a	From where you have learnt about the danger sign?	……	
523b	Have you attended any advocacy meeting (health education session on danger signs of pregnancy period or newborn)	Yes ..... 1 No……..2 →	524
523c	Who has conducted the advocacy meeting (health education session on danger signs of pregnancy period or newborn)	……..	
Opinion regarding Barriers of Visiting Health Facility for Maternal & Child Healthcare			

524	What are the barriers in your area for not visiting health facility during ANC/PNC/Delivery?	
525	What are your suggestions to increase access (mother and children) to health facilities?	
Impact & Sustainability Section:		
601	What are the services you are getting from the UHFWC?	ANC ……..1 PNC ……2 Delivery…… 3 Immunization……..4 Medicine……5 Tests……6 Health education ……7 Proper referrals……..8 Treatment of common illness……..9 Child care……10 Received no services ……96 Others (Specify)…….99
602	How has the service changed over the last 5 years?	Improved a lot Improved somewhat Remained the same Deteriorated somewhat Deteriorated a lot N/A
603	What would be your suggestion on how to improve service quality or continue the services?	
COVID19 Question:		
701	What have you heard about COVID19? **[Multiple Answer]**	Have not heard anything ……..1 Have to wash hand ……2 Have to wear mask ……3 Have to maintain social distance ……4 Others……96
702	Where are you getting your information from on COVID19? **[Multiple Answer]**	From UHC ……1 UHFWC/RD……..2 Community Clinic……3 Satellite clinic……4 Field worker (FWA/SBA)……5 Family & Relatives……..6 Mass media (TV, Radio, Paper)……..7 Social media (facebook, YouTube)…….8 Mobile ……9

		Miking …….10 Others ……96

Survey Questionnaire - Part B

Mamota Project

(Maternal-Neonatal Health Care and Family Planning)

Household Questionnaire for the Endline Study

Eligibility of households (Part-B)

Households eligible for capturing information on Family Planning Services which have a married woman who are not currently pregnant or not given birth in the last one year.

INFORMED CONSENT
Hello. I am ……., have come from Save the Children/FIVDB located in Sylhet. They are working with govt. to improve health status in your area. I would like to know some information about health services e.g. ANC, PNC and Family Planning that are providing by govt. in your area. This information will help Save the Children to implement health project in this area very competently. The survey will take approximately 20 minutes. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. The information will be used only for research purpose. Participation in the survey is completely voluntary and depends on your will. You have the freedom for not participating in the survey or you can stop the interview at any point of time. But, I hope that you will participate the survey, because your opinion in very much valuable for this survey. I would be very happy if you participate the survey, which are immensely important for proper implementation of the project by the Government of Bangladesh and the Save the Children/FIVDB. May I begin the interview now? ☐Yes ☐No Name of Respondent: Signature of Respondent: Date:

1. Information about interviewer

1.1	Name and signature of Interviewer			
1.2	Supervisor's name and signature			
1.3	Date of Interview			
1.4	Starting time		Ending time	

2.1 Information about Study Area

		Name	**Code**
2.1	Upazila		
2.2	Union		
2.3	Village		

2.4	Ward		
2.5	Household No.		

Information on Respondent's Background, Reproductive Health and Family Planning Practices

Section A: Respondent's Background (Married women of reproductive age (15-49 years) who are not pregnant or has not given birth within last 24 months)			
Now I want to ask you some information about you and your family:			
No.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
101	What is your current age? (Crosscheck between 102 and 101)	Year (full year)	
102	What is your marital status?	Married ..... 1 Separated ..... 2 Abandoned ..... 3 Divorced ..... 4 Widow 5	
103	What was your age at marriage?	Year (full year).....	
104	Did you study in school or madrasa?	Yes, School..... 1 Yes, Madrasa..... 2 Yes, Both ..... 3 No ..... 4 →	**106**
105	What is the highest class you completed (years of schooling)?	Illiterate……..1 No Formal Education……2 Primary ..... 3 Secondary..... 4 Graduate..... 5 Others..... 6 Don't know 99	
106	What is your main occupation?	Agriculture in own land..... 1 Agriculture in rented land (Borga) ……..2 Day laborer/unskilled laborer (household, farming, etc.)..... 3 Skilled laborer (long term employee/ carpenter/mason/fisherman/boatman/ Handicraft)... ..... 4 Housewife……..……5 Own small business/Entrepreneurship ….6 Service Holders ..... 7 Others_____ ..... 96 (specify) (specify)	
107	What is your religion?	Islam ..... 1 Hinduism..... 2 Buddhism..... 3 Christian ..... 4 Others_____..... 96	

		(specify)	
108	What is the age of your husband?	Year (full year) ..... ☐☐ Don't know..... 99	
109	Had your husband attended School or Madrasha?	Yes, school ..... 1 Yes, madrasa ..... 2 Yes, both ..... 3 No ..... → Don't know..... 99	**111**
110	What is the highest class your husband had completed? (Write 00 for no class passed)	Illeterate No formal education Primary Secondary Graduate Others	
111	Has your husband engaged with any economic activities?	Yes ..... 1 No ..... 2→	**113**
112	What is the main occupation of your husband?	Agriculture in own land..... 1 Agriculture in rented land (Borga) ……..2 Day laborer/unskilled laborer (household, farming, etc.)..... 3 Skilled laborer (long term employee/ carpenter/mason/fisherman/boatman/ Handicraft)... ..... 4 Housewife……..……5 Own small business/Entrepreneurship ….6 Service Holders ..... 7 Others_____ ..... 96 (specify) (specify)	
113	Mobile number (personal or familial)	.....	

(99-do not know, 96 & X-others use for all options)

Section B:Household Information			
Now I want to some questions about your household			
No.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
201	Who is the head of the household?	Husband .....1 Father-in-law.....2 Respondent Heself.....3 Mothe-in-law……4 Others……..96	
202	What is the current age of the household head? (Please crosscheck between 201 and 202)	Year (full year) ..... ☐☐	
203	Did the household head study in school or madrasa?	Yes, School .....1 Yes, Madrasa.....2 Yes, Both.....3	

		No.....4 Don't know……99 →	**206**
204	What is the highest class had the household head completed (years of schooling)?	Illiterate……..1 No Formal Education……2 Primary .....3 Secondary .....4 Graduate.....5 Others.....6 Don't know 99	
205	What is the main occupation of the household head?	Agriculture in own land.....1 Agriculture in rented land (Borga) ……..2 Day laborer/unskilled laborer (household, farming, etc.).....3 Skilled laborer (long term employee/ carpenter/mason/fisherman/boatman/ Handicraft)... .....4 Housewife……..……5 Own small business/Entrepreneurship ….6 Service Holders .....7 Others_____ ..... 96 (specify) (specify)	
206	How many members are there in your household?	Feale.. .. .. ……. ☐☐ Male .. .. …… ☐☐	
207	What type of toilet do your household members use?	Sanitary/*Pucca*/Pit Toilet (waterproof) .....1 *Pucca*/Pit toilet (not waterproof) .....2 *Kutcha* toilet.....3 Open field .....4 Others_____.....96 (specify)	
208	Does the household have electricity facility?	No Electricity .....1 Polly Bidut.....2 Solar…….3 Others……96	
209	What is the main source of drinking water of the household?	Supply water/tap water from deep tubewell .....1 Tube well .....2 Dug well/Spring .....3 River/Canal/Lake/Ponds .....4 Others_____..... 96 (specify)	
210	What is the total amount of land of the household including homestead?	Decimal ☐☐	
211	What is the amount of annual expenditure of the household?	_____taka	
212	What is the amount of annual **health expenditure** of the household?	_____take Don't know	
213	Whether the household taken loan to meet food demand in any	Yes .....1 No 2	

	point of time during the last one year?		
214	What is your nearest health centre/hospital?	Medical College Hospital.....1 District Sadar Hospital .....2 Mother and Child Welfare Centre.....3 Upazila Health Complex.....4 Union Health & Family Welfare Centre/Sub Centre/RD.....5 Comunity Clinic .....6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals .....9 Private Hospital/Clinic .....10 Doctor's Chamber .....11 Others _____ .....96 (Specify)	
215	What is the distance of the nearest health centre/hospital from your home?	Less than 1 km 1 km 2 km 3 km 4 km More than 4 km	
216	How long have you been living in that village?	_____years	

Section C: Knowledge, Attitude and Practice (KAP) about Family Planning (FP) and Contraceptive Use			
I want to ask some questions about knowledge, attitude, practice of FP and contraceptive use (Omit the women whose husbands are currently residing abroad)			
No.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
301	Do you know about family planning method?	Yes ..... 1 No ..... 2 →	**303**

302	Whom/where do you know about family planning method?	Medical College Hospital..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Print and electronic media……12 Social media……13 Family/friend/relatives……..14 Others _____..... 96 (Specify) **Other Sources** Print and Electronic Media .....M Social Media .....N Family/Friend/Relative .....O Others _____ ..... X (Specify)	
303	According to your opinion, what is the proper age of carrying a baby?	Year (full year)..... ☐☐ Don't know..... 99	
304	Do you know where family planning services are available?	Medical College Hospital..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Don't Know……99 Others _____..... 96 (Specify)	
305	What services are available there?	Family Planning Methods ..... 1 Immunization/Vaccine ..... 2 Child Health..... 3 Tetanus Injection..... 4 Vitamine A Tablet for Children ..... 5 Medicine……6 Others 96	
306	Did you ever use government health facilities for healthcare?	Yes……1 No……2	
307	If yes, then which facilities do you usually	Medical College Hospital..... 1 District Sadar Hospital..... 2	

	visited for healthcare services? (multiple response)	Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Others _____..... 96 (Specify)	
308	How good was the behavior of the service provider?	Very Good Good Average Below Average Poor	
309	How was the overall quality of service?	Very Good Good Average Below Average Poor	
310	What services did you receive from there? Multiple responses	FP……..1 MR……...2 Common Illness……..3 Immunization……4 For children's Illness……..5 Health education……6 Others……96	
311	Which transportation do you use generally to go to healthcare?	Boat .....1 Van/Rikshaw.....2 CNG/Motor Vehicle.....3 Others.....96	
312	Is there any satellite health clinic/centre in this village or *para*?	Yes ..... 1 No……..2	
313	Did you visit such a satellite health clinic/centre in the last 6 months?	Yes ..... 1 No……..2 →	**315**
314	How satisfied are you with family planning services you received from the health centers?	Very Good Good Average Below Average Poor	
315	In last 2 months did any health worker visit you and discuss/distribute family planning methods?	Yes ..... 1 No ..... 2 →	**318**
316	If yes, who came?	Government Health worker..... .1 NGO Health worker ..... 2 Others 96	

317	During the last six months, how many times did a health worker visit you to talk about family planning or to give you family planning methods?	N|umber.....	
318	Are you currently using any method to avoid or delay pregnancy?	Yes ..... 1 No ..... 2 ⟶	**322**
319	If yes, Which method are you using now?	Female Starilization..... 1 Male Starilization ..... 2 IUCD..... 3 Implant ..... 4 Injection..... 5 Condom ..... 6 Pill ..... 7 Abstinence/Natural/ Withdrawl……..8 Don't Know 99	
320	If yes, where did you get the current method?	College Hospital ..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4 Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Pharmacy ……12 Others _____..... 96 (Specify)	
321	Are you satisfied with their services?	Highly satisfied Satisfied Neutral Unsatisfied Very Unsatisfied	
322	What are the reason for not using FP method?	Want to carry child ..... 1 Unavailability of contraceptives..... 2 Not Interested (due to religious factors)……..3 Fear of side-effects……4 Others..... 96	
323	Did you experience any side effects for using contraceptives?	Yes ..... 1 No……..2 ⟶	**326**
324	If yes, did you seek any treatment to overcome the side effects?	Yes ..... 1 No……..2 ⟶	**326**
325	If yes, where/to whom did you seek the treatment to overcome the side effects?	College Hospital ..... 1 District Sadar Hospital..... 2 Mother and Child Welfare Centre ..... 3 Upazila Health Complex..... 4	

		Union Health & Family Welfare Centre/Sub Centre/RD ..... 5 Comunity Clinic ..... 6 Satellite Climic/EPI Centre.....7 NGO Health Centre ……..8 NGO Clinics/Hospitals..... 9 Private Hospital/Clinic ..... 10 Doctor's Chamber ..... 11 Pharmacy ……..12 Others _____..... 96 (Specify)	
326	Does your husband support you adopting the family planning method?	Yes ..... 1 No……..2	
327	Does any of your family members support you adopting the family planning method?	Husband ..... 1 Father-in-law ..... 2 Sister-in-law…….....3 Mothe-in-law……..4 Others……..96	
328	Did you use this method spontaneously?	Yes ..... 1 No……..2	
329	Did you want to become pregnant at the time of your last pregnancy?	Yes ..... 1 No……..2	
Information about Knowledge on Danger Sign of Prgnancy (For the women who has given any birth previously or became pregnant earlier)			
330	Do you have any idea about danger sign during pregnancy, delivery and after delivery?	Yes ..... 1 No……2	
331	If yes, what are the danger signs?	Bleeding……...…1 Headaches and/or blurred vision…….2 High Fever……3 Prolong labor……..…..4 Convulsion……..5	
331a	From where you have learnt about the danger sign?	Medical College Hospital District Sadar Hospital Mother and Child Welfare Centre Upazila Health Complex Union Health & Family Welfare Centre/Sub Centre/RD Comunity Clinic Satellite Climic/EPI Centre NGO Health Centre NGO Clinics/Hospitals Private Hospital/Clinic Doctor's Chamber Print and electronic media Social media Family/friends/relatives FWV FWA Billboard	

		Signboard Mobile/social media Others	
332	Write the correct number of danger signs stated by the respondents		
333	Do you have any idea about neonatal danger signs?	Yes……1 No……..2	
334	If yes, what are the dangers signs for neonatal?	Not feeding since birth or stopped feeding….1 Convulsion……..……2 Fast breathing……..…3 Fever or hypothermia……...4 Weakness or lethargy…….5 Infection of umbilicus (Omphalitis)…….6 Others ……..99	
334a	From where you have learnt about the danger sign?	Medical College Hospital District Sadar Hospital Mother and Child Welfare Centre Upazila Health Complex Union Health & Family Welfare Centre/Sub Centre/RD Comunity Clinic Satellite Climic/EPI Centre NGO Health Centre NGO Clinics/Hospitals Private Hospital/Clinic Doctor's Chamber Print and electronic media Social media Family/friends/relatives FWV FWA Billboard Signboard Mobile/social media Others	
334b	Have you attended any advocacy meeting (health education session on danger signs of pregnancy period or newborn)	Yes ..... 1 No……..2 ⟶	335
334c	Who has conducted the advocacy meeting (health education session on danger signs of pregnancy period or newborn)	……..	
Opinion regarding Barriers of FP and Healthcare services in Facility			
335	What are the barriers in your area for not visiting health facility during ANC/PNC/Delivery and Family planning?		

336	What are your suggestions to increase access (mother and children) to health facilities?	
	Impact section:	
401	What are the services you are getting from the UHFWC?	ANC ……..1 PNC …….2 Delivery…… 3 Immunization……..4 Medicine…….5 Tests……6 Health education ……7 Proper referrals…….8 Treatment of common illness……..9 Child care……10 Received no services ……11 N/A …….88 Others…….96 Specify
402	How has the service changed over the last 5 years?	Improved a lot Improved somewhat Remained the same Deteriorated somewhat Deteriorated a lot Don't know
403	What would be your suggestion on how to improve service quality?	
	COVID19 Question:	
501	What have you heard about COVID19? (Multiple)	Have not heard anything ……..1 Have to wash hand ……2 Have to wear mask …….3 Have to maintain social distance ……4 Others……..96
502	Where are you getting your information from on COVID19? (Multiple)	From UHC ……1 UHFWC/RD……..2 Community Clinic……3 Satellite clinic……..4 Field worker (FWA/SBA)……5 Family & Relatives…….6 Mass media (TV, Radio, Paper)……..7 Social media (facebook, YouTube)…….8 Others ……96

Checklists for FGDs and In-depth Survey

1. FGD with direct and indirect beneficiaries including CV/TBA (04)

(Objective: Decision making at HH level)
(উদ্দেশ্যঃ HH লেভেলে সিদ্ধান্ত গ্রহণ)

Issue 01: Knowledge and services of Mamota Project
(মমতা প্রজেক্টে সম্পর্কিত সেবাসমূহ ও জ্ঞান)

- *What are the services you have so far received from Mamota project for ANC, PNC and family planning?*
  ANC, PNC এবং পরিবার পরিকল্পনার জন্য স্বাস্থ্যকেন্দ্র থেকে এখন পর্যন্ত আপনি কি কি সেবা পেয়েছেন?
- *Are you benefited/satisfied with the services?*
  আপনি কি সেবাগুলো দ্বারা উপকৃত/ সন্তুষ্ট হয়েছেন?
- *Do you get essential drugs/family planning materials from Mamota Project?*
  আপনি কি ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্রথেকে প্রয়োজনীয় ওষুধ/ পরিবার পরিকল্পনার সামগ্রী পান?
- *Does Mamota frequently carry out urine test, BP measurement, hemoglobin test etc. for ANC and PNC?*
  ANC এবং PNC এর জন্যইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র দ্বারা প্রায়ই কি প্রস্রাব পরীক্ষা, ব্লাড প্রেশার পরীক্ষা, হিমোগ্লোবিন পরীক্ষা ইত্যাদি করা হয়?

Issue 02: Motivation to seek services
সেবা গ্রহণের অনুপ্রেরণা

- *Why do you seek services from health centres?*
  আপনি কেন স্বাস্থ্য কেন্দ্রগুলো থেকে সেবা চান?
- *Do your family members support you? Explain…*
  আপনার পরিবারের সদস্যরা কি আপনাকে সমর্থন করে? কিভাবে ব্যাখ্যা করুন।
- *Please explain your experience in receiving services (ANC, delivery, PNC and family planning services)*
  ANC, PNC এবং পরিবার পরিকল্পনা সম্পর্কিত যে সেবা পেয়েছেন, সে বিষয়ে আপনার অভিজ্ঞতা ব্যাখ্যা করুন।
- *What are the challenges you are facing in receiving services?*
  সেবা গ্রহণের ক্ষেত্রে আপনি কি কি প্রতিবন্ধকতার সম্মুখীন হচ্ছেন?

Issue03: Decision making to receive services (Who decides and why)
সার্ভিস গ্রহনের সিদ্ধান্ত কে নেন এবং কেন

- *Who are usually decides for receiving services at household level?*

পরিবার পর্যায়ে কারা সাধারণত সার্ভিস গ্রহণের জন্য সিদ্ধান্ত নেন?

- *Are the family members actively helping the beneficiaries for receiving services?*
  পরিবারের সদস্যরা সার্ভিস গ্রহণের জন্য আপনাদের সক্রিয়ভাবে সহায়তা করছেন কি?
- *Whether the services of CV are satisfactory?*
  কমিউনিটি স্বেচ্ছাসেবীর (CV) সার্ভিস সন্তোষজনক কি?
- *How do CV and TBA influence you to seek the services (ANC, delivery, PNC and family planning services)?*
  ANC, PNC এবং পরিবার পরিকল্পনা সম্পর্কিত সেবা পেতে CV এবং TBA আপনাকে কিভাবে প্রভাবিত করেছে?

2. FGD with Community Decision Makers and other Stakeholders (04)

(Objective: Decision making at Community level)

(উদ্দেশ্যঃ সামাজিক পর্যায়ে সিদ্ধান্ত গ্রহণ)

Issue 01: Services of the health center supported from Mamota Project

মমতা প্রকল্প সমর্থিত স্বাস্থ্য সেন্টারের সার্ভিস সমূহ

- *What are the services Mamota project provides?*
  ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র কি কি সার্ভিস প্রদান করে?
- *Who are benefited through Mamota project and how?*
  কারাইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র দ্বারা উপকৃত হয়েছে এবং কিভাবে?
- *Whether the essential drugs/family planning materials provided by the health center are sufficient? How?*
  স্বাস্থ্য কেন্দ্র থেকে সরবরাহকৃত প্রয়োজনীয় ওষুধ/ পরিবার পরিকল্পনার উপকরণগুলো পর্যাপ্ত ছিল কি? কীভাবে?

Issue 02: Motivation and decision making for promoting health center services

স্বাস্থ্য কেন্দ্রের সেবাগুলোর প্রচারণার জন্য অনুপ্রেরনা এবং সিদ্ধান্ত গ্রহণ

- *Why do you promote this health service center in your community?*
  আপনি কেন আপনার এলাকায় এই স্বাস্থ্য কেন্দ্রটির সার্ভিসগুলোর প্রচারনা করেন?
- *What are the challenges of the health center for carrying out the services?*
  সার্ভিসগুলো পরিচালনার জন্য স্বাস্থ্য কেন্দ্রকে কি কি প্রতিবন্ধকতার সম্মুখীন হতে হয়?
- *How the challenges are overcome? [Community contributions]*
  কিভাবে প্রতিবন্ধকতাগুলো কাটানো হয়েছে? [সম্প্রদায়ের ভূমিকা]
- *What are the roles you play to address the challenges? [Road construction, supplying drugs, etc.]*
  প্রতিবন্ধকতাগুলো সমাধানের জন্য আপনার ভূমিকা কি ছিল? [রাস্তা তৈরী, ঔষধ সরবরাহ ইত্যাদি]
- *What are the community contributions to improve health services in your area?*
  আপনার এলাকায় স্বাস্থ্যসেবা উন্নয়নের জন্য জনসমাজের ভূমিকা কি কি?
- *Your suggestions to improve the quality of services provided by the health center*
  স্বাস্থ্যকেন্দ্রের সেবাগুলোর উন্নতির জন্য আপনার পরামর্শ কি?

Issue 03: Sustainability of the services provided from the health center

স্বাস্থ্য কেন্দ্র থেকে প্রদত্ত সেবাগুলোর স্থায়িত্ব

- *Whether the existing referral system and practice created by Mamota project is useful for ensuring maternal and child health of the community?*
  এলাকায় মা এবং শিশু স্বাস্থ্য নিশ্চিত করার জন্য ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্রের বিদ্যমান সুপারিশ ব্যবস্থা বা এর অনুশীলন কার্যকর কি?

- *Do you think health center should continue supporting the women and newborn baby in future?*
  স্বাস্থ্যকেন্দ্রটির ভবিষ্যতে মা ও নবজাতককে সহয়তা প্রদান করা উচিত বলে আপনি মনে করেন কি?
- *Do you think if there is no support from Mamota, your community will still get the services?*
  যদি মমতা প্রকল্প থেকে কোনও সমর্থন না পাওয়া যায়, তবে আপনার এলাকাবাসী কি ভবিষ্যতে সেবাগুলো পাবে?
- *What will be your role as stakeholder to maintain and continue the present services after the Mamota ends*
  মমতা প্রকল্প শেষ হওয়ার পরে বিদ্যমান সেবাগুলো বজায় রাখতে এবং চালিয়ে যেতে আপনার কী ভূমিকা থাকবে?
- *Your overall comments about Mamota project that is under implementation in your community.*
  আপনার এলাকায় চলমান মমতা প্রকল্প সম্পর্কে আপনার সামগ্রিক মন্তব্য কি?

3. Guidelines for Focus Group Discussion of unmarried adolescents (youths aged between 10-19)

FGD Location: Village _____ Union _____ Thana _____ Zilla: Sylhet
Date _____ Time _____
Number of adolescents _____

Name of FGD Conductor: _____ Name of notetaker: _____ Name of Recordkeeper: _____

1. *Introduce yourself*
2. *Tell them a little about the purpose of the FGD*
3. *Let them know that their names and identities will not be disclosed and only their responses will be considered for this project's evaluation.*
4. *At this point, please take their consent and if anyone does not want to participate voluntarily, then please let them know that they can refrain from participating in this FGD*
5. *Age: a) How many are aged between 10-13? _____ b) How many are aged between 13-15? _____ c) How many are aged between 15-19? _____*
6. *Education: How many attend schools? _____ b) How many attend madrasas? _____ c) How many do not attend schools or madrasas? _____*
7. *a) How many with both parents alive? _____ b) How many with deceased father? _____ c) How many with deceased mother? _____*
8. *Occupation of father: a) Agricultural work/Farmer _____ b) Job _____ c) Labor ___ d) Remittance worker/Works abroad/Migrant worker _____e) Business _____ f) Other _____*
9. *Have any of the adolescents ever taken treatment/care at Union Health and Family Welfare Center, Upazila healthcare, community healthcare or satellite clinics? a) Yes _____number of adolescents b) No _____ number of adolescents c) Never even heard of these places _____ number of adolescents*
10. *Do you know who are adolescents?*
11. *What are the health issues/problems that you can face at this age?*
12. *What are the psychological/mental issues/problems that you can face at this age?*
13. *When/if you face problems, who do you share them with?*
14. *How do you solve those issues/problems? Do you visit healthcare centers at all?*
15. *If not, from whom do you seek help from/ to whom do you go to?*
16. *If not, why don't you go to a healthcare center?*
17. *If you do go to a healthcare center, who takes you there?*
18. *Which healthcare centers do you visit?*
19. *Do you get the expected/adequate/required treatment there?*
20. *How should adolescents care for themselves?*
21. *Have you ever received any advice on adolescent health and wellbeing? If yes, from whom did you receive such advice from? Has a healthcare worker ever advised you on such matters?*
22. *Girls of 13 years of age and above, do you take folic acid supplements?*
23. *Girls of 15 years of age and above, have you received TT vaccination (prevention of tetanus)?*
24. *What is the appropriate age of marriage for women? What is the appropriate age of marriage for men?*
25. *Do healthcare workers from healthcare centers visit your school?*
26. *Do healthcare workers visit your home?*
27. *Do they teach you about adolescent health at school?*
28. *What do you know about Corona (COVID 19)?*
29. *What should you do to keep yourself safe from Corona (COVID 19)?*
30. *Who in your family can you open up to and discuss matters with freely?*

- *Please hold the microphone up close when anyone is speaking and ask them to state their identity (name, age and school grade) before their response.*
- *Thank everyone once the session has been concluded and provide light refreshments for everyone.*

4. In-depth interviews

4.1 Service Providers (09)

[Objective: Sustainability of the services]
[সার্ভিসের স্থায়িত্ব]

1. *Name:*
   নামঃ
2. *Age:*
   বয়সঃ
3. *Educational qualification:*
   শিক্ষাগত যোগ্যতাঃ
4. *Occupation/Status:*
   পেশাঃ
5. *Location:*
   ঠিকানাঃ
   6. কতদিন ধরে এই সেবা কেন্দ্র কাজ করছেন?

6. *How do you feel serving the women and newborn baby?*
   নারী এবং নবজাতকের সেবা প্রদান করতে আপনি কেমন বোধ করেন?
7. *What is the additional knowledge/skill/capacity you have gained from the Mamota project?*
   মমতা প্রকল্প দ্বারা আপনি অন্যান্য কি জ্ঞান/ দক্ষতা/ সক্ষমতা অর্জন করেছেন?
8. *How do you apply that knowledge/skill/capacity?*
   আপনি কীভাবে সেই জ্ঞান / দক্ষতা / ক্ষমতা প্রয়োগ করেন?
9. *Do you think the trainings you have taken are sufficient or you need more training?*
   আপনি যে প্রশিক্ষণ নিয়েছেন তা যথেষ্ট বা আপনার আরও প্রশিক্ষণের প্রয়োজন আছে বলে মনে করেন কি?
10. *Do you think that it is your responsibility to serve the mother and newborn baby?*
    মা এবং নবজাতকের সেবা করা আপনার দায়িত্ব বলে মনে করেন কি?
11. *Explain the challenges you face to provide services?*
    সেবা প্রদানের ক্ষেত্রে আপনি কি কি প্রতিবন্ধকতার সম্মুখীন হন?
12. *How do you overcome the challenges?*
    প্রতিবন্ধকতাগুলো কিভাবে কাটিয়ে উঠেন?
13. *Are you appreciated by your family members/relatives for your work?*
    আপনি কি আপনার কাজের জন্য পরিবারের সদস্য / আত্মীয়দের দ্বারা প্রশংসিত হয়েছেন?
14. *Whether the existing referral system and practice created by Mamota project is useful for ensuring maternal and child health of the community?*

এলাকায় মা এবং শিশু স্বাস্থ্য নিশ্চিত করার জন্য মমতা প্রকল্পের বিদ্যমান সুপারিশ ব্যবস্থা বা এর অনুশীলন কার্যকর কি?

15. *What else Mamota should do for providing better services?*
    উন্নত সেবা প্রদানের জন্য মমতা প্রকল্পের আর কি করা উচিত?
16. *Will you continue your work after the Mamota project?*
    মমতা প্রকল্প শেষে আপনি আপনার কাজ চালিয়ে যাবেন কি?

4.2 UP bodies (Chairman/Member) (05)

[Objective: Knowledge on Health services by Mamota]
[উদ্দেশ্যঃ মমতা প্রকল্পের স্বাস্থ্যসেবা সম্পর্কিত জ্ঞান]

1. *Name:*
   নামঃ
2. *Age:*
   বয়সঃ
3. *Educational qualification:*
   শিক্ষাগত যোগ্যতাঃ
4. *Occupation*
   পেশাঃ
5. *Location*
   ঠিকানাঃ
6. *What are the services provided from the health centers in your area?*
   আপনার এলাকায় স্বাস্থ্য কেন্দ্রগুলো থেকে কি কি সেবা প্রদান করা হয়?
7. *How does the health center provide services?*
   স্বাস্থ্য কেন্দ্র কীভাবে সেবা প্রদান করে?
8. *Whether the existing referral system and practice created by Mamota project is useful for ensuring maternal and child health of the community?*
   এলাকায় মা এবং শিশু স্বাস্থ্য নিশ্চিত করার জন্য মমতা প্রকল্পের বিদ্যমান সুপারিশ ব্যবস্থা বা এর অনুশীলন কার্যকর কি?
9. *How effective was the service of Mamota project for women/children?*
   নারী / শিশুদের জন্য ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্রের সেবাগুলো কেমন কার্যকর ছিল?
10. *How do you involve yourself in this service promotion?*
    আপনি কিভাবে এই সেবা প্রচারণায় নিজেকে জড়িত করেন?
11. *What was UP's contribution to upgrade health facilities in your area?*
    আপনার এলাকায় স্বাস্থ্য সুবিধাগুলো উন্নত করতে ইউনিয়ন পরিষদের অবদান কি ছিল?
12. *What are the processes for co-ordination between the UP health center and the Upzilla health and family planning administration? What is your role in coordination?*
    ইউনিয়ন পরিষদ স্বাস্থ্য কেন্দ্র এবং উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা প্রশাসনের মধ্যে সমন্বয়ের প্রক্রিয়াগুলি কি কি? সমন্বয়ের ক্ষেত্রে আপনার ভূমিকা কি?
13. *Ownership of the health center*
    স্বাস্থ্য কেন্দ্রের মালিকানা
14. *How often UWC management committee meet and how they solve problem of FWC?*

কতবার UWC পরিচালনা কমিটির মিটিং হয় এবং কীভাবে তারা FWC সমস্যা সমাধান করে?

15. *How do you continue the health facilities if there is no extra support?*

    অতিরিক্ত সহায়তা না থাকলে কীভাবে আপনি স্বাস্থ্যসেবা চালিয়ে যাবেন?

16. *Involvement of CVs in the project and your relationship with the CVs.*
    প্রকল্পে CV কিভাবে জড়িত এবং CV দের সাথে আপনার সম্পর্ক কেমন?

17. *Your confidence on CVs to continue the services in absence of Mamota project.*
    মমতা প্রকল্পের অনুপস্থিতিতে সেবাগুলো চালিয়ে যেতে CV দের প্রতি আপনার আস্থা কেমন?

18. *What more needs to be done by Mamota to provide better service?*
    আরো ভাল সেবা প্রদানের জন্য মমতা প্রকল্পের আরো কি করা দরকার ছিল?

19. *Your overall comments on the health promotions by the health center.*
    স্বাস্থ্যকেন্দ্রের মাধ্যমে স্বাস্থ্য প্রচারণা সম্পর্কে আপনার সামগ্রিক মন্তব্য কি?

4.3 Upazilla-level health and family planning managers (06)

[Objective: Knowledge on Health services by Mamota]
[উদ্দেশ্যঃ মমতা প্রকল্পের স্বাস্থ্যসেবা সম্পর্কিত জ্ঞান]

1. *Name:*
   নামঃ
2. *Age:*
   বয়সঃ
3. *Educational qualification:*
   শিক্ষাগত যোগ্যতাঃ
4. *Occupation*
   পেশাঃ
5. *Location*
   ঠিকানাঃ

   6. কতদিন ধরে এই কেন্দ্রে কাজ করছেন?
6. *What are the services provided from the health centers in your area?*
   আপনার এলাকায় স্বাস্থ্য কেন্দ্রগুলো থেকে কি কি সেবা প্রদান করা হয়?
7. *How does the health center provide services?*
   স্বাস্থ্য কেন্দ্র কীভাবে সেবা প্রদান করে?
8. *Whether the existing referral system and practice created by Mamota project is useful for ensuring maternal and child health of the community?*
   এলাকায় মা এবং শিশু স্বাস্থ্য নিশ্চিত করার জন্য মমতা প্রকল্পের বিদ্যমান সুপারিশ ব্যবস্থা বা এর অনুশীলন কার্যকর কি?

   9. আপনি কি মমতা প্রকল্প থেকে কোন প্রশিক্ষণ পেয়েছেন? তা কি যথেষ্ট ছিল?
9. *How effective was the service of Mamota project for women/children?*
   নারী / শিশুদের জন্য মমতা প্রকল্পের সেবাগুলো কেমন কার্যকর ছিল?
10. *How do you involve yourself in this service promotion?*
    আপনি কিভাবে এই সেবা প্রচারণায় নিজেকে জড়িত করেন?
11. *What are the processes for co-ordination between the UH & FWC management committee and the Upzilla health and family planning administration? What is your role in coordination?*
    UH & FWC ব্যবস্থাপনা কমিটি এবং উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা প্রশাসনের মধ্যে সমন্বয়ের প্রক্রিয়াগুলি কি কি? সমন্বয়ের ক্ষেত্রে আপনার ভূমিকা কি?
12. *What more needs to be done by Mamota to provide better service?*
    আরো ভাল সেবা প্রদানের জন্য মমতা প্রকল্পের আরো কি করা দরকার ছিল?
13. *What is your back up plan to continue the current services from the UH & FWCs after Mamota project?*

মমতা প্রকল্পের শেষে UH & FWC থেকে বর্তমান সেবাগুলো চালিয়ে যাওয়ার জন্য আপনার বিকল্প পরিকল্পনা কী?

14. *Your overall comments and recommendations on the Mamota project.*
মমতা প্রকল্প সম্পর্কে আপনার সামগ্রিক মন্তব্য এবং পরামর্শ কি কি?

Guidelines for collecting/compiling case stories of pregnant women/expecting mothers

1. *Greet the respondent respectfully*
2. *Explain the purpose behind compiling/composing the case stories*
3. *Please tell the case story respondent that her name and identity will not be disclosed, only her story will be used for evaluation. After transcription, the recorded conversation will be erased. If she consents, only then will the case story be developed, if not she can refrain from participating.*
4. *Name*
5. *Age*
6. *Educational qualification*
7. *At what age did you get married?*
8. *What does your husband do?*
9. *What is his educational qualification?*
10. *What do you do?*
11. *Have you ever used any family planning methods before? If yes, what were they?*
12. *Have you ever been pregnant before? If yes, how many times?*
13. *For how many months have you been pregnant?*
14. *Where was your last child born?*
15. *During your last pregnancy, where did you receive prenatal care?*
16. *In your current pregnancy where are you receiving prenatal care from?*
17. *Who is providing that care?*
18. *Are you satisfied with the service you are getting?*
19. *If yes, why are you satisfied?*
20. *In not, why are you not satisfied?*
21. *Do you receive your medications from the center or do you have to buy them?*
22. *Who accompanies you when you travel back and forth from the center?*
23. *How far away is the service center/care center/healthcare center from your house?*
24. *How do you travel? How much money do you have to spend on transport every time you visit?*
25. *In your current pregnancy have you received tetanus vaccination?*
26. *Where did you receive it from?*
27. *If you haven't taken it for this pregnancy, have you taken it before? If yes, how many tetanus vaccine shots have you taken?*
28. *During this pregnancy, are you experiencing any problems/issues?*
29. *If yes, from whom are you receiving treatment from for it?*
30. *Can you seek medical help or visit a health center without anyone else's consent? Or do you have to take permission from someone else in your family?*
31. *If yes, from whom do you have to take permission from?*
32. *Did you receive all sorts of treatment/care at the heath center?*
33. *Did you get any tests done? (blood, urine, ultrasonogram)? From where did you get them done?*
34. *During your pregnancy, did any healthcare worker come and give you vitamins, iron (blood inducing pills)?*
35. *This time, till now, how many times have you sought prenatal care?*
36. *Have you received any health education regarding the practices and care you should maintain during pregnancy?*
37. *If yes, from whom did you receive it from?*
38. *What should you eat during pregnancy?*
39. *How should you care for yourself during pregnancy? What are the things you should do and what should you avoid?*
40. *Does everyone in your family help and cooperate with you in maintaining these things during your pregnancy?*
41. *Do you face any resistance from your family members while seeking health care or while taking care of yourself? If yes, from whom do you face this resistance from?*
42. *What is the expected date of your delivery?*

43. *Where are you planning to deliver your baby?*
44. *Have you saved up any money for this purpose?*
45. *Have you arranged any transportation for going to the delivery center when your contractions begin?*
46. *How/What arrangements have you made?*

Union Health and Family Welfare Center Inspection Checklist (If furniture and supplies were provided/arranged by Mamota Project then please write 'M'

_____ Union Health and Family Welfare Center. Upazila: _____Date _____

1. *Transport accessibility: a) There is a road/No road b) Metal road/Dirt road/Brick-soling road c) Transportation: Rickshaw/CNG/Van/Car/Bus*
2. *Boundary Wall: a) There is a wall/No wall b) Completely surrounded/Partly surrounded*
3. *Citizen Charter (a list of all the services provided by the center): Displayed in front of the center/Not displayed*
4. *Balcony where health education is provided: a) Bench Yes/No b) IEC material: Adequately provided/ Inadequate*
5. *Bathroom: Clean/Dirty (Not clean)*
6. *Assistant community medical officer's room:*
    I. *Has been renovated/Has not*
    II. *List all the furniture that has been provided in the room*
    III. *Equipment: a) BP machine – Yes/No b) Stethoscope Yes/No c) Thermometer Yes/No d) Torch Yes/No e) Bathroom scale Yes/No f) Height measuring machine Yes/No*
    IV. *Registrar related questions:*

General Patients Registrar: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many general patients have you (the center) seen? _____ general patients

Adolescent Registrar: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many adolescents have you (the center) cared for? _____ adolescents

Child Registrar: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many children have you (the center) cared for? _____ children

Satellite: a) How many takes place in a month? _____ b) Does it take place in school Yes/No

Movement Register: a) Yes/No b) Regularly maintained/Not regularly maintained

Workers Attendance Register: a) Yes/No b) Regularly maintained/Not regularly maintained

7. *FWV Room:*
    I. *Has been renovated/Has not*
    II. *Is the list of pregnant women, along with their phone numbers updated every two months? a) Yes/No b) Is displayed/Not displayed*
    III. *List all the furniture that has been provided in the room*
    IV. *Equipment: a) BP machine – Yes/No b) Stethoscope Yes/No c) Thermometer Yes/No d) Torch Yes/No e) Bathroom scale Yes/No f) Height measuring machine Yes/No*
    V. *Registrar related questions:*

Expecting Mothers' or Pregnant women Registrar: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many expecting mothers have you (the center) seen? _____ expecting mothers

PNC Registrar: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many mothers have you (the center) given PNC services or care? to? _____ mothers

Oral Pill Register: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many people have taken oral pills? _____ people

Injectable Register: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many people have taken injections? _____ people

Satellite Register: a) Yes/No b) Regularly maintained/Not regularly maintained

MR Register: a) Yes/No b) Regularly maintained/Not regularly maintained c) In the last month, how many people have done MR? _____ people

Inspection Register: a) Yes/No b) Regularly maintained/Not regularly maintained

8. *Pharmacist's work: There is a pharmacist/ No pharmacist*
    I. *Store: a) List of furniture b) Have they been organized properly? Yes/No c) Clean/Dirty*
    II. *Method of organizing medicine: a) Have they been organized/arranged according to their date of expiry? Yes/No*
    III. *Register a) Do the stock and disbursement records match? Yes/No b) Has it been kept up to date? Yes/No c) Other _____*
9. *Residing at a center: Do you reside in the quarters adjacent to FWV and SACMO center? Yes/No*
10. *Supply of DDS kits and adequacy: a) How many kits do you receive in a month? _____kits b) Adequately provided/Inadequate*
11. *Supply of contraceptives and adequacy: Adequate/Inadequate*
12. *Misoprostol: There is supply/No supply*
13. *ICP: There is supply/No supply*
14. *Iron and Folic Acid: a) There is supply/No supply b) Adequate/Not adequate*
15. *How many 24/7 normal delivery services are provided? _____number*
16. *Labor/IUD Room: a) Equipment: Adequate/Inadequate b) Cleanliness: Clean/Dirty*
17. *Recovery Room: a) Necessary furniture is provided/ Not provided*
18. *Generator: a) Yes/No b) Functional/ Out of order*
19. *Running water: Yes/No*
20. *Toilet: a) Has been renovated/Has not b) Clean/Dirty c) There is water/ No water*
21. *Residential Facilities: a) Quarters have been renovated/Has not b) Habitable/Inhabitable*
22. *MLSS cum Night Guard: a) Yes/No b) Appointed by government/Employed by Mamota Project*
23. *Aaya: a) Yes/No b) Appointed by government/Employed by Mamota Project*
24. *What are the noteworthy problems?*
25. *Monthly meeting and reporting: a) Conducted/not conducted b) Keeps record/does not keep record*
26. *FWC management committee meeting: a) Conducted/not conducted b) Keeps record/does not keep record*
27. *General opinion: _____*

Enumerator/Data Collector's name and date: _____

ANNEX 2: FINDINGS TABLE

Table 13: Socio Demographic Status of the Respondents

Indicators	Variables	Frequency	Percentage
Age Group of the Respondents (n=485)	Below 18	6	1.2
	18-28	337	69.5
	28-38	137	28.2
	38-48	5	1.0
Respondent age at Marriage (n=485)	Below 18	207	42.7
	18-24	268	55.3
	24-30	9	1.9
	30-36	1	.2
Respondents Educational Status (n=485)	Illiterate	57	11.7
	No Formal Education	28	5.8
	Primary	318	65.6
	Secondary	47	9.7
	Graduate	8	1.6
	High Secondary	27	5.6
Age of Respondent's Husband (n=485)	Below 18	3	.6
	18-28	116	23.9
	28-38	235	48.5
	38-48	109	22.5
	48-58	19	3.9
	58 and Above	3	.6
Educational Status Respondent's Husbands (n=485)	Illiterate	73	15.0
	No Formal Education	101	20.8
	Primary	256	52.8
	Secondary	23	4.7
	Graduate	13	2.7
	High Secondary	19	3.9
Main Occupation of the Respondents Husbands (n=485)	Agriculture in Own Land	34	7.0
	Agriculture in Rented Land (Borga)	22	4.5
	Day Laborer/Unskilled Laborer (Household, Farming, Etc.)	167	34.4
	Skilled Laborer (Long Term Employee/ Carpenter/ Mason/Fisherman/Boatman/ Handicraft)	86	17.7
	Own Small Business/Entrepreneurship	82	16.9
	Service Holders	40	8.2
	Do not Know	1	.2
	Others (Driver, CNG Driver, etc.)	53	10.9
Household Head Status (n=485)	Husband	345	71.1
	Father-in-Law	55	11.3
	Respondent Herself	9	1.9
	Mother-in-Law	51	10.5
	Others (Brother, Mother, Father, Brother-in-law, etc.)	25	5.2
Age group of the	18-28	2	.4

Indicators	Variables	Frequency	Percentage
Household head (Other than husband) (n=485)	28-38	3	.6
	38-48	23	4.7
	48-58	23	4.7
	58-68	50	10.3
	68-78	21	4.3
	78 and Above	9	1.9
Type of Toilet Use in the Respondents' Households (n=485)	Sanitary/Pucca/Pit Toilet (Waterproof)	100	20.6
	Pucca/Pit Toilet (Not Waterproof)	214	44.1
	Kutch Toilet	151	31.1
	Open Field	20	4.1
Total Amount of Land of the Households Including Homestead of the Respondents (n=485)	No Land	32	6.6
	Less than 20 decimals	288	59.4
	20-40 decimals	47	9.7
	40-60 decimals	24	4.9
	60-80 decimals	17	3.5
	80-100	26	5.4
	100 and Above	51	10.5
Annual Expenditure on Household (in BDT.) (n=485)	Below 5000	27	5.6
	5000-10000	221	45.6
	10000-20000	200	41.2
	20000-30000	23	4.7
	30000 and Above	14	2.9
Annual Expenditure on Health (in BDT) (n=485)	Below 5000	449	92.6
	5000-10000	27	5.6
	10000-20000	8	1.6
	20000-30000	1	.2
Nearest Health Centre/Hospital (n=485)	Mother and Child Welfare Centre	8	1.6
	Upazila Health Complex	83	17.1
	Union Health & Family Welfare Centre/Sub-center/RD	179	36.9
	Community Clinic	166	34.2
	Satellite Clinic/EPI Outreach Centre	23	4.7
	NGO Health Centre	1	.2
	Private Hospital/Clinic	6	1.2
	Doctor's Chamber	9	1.9
	Others (Pharmacy)	10	2.1
Distance of the Nearest Health Centre/Hospital from Respondent's Home (n=485)	Less Than 1 Km	199	41.0
	1 Km	118	24.3
	2 Km	68	14.0
	3 Km	36	7.4
	4 Km	26	5.4
	More Than 4 Km	38	7.8
Religion of the Respondents (n=485)	Islam	472	97.3
	Hinduism	13	2.7

Table 14: Profile of the respondents

Indicators	Variables	Frequency (n)	Percentage
Age group of the respondents (n=470)	Below 18	11	2.3
	18-28	168	35.7
	28-38	210	44.7
	38 and above	81	17.2
Schooling of the respondents (n=470)	Attended School	310	66.0
	Attended Madrasa	20	4.3
	Studied both in school & madrasa	3	.6
	No schooling	137	29.2
Educational Status (n=470)	Illiterate	87	18.5
	No Formal Education	67	14.3
	Primary	264	56.2
	Secondary	44	9.4
	Graduate	1	.2
	Others (HSC)	7	1.5
Occupation of the respondents (n=470)	Housewife	460	97.9
	Day laborer/unskilled laborer (household, farming, etc.)	2	.4
	Own small business/Entrepreneurship	2	.4
	Service Holders	5	1.1
	Others (Driver,	1	.2
Educational status of the respondents' Husbands (n=470)	Illiterate	124	26.4
	No Formal Education	87	18.5
	Primary	209	44.5
	Secondary	39	8.3
	HSC	5	1.1
	Graduate	6	1.3
Respondent's husband's occupation (Multiple Response, n=470)	Day laborer/unskilled laborer (household, farming, etc.)	140	29.8
	Own small business/Entrepreneurship	94	20
	Skilled laborer (long term employee/carpenter/mason/fisherman/boatman/ Handicraft)	91	19.4
	Agriculture in own land	65	13.8
	Agriculture in rented land (Borga)	36	7.7
	Service Holders	36	7.7
	Others	32	6.8
Respondents Religious Believe (n=470)	Islam	458	97.4
	Hinduism	12	2.6
Monthly household expenditure of the respondent (n=470)	Below 10000	259	55.1
	10000-20000	175	37.2
	20000-30000	30	6.4
	30000 and Above	6	1.2
Monthly household expenditure on health of the	Below 5000	451	96.0
	5000-10000	14	3.0
	10000-15000	3	.6
	15000 and Above	2	.4

Indicators	Variables	Frequency (n)	Percentage
respondent (n=470)			
Household food Shortage in any point of time in last 2 years (n=470)	Yes	252	53.6
	No	218	46.4
Nearest Health Facility (Multiple response, n=470)	District level facilities	9	1.9
	Upazila Health Complex	88	18.7
	Union Health & Family Welfare Centre/Sub, Centre/RD	222	47.2
	Community Clinic	153	32.6
	NGO Health Centre	3	0.6
	Private Hospital/Clinic/chamber	36	7.7
	Pharmacy	42	8.9
	Others	6	1.3
Distance of the nearest health center/hospital from	Less than 1 km	180	38.3
	1 km-2 km	198	42.1
	3 km-4 km	61	13
	More than 4 km	31	6.6

Table 15: Information about ANC, Delivery, PNC, FP & Other Issues

Indicators	Variables	Frequency (n)	Percentage
Number of Children	≤2	271	55.9
	2-4	120	24.8
	≥5-Times	94	19.3
Birth Place of the Last Child of the Respondent (n=485)	Home	238	49.1
	Facility	247	50.9
For home Birth: Who conducted the delivery	SBA	32	13.6
	TBA/Dai	140	58.83
	Relatives	23	9.66
	Mother/Aunty/ Grandmother	34	14.29
	Others (Neighbor/Own delivery)	9	3.8

Table 16: Information about ANC

Indicators	Variables	Frequency (n)	Percentage
Respondent's ANC Service Receiving Status During Last Pregnancy	Yes	366	75.5
	No	119	24.5
Number of ANC n=366	at least 1	78	21.0
	2-3	160	44.0
	≥4	128	35.0
Where/to whom did	Medical College Hospital	13	3.5

Indicators	Variables	Frequency (n)	Percentage
Respondents received ANC (MRQ)	District Sadar Hospital	11	3.0
	Mother and Child Welfare Centre	6	1.6
	Upazila Health Complex	53	14.4
	Union Health & Family Welfare Centre/Sub, Centre/RD	136	37.0
	Community Clinic	44	12.0
	Satellite Clinic/EPI Centre	14	3.8
	NGO Health Centre	4	1.1
	NGO Clinics/Hospitals	15	4.1
	Private Hospital/Clinic	141	38.3
	Doctor's Chamber	64	17.4
	Others	2	0.5
Provider of ANC Services (MRQ)	CSBA/CHCP	38	10.3
	PCSBA//Paramedics/Private	20	5.4
	Nurse/FWV	131	35.6
	Doctor/MBBS	272	73.9
	Polli Doctor	6	1.6
	NGO worker	11	3.0
	Don't Know	2	0.5
	Others	3	0.8
Tests done during ANC n=? (MRQ)	Weight Monitoring	312	84.8
	BP Checking	284	77.2
	Blood Grouping	179	48.6
	Routine Urine Test	274	74.5
	Ultrasonogram	258	70.1
	Per abdominal Examination	198	53.8
	Others	5	1.4
Home-visit by field worker (FWA, HA) n=485	Yes	114	23.5
	No	371	76.5
Number of visits by field worker=114	1-Time	43	8.9
	2-Times	35	7.2
	≥3-Times	36	7.3
Advice to take ANC or importance of ANC n=485	Yes	280	57.7
	No	205	42.3
Health Education sessions attended by the respondents n=? n=485	Yes	62	12.8
	No	423	87.2
TT Injection Received During Last Pregnancy n=485	Yes	162	33.4
	No	323	66.6
From where they get TT vaccine n=162	District level public hospital	6	39.51
	Upazila Health Complex	7	.32
	Union Health & Family Welfare Centre/Sub Centre/RD	25	15.43
	Community Clinic	18	11.11
	Satellite Clinic/EPI Centre	100	61.73
	NGO & Private Clinics/Hospitals	2	1.23
	Other (home, pharmacy)	4	3
Have you seen any	Yes	97	20.0

Indicators	Variables	Frequency (n)	Percentage
breastfeeding corner at UH&FWC? n=485	No	388	80.0
Have you used breastfeeding corner at UH&FWC? n=97	Yes	43	8.9
	No	54	11.1

Table 17: Information about PNC Services

Indicators	Variables	Frequency (n)	Percentage
Distribution of Respondents by PNC Received at the facilities	No PNC Received	13	5.26
	PNC Received within 24 Hours	156	63.16
	PNC Received after 24 Hours	78	31.58
Distribution respondents by counseling on Family Planning (n=255)	Yes	129	50.6
	No	126	49.4
Have you received or accepted any method of FP(n=255)	Yes	152	59.6
	No	103	40.4
How was the behavior of the service provider? (n=255)	Very Good	54	21.2
	Good	151	59.2
	Average	38	14.9
	Below Average	5	2.0
	Poor	7	2.7
How was the overall quality of service?	Very Good	43	16.9
	Good	161	63.1
	Average	39	15.3
	Below Average	7	2.7
	Poor	5	2.0
Did your child receive any sort of PNC checkup within 24 hours of delivery?	Yes	194	75.2
	No	64	24.8
Did you receive any sort of PNC checkup within 24 hours of delivery?	Yes	171	66.3
	No	87	33.7
In case of Home Delivery did your child receive any PNC checkup within 24 hours?	Yes	19	8.2
	No	212	91.8
In case of Home Delivery did you receive any PNC checkup within 24 hours?	Yes	13	5.6
	No	218	94.4

Table 18: Information about COVID-19

Indicators	Frequency	Percentage
Have not heard anything	2	0.4%
Have to wash hand	459	97.7%
Have to wear mask	444	94.5%
Have to maintain social distance	246	52.3%
Others (Stay Home, Eat Health Food, Keep Clean, etc.)	14	3.0%

Table 19: The percentage of women who are currently using different modern contraceptive methods.

Indicator	Variable	Frequency (n)	Percentage
Knowledge about family planning method	Yes	470	100
	No	0	00
Source of Information on Family planning Methods (MRQ)	Medical College Hospital	6	1.3
	District Sadar Hospital	5	1.1
	Mother and Child Welfare Centre	5	1.1
	Upazila Health Complex	83	17.7
	Union Health & Family Welfare Centre/Sub, Centre/RD	186	39.6
	Community Clinic	110	23.4
	Satellite Clinic/EPI Centre	100	21.3
	NGO Clinics/Hospitals	14	3
	Private Hospital/Clinic	29	6.2
	Doctor's Chamber	64	13.6
	Print and Electronic Media	2	0.4
	Social Media	29	6.2
	Family/Friend/Relative	252	53.6
	Others (Pharmacy, TV, Reading Book, Family Health Assistant)	25	5.3
Using any contraceptives method n=470	Yes	389	82.8
	No	81	17.2

Table 20: Status of infrastructural facility in the surveyed UHC and UH&FWC

Indicators	Present	Absent
Boundary Wall (all around)	UHC- 2 (UHC of Balaganj and Jaintapur) UH&FWC – 7 (UH&FWC of Balaganj (purbo gouripur); Balaganj(Boaljur), Companiganj (Islampur), Companiganj (Telikhal), Golapganj (Budhbari Bazar), Golapganj (Bagha), Golapganj (Bhadeshwar)	UH&FWC - 4 (UH&FWC of Rustampur (Goainghat), Doubari (Goainghat), Darbost, (Jaintapur), Jaintapur (charikata)
Generator	UHC -2 (Balaganj and Jaintapur) UH&FWC- 3 Companiganj (Islampur), Golapganj (Budhbari Bazar), Golapganj (Bhadeshwar)	UH&FWC- 8 Rustampur (Goainghat), Doubari (Goainghat), Darbost, (Jaintapur), Jaintapur (charikata), Balaganj(purbo gouripur), Balaganj(Boaljur), Companiganj (Telikhal), Golapganj (Bagha)
Hygiene and Cleanliness in the toilet	UHC-2 UH&FWC- 11	

and overall health center		
Delivery room	UHC-2 UH&FWC-11	
Adjacent staff quarters	UHC – 2 UH&FWC -11	
SACMO and FWV's room	UHC-2 UH&FWC-11	

Table 21: Performance of the UH&FWCS the Month before the Survey

Name of FWC	Child Care	Adolescent	General patient	Oral pill	Condom	Injectable	ANC	Delivery conducted	PNC	MR done	Referred cases
Bhaga	710	105	271	55	30	29	241	31	76	0	2
Bhadeswar	22	47	192	15		14	200	24	70	0	
Budhbari Bazar	22	30	248	20		15	125	20	50	0	
Doubari	650	50	500	40		45	142	22	19	0	
Rustampur	100	30	250	40		0	80	10	60		
Islampur	50	30	150	20		13	110	0	30	0	
Telikhal	47	24	148	18		12	107	5	13		
Darbasto	211	0	0	83		29	287	81	87		
Charikata				74		24	297	82	79		
Purba Gouripur	57	55	100	52		27	138	24	47		
Boaljur	101	105	100	9		11	169	25	49		
Jaintapur UHC	643	132	900	228		77	981		237	27	
Balaganj UHC	827	343	1272	321		141	1048		346	35	

Table 22: Comparison between Baseline (July 2018) and Endline (October 2020) Survey Data of Mamota Project

Variable/Indicator	Baseline (2018)	End line (2020)
Survey Method		
Area of study	8 unions of Golapganj & Balaganj Upazila of Sylhet	11unions of Golapganj, Balaganj, Jaintapur, Companiganj and Gowainghat upazila of Sylhet

Study Design	Mixed (Quantitative & Qualitative) Interview, Checklist FGD, KII/IDI & case study	Mixed (Quantitative & Qualitative) Interview, Checklist FGD, KII/IDI & case study
Sample size	385 women of reproductive age having children less than 1 year 384 women of reproductive age who were not pregnant and had not given birth in 1 year	485 women of reproductive who given birth a child in 2 years of survey 470 women of reproductive age who were not pregnant and not given birth in 2 years of survey;
Survey Instrument	Semi structured questionnaires, checklist, guideline	semi structured questionnaires, checklist, guideline
Method	Multistage clustering	Multistage clustering
Demographic Indicator		
Age of the respondents	70% belongs to 20-29 years & 69% belongs to 20-34 years;	69.5% & 35.7% belongs to18-28 years
Education	30% completed Secondary level education	65.6% & 56.2% primary, 9.7% & 9.4% completed secondary
Occupation	all housewives& 97% housewives	all & 97.9% housewives
Socioeconomic status	20% households' monthly expenditure ≤10,000 47% food in secured	51.2% & 55.1% households' monthly expenditure ≤10,000
Household ≤1km from Health Center	43.1% &39.6%	65.3% & 63.2%
Illiteracy of Husband	20.8% & 25.5% in two groups	15% & & 26.4%

Table 23: The respondent list of the IDIs

Type of Respondent	Sample Size
Medical Officer	2
AUFPO	1
Family Welfare Visitor (FWV)	2
Paramedics	1
Sub-Assistant Community Medical Officer (SACMO)	1
Family Welfare Assistant (FWA)	3
Technical Officer (FIVDB)	2
FPI	2
National Level Actors	
Divisional Director, Sylhet	1
Director, FIVDB	1
Director, MCH Services	1
Deputy Director, MCH services	1

Table 24: The respondent types of the FGDs

Type of Respondent	Number of FGDs	Location of the FGDs
Frontline Health Workers, (Such as, Family Welfare Assistant Health Assistant, Family Planning Inspector and CHCP) Paramedics, Family Welfare Visitor, and Sub-assistant Community Medical Officer	5	Bagha union of Golapganj, Doubari union of Golapganj, Boaljur union of Balaganj, Darbaste union of Jaintapur, and Telikhal union of Companiganj
Female Group (All were housewife, age range 18-60, average age 34, education level primary to SSC)	3	Darbaste union of Jaintapur, Rustompurunion of Gowainghat and Boaljur union of Balaganj
Married Male Group (Farmers, businessmen, day laborer, Driver, private job holder, age range 20-40 years, average 31 years)	2	Charikata union of Jaintapur and Companiganj UHC
Community Group (UP Chairman, UP Members, Teachers, Retired Govt. Officer, Businessmen)	1	Bhadeshwar union of Golapganj
Adolescent group (Current student and few drop out students from school, age range 12-19)	4	Darbaste union of Jaintapur, Rustompur union of Gowainghat, Bagha union of Golapganj and Telikhal union of Companiganj

ANNEX 3: VOICES FROM THE FIELD

The study team has conducted a total of four (04) case studies with five types of primary beneficiaries. The types of the beneficiary are given below:

- Woman receiving ANC from the UH&FWC
- Woman receiving contraceptives from the UH&FWC
- Woman delivered at the UH&FWC
- Woman referred from the UH&FWC to higher facility

Case-Study: 1 (A Woman received delivery care from UH&FWC)

Mitu, a 22-year-old woman came to Bagha UH&FWC of Golapganj Upazila of Sylhet district for her first post-natal visit. She delivered a baby boy, her first, in Bagha UH&FWC 2 weeks back.

"Though my labour pain started from night, I came here early in the morning as I wanted to wait till daylight arrived" she said. She was brought to the center with a CNG of her husband's friend and was accompanied by her husband and mother-in-law.

"I was received by the paramedic apa as she lives in the staffs' quarter of the center". Mitu had been married for 9 months. Her husband worked in the Middle East and came to the country for marriage but had been unable to return due to the COVID-19 pandemic. She became pregnant soon after marriage and received antenatal care (ANC) from Bagha UH&FWC. This included 4 ANC visits along with a dose of Tetanus Toxoid vaccine (as she had already received the first three doses).

Mitu lives with her in-law's family in a village close to the center. It takes her approximately a 20-minute drive via CNG to get to the center. She had told us that her family members and husband have all been very helpful to her.

"The paramedic apa told me not to lift any heavy objects during my pregnancy. She also told me to eat healthy and take rest during the day" said Mitu who first visited this UH&FWC at 12 weeks of amenorrhea with excessive vomiting. *"FWV apa tested my urine sample and detected pregnancy. She also measured my blood pressure, weight and height"*, she said. Her pregnancy period was relatively uneventful. Furthermore, every time she visited UH&FWC for ANC, she had been accompanied by her husband.

She delivered a full-term baby boy on October 13, 2020 by normal vaginal delivery with episiotomy. *"From the moment I was brought to UH&FWC till discharge, the paramedic apa was always beside me,"* she said. *A saline (medical induction of labour) was given to my "shira" and within one hour of admission, I gave birth to my baby"*, she added. She was taken to the post-natal room just after delivery and was asked to feed the baby colostrum. Born at a weight of 3kg, she gave birth to a healthy baby, who was crying immediately after birth. They returned home one hour after the delivery as her mother-in-law wanted to show her grandson to the rest of the family and neighbors.

"Why did you come today?" I asked her to and she replied: *"for post-natal care; I am very much satisfied with UH&FWC's services; I will use services from this center if I need to in the future."* She was told to exclusively breastfeed her child till 6 months and was also made aware of post-partum contraception.

Case-Study: 2 (A woman receiving Family Planning Services)

23-year-old woman, named Hasina had been married for 3 years. She has two daughters; the second baby was born at UH&FWC just a month and three days before. Her second postpartum visit to the center, this time however, to be put on the progesterone only pill. A trip to UH&FWC from her home typically takes 5-10 minutes via CNG but today Hasina walked her way to the center for 30 minutes, accompanied by one of her brother-in-laws and his wife. She lives with her husband, who is a tailor and her in-laws comprising of her mother-in-law, her three brother-in-laws and their wives.

Having conceived two months after her marriage, Hasina was told about the progesterone only pill after her first daughter was born. She would then have her second daughter less than 15 months after the first. She had previously not taken contraceptives and when asked why, said that she did not have her husband's approval before as he wanted a second child. The couple had, however, now decided that they would like to wait before having a third child and this time, she had her husband's permission in taking pill, which she had been told to take for 6 months. Hasina did not need permission from her in-laws to go on the pill and they were also content with her having only daughters till now. When asked if they were supportive to her regarding all matters, she said they were. Her husband, however, wants another child, preferably a son 3-4 years later.

"Do you come to this centre often?" I asked her.
"Yes"
"And do you like it?"
"Yes"
"Why?"
"The treatment is good and so are the doctors and their behavior", was Hasina's response. She was also content that she never had to wait too long whenever she came to the center. Hasina was also briefed on the benefits and possible side effects of going on the progesterone only pill.

'Are you scared or anxious of taking the pill?' I asked her as a final question. She calmly replied *"No"*. People are often scared of what they do not understand but it had been clear that Hasina was well-informed about her birth control.

Case-Study: 3 (A woman referred for hospital delivery)

Kawla Begum (21) had been married for 9 months. Her husband is a teacher and Kawla is a mother of one child. Kawla is expecting her second child this year and is 6 months pregnant now. She has visited the UH&FWC of Goainghat upazila of Sylhet twice for antenatal checkup during her second pregnancy.

Kawla also used to take antenatal care from Goainghat UH&FWC during her first pregnancy. The first phase of her pregnancy was quite uneventful. Until the nine months of her first pregnancy, she had no complications, except for some common pregnancy related health problems (vomiting, headache, backpain, etc.).

However, while giving birth to her first child, Kawla faced some complications. While sharing her experience of giving birth to her first child, Kawla said, *"I became scared and nervous when my delivery date was over and still did not feel any signs of labor pain. I immediately went to the UH&FWC early in the morning because I did not want to take any risk by staying at home"*

She was taken with a CNG to the Goainghat UH&FWC that was 1 km away from her home and was accompanied by her husband and family members. From the moment she was brought to UH&FWC the paramedic apa and other staffs were there for Kawla to help her during her delivery. A saline (medical induction of labour) and some tablets for inducing labour pain was given to Kawla.

"Paramedic apa waited for next seven hours after injecting the saline, but I felt no labour pain at all. After seven hours, in the evening my vomiting started and I was not feeling well", she said. Kawla was then sent to Sylhet M.A.G. Osmani Medical College & Hospital for better management of her delivery after getting referred by the paramedic of the Goainghat FWC. Kawla, however, reported that the environment of the Hospital was not very satisfactory and then she was moved to Ragib Medical College & Hospital. There she was again given saline to induce labour pain. *"By the grace of Almighty, after 2-3 hours of injecting the saline, my labour pain started and I gave birth to my baby",* Kawla said. She delivered a full-term baby by normal vaginal delivery with episiotomy.

Although Kawla had to face some hassle at the very last moment of her delivery and eventually had to give birth to her child at the hospital, she still said that, the paramedic had tried her best to perform her normal delivery and had referred her to the hospital at the right time before any accident occurred. Kawla is very pleased with Doubari (Goainghat) UH&FWC services and

Case-Study: 4 (A women receiving ANC from UH&FWC)

A 35-year-old married woman named Hosna Begum came to Boaljoor UH&FWC of Balaganj upazila in Sylhet district for her fourth (4TH) ANC l visit. Hosna is now experiencing her nine months pregnancy journey and will soon be the mother of her fourth child.

Hosna is about to deliver her fourth child after an eight-year break from giving birth to her third child. She said she lost her first child due to an accident who was18-month-old during the time of death. Later on, she conceived her second child, who is now 10 years old, and her third child is 8 years old now. Without the presence of a skilled birth attendant (SBA), Hosna gave birth to all of her three children by normal vaginal delivery at home. However, her mother-in-law opposed the idea of giving birth to Hosna's fourth child at the UH&FWC this time in the first place, as she wanted Hosna to give birth to her fourth child at home like her previous children. But Hosna was recommended by the paramedic apa of the UH&FWC to take antenatal check up from the UH&FWC due to her high blood pressure as her family members would not be able to monitor and regulate her blood pressure at home during her pregnancy period.

On the date of interview, Hosna completed her fourth visit to UH&FWC for her antenatal checkup. When she was five months pregnant, she first visited UH&FWC.

"On my first visit to the UH&FWC, this time, I came with my husband and mother-in-law. Here, FWV apa checked a sample of my blood and urine. She also checked my blood pressure, weight and height."

At her first ANC visit for 4th pregnancy to the UH&FWC, Hosna was given calcium and iron supplements and was advised by the paramedic apa not to lift any heavy items during pregnancy period. During her pregnancy, she was also advised to eat nutritious food and take rest. A health card was also issued for Hosna at her first visit to the UH&FWC which included 4 ANC visits along with required vaccinations during pregnancy. Hosna said, she was pleased with the behavior and treatment of the paramedic as the paramedic shared her contact number with Hosna to contact in case of any emergency, if arise.

Taking permission from her husband and mother-in-law, Hosna visited the UH&FWC for the second time along with her brother-in-law's wife when she was on her 7th months of pregnancy. Her third visit took place during her 9th month of pregnancy. Hosna's pregnancy period was relatively uneventful. Furthermore, every time she visited UH&FWC for ANC, she had been accompanied by her husband/family members.

While asking about Hosna's experience of her current pregnancy journey, she said that her in-law's family members and her husband have all been very helpful to her during this journey. They didn't let her do any heavy works or take any stress. Her brother-in-law's wife was the one who supported and cared for her the most.

When Hosna was asked why she had decided to take services from this UH&FWC, she replied that, her family members and husband were quite concerned about her high blood pressure and heard about the facilities and good treatment of the UH&FWC over here. Moreover, commuting to this UH&FWC is quite hassle free for her. A trip to UH&FWC from her home typically takes 30 minutes via CNG. Moreover, she was also was content with the fact that the treatment was free of cost.

"I am very satisfied with the services of UH&FWC and the behavior of the paramedic apa; if I need to, I will use services from this center in the near future."